THE OHIO DEPARTMENT OF MEDICAID
OHIO RESILIENCE THROUGH INTEGRATED SYSTEMS AND EXCELLENCE (OhioRISE)
PLAN PROVIDER AGREEMENT

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INTRODUCTION

1. Ohio Department of Medicaid Mission and Goals

a. The Ohio Department of Medicaid's (ODM's) mission is to improve the health outcomes of the individuals we serve. Accordingly, ODM has designed the Next Generation Ohio Medicaid managed care program to achieve the following goals:

   i. Focus on the individual;

   ii. Improve individual and population wellness and health outcomes;

   iii. Create a personalized care experience;

   iv. Support providers in continuously improving care;

   v. Improve care for children and adults with complex needs; and

   vi. Increase program transparency and accountability.

b. The Ohio Resilience through Integrated Systems and Excellence (OhioRISE) vendor must perform its responsibilities and deliver services under this Agreement in a manner consistent with achieving these goals.

2. Next Generation Ohio Medicaid Managed Care Program

a. ODM envisions a Medicaid managed care program where ODM, the OhioRISE Plan, the MCOs, and the single pharmacy benefit manager (SPBM) coordinate and collaborate to achieve health care excellence through a seamless service delivery system for members, providers, and system partners.

b. The Next Generation Ohio Medicaid Managed Care Program consists of the following three types of managed care entities that, under ODM's leadership, must collaborate closely to meet program goals:

   i. The OhioRISE Plan is a single, statewide prepaid inpatient health plan responsible for providing, managing, and coordinating behavioral health care for children eligible for the OhioRISE Program. The OhioRISE Program is designed to provide comprehensive and highly coordinated behavioral health services for children with serious/complex behavioral health needs involved in, or at risk for involvement in, multiple child-serving systems; and

   ii. MCOs are responsible for providing, managing, and coordinating:

      1. All covered services for adult members;

      2. Physical health services for child members; and

      3. Behavioral health services for child members not enrolled in the OhioRISE Plan.

   iii. A statewide SPBM is responsible for providing and managing pharmacy benefits for all individuals.

c. To reduce provider burden and promote consistency across the Ohio Medicaid managed care program, ODM has retained the administrative responsibilities for centralized claims submissions, provider enrollment, and for credentialing and re-credentialing.

   i. ODM's OMES serves as a single clearinghouse for all medical (non-pharmacy) claims. All medical claims will be submitted to ODM's OMES, ODM's electronic data interchange (EDI) vendor will apply specified Strategic National Implementation Process (SNIP) level edits, and ODM's OMES will send the claim to the OhioRISE Plan for claims processing and payment.

   ii. ODM's OMES serves as the single, centralized location for provider submissions of prior authorization requests for all medical (non-pharmacy) services. The OMES streamlines the prior authorization process and reduce provider burden by systemically standardizing prior authorization forms and the necessary clinical documentation to support the request.

   iii. ODM has adopted a centralized credentialing approach, creating efficiencies through a system-level consolidation of provider screening, enrollment, and credentialing activities. Providers will submit an application for Medicaid enrollment and credentialing materials using a single, electronic application. This streamlined process will eliminate the need for providers to submit credentialing and re-credentialing materials to the OhioRISE Plan and multiple MCOs. ODM's provider network management (PNM) system is the State's system of record for Medicaid provider data.

3. **Population Health Approach**

a. ODM seeks to advance ODM's population health approach through the Ohio Medicaid managed care program, including the OhioRISE program. ODM's population health approach requires the OhioRISE Plan to use the following population health management principles to achieve optimal outcomes for the holistic well-being of all populations it serves:

   i. Using data and scientific principles to proactively identify and strategically address member needs;

   ii. Implementing the support structure (e.g., leadership, staffing, information systems) necessary to support population health strategies; and

   iii. Strategically employing approaches and evaluating those approaches to further inform and refine the population health management approach.

b. The OhioRISE Plan's population health approach must include the following strategies:

   i. Keeping individuals and their families at the center of all efforts to identify and meet population needs. This includes:

      1. Removing barriers to care through supporting alternative sites and providers of care (school-based, telehealth, community-based providers) and simplifying/streamlining interactions with the OhioRISE Plan from the perspectives of both the member and the provider;

2. Optimizing coordination and collaboration across the system through a systematic and systemic use of information to ensure consistency in coverage and tailored approaches to meeting member needs; and

3. Connecting with communities, including having a physical presence in the communities where OhioRISE Plan members live.

ii. Ensuring all policies, practices, and operations consider population-specific perspectives and needs; and

iii. Recognizing the significance of behavioral health needs to overall health and wellbeing, and, emphasizing a strengths-based approach to behavioral health, while strongly collaborating with ODM-contracted MCOs, the SPBM, community partners, and providers to fully integrate physical and behavioral health care.

c. The OhioRISE Plan must demonstrate congruence with these principles and strategies in all aspects of OhioRISE Plan performance under this Agreement, including executing OhioRISE Plan responsibilities, coordinating with ODM-contracted MCOs and the SPBM, collaborating with community stakeholders, supporting providers, and delivering services to members.

4. The OhioRISE Program

a. As part of the Governor's overarching goal to improve care for children and adults with complex needs, Ohio is designing a reimagined Medicaid system and structure to serve multi-system youth and other children with complex behavioral health needs. Ohio's approach to achieve this goal is through implementation of the OhioRISE Program. OhioRISE will facilitate ODM and other state child serving agency goals by:

i. Creating a seamless delivery system for children, families, and system partners;

ii. Providing a "locus of accountability" by offering intensive care coordination; and

iii. Expanding access to critical services needed for this population and assisting families, state and local child serving agencies, and other health providers to locate and use necessary services.

b. The OhioRISE Program has been jointly developed by ODM, the Governor’s Office of Children’s Initiatives, and other state child serving agencies. This multi-agency partnership will be responsible for the shared governance of the OhioRISE Program. The OhioRISE Plan will have a contractual relationship with ODM. This approach reflects the OhioRISE target population that includes children and youth with serious or complex behavioral health needs who are at risk of involvement or are involved in multiple child-serving systems. These child serving systems include the Department of Developmental Disabilities (DODD), Ohio Department of Education (ODE), Ohio Department of Health (ODH), Ohio Department of Job and Family Services (ODJFS), Ohio Department of Mental Health and Addiction Services (OMHAS), Ohio Department of Rehabilitation and Correction (ODRC), Ohio Department of Youth Services (DYS), and Ohio Family and Children First (OFCF).

c. The OhioRISE Program will use intensive and moderate care coordination, through the creation of local care management entities (CMEs) to improve the timeliness and appropriateness of

service delivery to its members. Through the use of enhanced care coordination offered by the CMEs, the OhioRISE Program seeks to:

i. Reduce unnecessary hospitalizations and emergency room visits;

ii. Decrease involvement with the juvenile justice and corrections systems;

iii. Reduce out-of-home and out-of-state placements (residential care and foster care);

iv. Increase school attendance and performance; and

v. Reduce custody relinquishment for children, youth, and families.

d. The OhioRISE Plan will be responsible for ensuring the care coordination efforts support rather than supplant other child-serving systems case managers and providers, including County Boards of Developmental Disability, Regional Department of Youth Services, Public Child Serving Agencies, Family and Children First Councils, and providers certified by the Ohio Department of Mental Health and Addiction Services;

e. The OhioRISE Program will include new Medicaid services for its members. In addition to Intensive Care Coordination, the OhioRISE Program will develop new or enhance existing services, such as:

i. Mobile Response and Stabilization Services (MRSS);

ii. Intensive Home-Based Treatment, including evidenced based practices such as Multi-systemic Therapy and Functional Family Therapy;

iii. In-state Psychiatric Residential Treatment Facilities (PRTF) to reduce the need for out-of-state placement; and

iv. Respite Services.

f. In addition to these new services, the OhioRISE Program will include or enhance existing Medicaid services for its members including:

i. Outpatient mental health and substance use disorder (SUD) services;

ii. SUD Residential services; and

iii. Inpatient mental health and SUD services.

5. OhioRISE Service Area

a. Under this Agreement, the OhioRISE vendor is responsible for providing covered services (see Appendix B, Coverage and Services) to all members statewide.

DEFINITIONS AND ACRONYMS

1. **General**

    a. Listed below are definitions of terms and acronyms used in this Agreement. Terms are consistent with federal and state requirements and must be construed and interpreted as follows for this Agreement.

2. **Definitions**

1915(c) Waiver – Carries the same meaning as described in 42 U.S.C. 1396 et seq.

Abuse – As defined in OAC rule 5160-26-01, provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary, or that fail to meet professionally recognized standards for health care. Abuse also includes member practices that result in unnecessary cost to the Medicaid program.

Abuse (of a Member) – The injury, confinement, control, intimidation, or punishment of a member by another person that has resulted, or could reasonably be expected to result, in physical harm, pain, fear, or mental anguish. Abuse includes but is not limited to physical, emotional, verbal, and/or sexual abuse, and use of restraint, seclusion, or restrictive intervention that results in, or could reasonably be expected to result, in physical harm, pain, fear, or mental anguish to the member.

Acquisition – Transaction in which one company acquires controlling interest of all of another targeted company's assets, capital, or stock.

Actuary – As defined in 42 CFR 438.2, an individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board.

Adverse Benefit Determination – As defined in OAC rule 5160-26-08.4, the OhioRISE Plan's:

a. Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
b. Reduction, suspension, or termination of services prior to the member receiving the services previously authorized by the OhioRISE Plan;
c. Denial, in whole or part, of payment for a service (a denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a “clean claim” is not an adverse benefit determination);
d. Failure to provide services in a timely manner as specified in OAC rule 5160-59-03.1;
e. Failure to act within the resolution timeframes specified in this rule; or
f. Denial of a member's request to dispute a financial liability, including cost sharing, co-payments, premiums, deductibles, coinsurance, and other member financial liabilities, if applicable.

Appeal – As defined in OAC rule 5160-26-08.4, a member's request for the OhioRISE Plan's review of an adverse benefit determination.

Artificial Intelligence (AI) – As defined by the National Institute of Standards and Technology, Trustworthy and Responsible AI Resource Center, Artificial Intelligence is a machine-based system that can, for a given set of objectives, generate outputs such as predictions, recommendations, or decisions influencing real or virtual environments. https://airc.nist.gov/AI_RMF_Knowledge_Base/Glossary.

Authorized Representative – Consistent with OAC rule 5160:1-1-01, a person, who is at least 18 years old, or a legal entity who stands in place of the individual. Actions or failures of an authorized representative will be accepted as the action or failure of the individual. If an individual has designated an authorized representative, all references to "individual" in regard to an individual's responsibilities include the individual's authorized representative.

Billing Guides - Documents created by the OhioRISE Plan that contain specific billing instructions that providers and/or Trading Partners must follow in order to submit all of the required information on a claim and for it to be properly adjudicated. The details may exist in separate documents including provider contracts, core system documentation, or other resources.

Business Associate – Consistent with 45 CFR 160.103, a person or entity that, on behalf of a covered entity, maintains, performs, or assists in the performance of a function or activity that involves the use or disclosure of "Protected Health Information."

Business Day – Monday through Friday, except for state of Ohio holidays.

Calendar Day – All seven days of the week, including state of Ohio holidays.

Care Coordination – A strategy that will be deployed by OhioRISE Program to deliberately organize and support children, youth, and their families by addressing needs to achieve better health outcomes.

Care Coordination Entity (CCE) – An entity (that is not a CME) that provides care coordination to a specific population.

Care Management Entity (CME) – An entity contracted with the OhioRISE Plan that provides behavioral health care coordination to OhioRISE Plan enrolled members within a catchment area. A single CME serves each catchment area.

Catchment Area- Catchment areas are geographically bound parts of the state established for the provision of certain types of services. Twenty Care Management Entity (CME) catchment areas will serve the OhioRISE population across the State of Ohio. CME catchment areas are based on geography and the population expected to enroll in the OhioRISE program.

Certificate of Authority – Document issued by the Ohio Department of Insurance pursuant to ORC section 1751.05 that recognizes the OhioRISE Plan as a Health Insuring Corporation with the powers as articulated in ORC section 1751.06.

Change in Ownership – Any change in the possession of equity in the capital, stock, profits, or voting rights with respect to a business such that there is a change in the persons or entities having the controlling interest of an organization, such as changes that result from a merger or acquisition, or, with respect to non-stock corporations (e.g., non-profit corporations), a change in the members or sponsors of the corporation or in the voting rights of the members or sponsors of the corporation.

Child and Family-Centered Care Plan (CFCP) - The individualized, child-centered, strength-based, and family-focused plan of services and supports developed by the child and family team (CFT), the care management entity (CME), the OhioRISE Plan, or a combination thereof.

Child and Family Team (CFT) - A group of people including the OhioRISE member and their family/caregiver(s), natural supports (relatives, friends, neighbors, etc.), and formal helpers (teachers, therapists, other professionals, etc.) who are involved with the child and family and who play an important role in the child's life.

Claim – A bill from a provider for health care services assigned a unique identifier. A claim does not include an encounter form. A claim can include any of the following: (1) a bill for services; (2) a line item of services; or (3) all services for one member within a bill.

Clean Claim – A claim that can be processed without obtaining additional information from the provider of a service or from a third party. Clean claims do not include payments made to a provider of service or a third party where the timing of the payment is not directly related to submission of a completed claim by the provider of service or third party (e.g., capitation). A clean claim also does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Consumer Contact Record – As defined in OAC rule 5160-26-01, the record containing demographic health-related information provided by an eligible individual, member, or the Ohio Department of Medicaid (ODM) that is used by the Ohio Medicaid consumer hotline to process membership transactions.

Control Charts – A type of statistical process control tool that uses the relationship of observations to the mean and control limits to study how a process changes over time, also known as Shewhart charts.

Covered Entity – A health plan, a health care clearinghouse, or health care provider under 45 CFR 160.103.

Covered Services – As defined in OAC rule 5160-26-01, the medical services set forth in OAC rule 5160-59-03 and 5160-59-05, or a subset of those services.

Cultural Humility – An approach that incorporates a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician-patient dynamic, and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations.

Date of Payment – The date of the check or date of electronic payment transmission.

Date of Receipt – The date the OhioRISE Plan receives the claim, as indicated by its date stamp on the claim.

Downstream Entity – Any party that enters into a written arrangement, acceptable to ODM, with a first tier or related entity or below the level of a first tier or related entity to provide administrative services for Ohio Medicaid-eligible individuals. These arrangements continue down to the level of the ultimate provider of the administrative services.

Electronic Health Record (EHR) – A record in digital format that is a systematic collection of electronic health information. EHRs may contain a range of data, including demographics, medical history,

medication and allergies, immunization status, laboratory test results, radiology images, vital signs, personal statistics such as age and weight, and billing information.

Eligible Individual – Consistent with OAC rule 5160-26-01, any Medicaid recipient who is a legal resident of the state of Ohio and is in one of the categories eligible for OhioRISE Plan enrollment as provided in OAC rule 5160-59-02.

Emergency Medical Condition – As defined in OAC rule 5160-26-01, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Emergency Services – As defined in OAC rule 5160-26-01, covered inpatient services, outpatient services, or medical transportation that are provided by a qualified provider and are needed to evaluate, treat, or stabilize an emergency medical condition.

External Medical Review – The review process conducted by an ODM-identified, independent, external medical review entity that is initiated by a provider that disagrees with the OhioRISE Plan's decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity.

External Quality Review Organization (EQRO) – As defined in 42 CFR 438.320, an organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs EQR, other EQR-related activities as set forth in 42 CFR 438.358, or both.

Family – A child's family or caregiver may include biological, adoptive, or foster parents, as well as extended family or non-biological adults who have a role in the care for and support of a child or youth.

First Tier Entity – Any party that enters into a written arrangement, acceptable to ODM, with the OhioRISE Plan to provide administrative services for Ohio Medicaid-eligible individuals.

Fraud – As defined in OAC rule 5160-26-01, any intentional deception or misrepresentation made by an individual or entity with the knowledge that the deception could result in some unauthorized benefit to the individual, the entity, or some other person. This includes any act that constitutes fraud under federal or state law. Member fraud means the altering of information or documents in order to fraudulently receive unauthorized benefits or to knowingly permit others to use the member's identification card to obtain services or supplies.

Grievance – As defined in OAC rule 5160-26-08.4, a member's expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include but are not limited to the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the OhioRISE Plan to make an authorization decision.

Health Care Effectiveness Data and Information Set (HEDIS) – Set of standardized performance measures developed, supported, and maintained by the National Committee for Quality Assurance (NCQA) designed to allow reliable comparison of health plan performance.

Health Disparity – A particular type of health difference closely linked with social or economic disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health based on characteristics historically linked to discrimination or exclusion (e.g., race or ethnic group; religion; socioeconomic status; gender; age; behavioralhealth; cognitive, sensory, or physical challenges; sexual orientation; or geographic location).

Health Equity – Exists when everyone has a fair opportunity to attain their full health potential and that no one is disadvantaged from achieving this potential.

Health Information Exchange (HIE) – As defined in ORC chapter 3798, any person or governmental entity that provides in this state a technical infrastructure to connect computer systems or other electronic devices used by covered entities to facilitate the secure transmission of health information. Health information exchange excludes health care providers engaged in direct exchange, including direct exchange through the use of a health information service provider.

Health Insuring Corporation – As defined by ORC section 1751.01(H), a corporation, that, pursuant to a policy, contract, certificate, or agreement, pays for, reimburses, or provides, delivers, arranges for, or otherwise makes available, basic health care services, supplemental health care services, or specialty health care services, or a combination of basic health care services and either supplemental health care services or specialty health care services, through either an open panel plan or a closed panel plan.

HealthTrack – Database operated by the Ohio Department of Medicaid that tracks member and provider complaints.

HUB – Network of community-based organizations that hire and train community health workers to reach out to those at greatest risk, identify their risk factors, and assure that they connect to medical, social, and behavioral health services to reduce their risk.

In Lieu of Services – Consistent with the requirements in 42 CFR 438.3(e)(2), services the OhioRISE Plan may cover for members that are in lieu of services covered under the Ohio Medicaid state plan and that ODM determines are medically appropriate and cost-effective substitutes for the covered service under the Ohio Medicaid state plan.

Incident – As defined in OAC 5160-44-05, an alleged, suspected, or actual event that is not consistent with the routine care of, and/or service delivery to a member.

Indian – Any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12.

Individual Crisis and Safety Plan - As defined in OAC 5160-59-01, a plan developed through care coordination and the Child and Family Team (CFT) to determine specific steps to ensure child and family safety and reduce the risk of harm in the home and community. The Individual Crisis and Safety Plan should include individualized, trauma-informed, interventions and de-escalation strategies. The Individual Crisis and Safety Plan encompasses what is also referred to as a behavior support plan, which details when an individual's intensive behavior warrants the use of restraints, seclusion, or restrictive intervention to ensure the safety of the individual and those with whom they interact. For members with behaviors that pose safety concerns for the member or others, the interventions and de-escalation strategies should be designed with the goal of preventing the use of restraints, seclusion, or restrictive interventions.

Inpatient Hospital Services Plan - A limited benefit plan that only pays for inpatient stays of 24 hours or more for individuals who are incarcerated as described in OAC rule 5160:1-1-03.

Limited English Proficiency (LEP) – Eligible individual or member who does not speak English as their primary language and who has a limited ability to read, write, speak, or understand English.

Machine Learning - As defined by the National Institute of Standards and Technology, Trustworthy and Responsible AI Resource Center, Machine Learning is a branch of Artificial Intelligence that focuses on the development of systems capable of learning from data to perform a task without being explicitly programmed to perform that task. Learning refers to the process of optimizing model parameters through computational techniques such that the model's behavior is optimized for the training task. https://airc.nist.gov/AI_RMF_Knowledge_Base/Glossary

Managed Care Entities (MCEs) – Entities that include managed care organizations, the single pharmacy benefit manager, and the OhioRISE Plan.

Managed Care Organization (MCO) – An entity that meets the requirements of 42 CFR 438.2 and is a health insuring corporation (HIC) licensed in the state of Ohio that enters into a managed care provider agreement with ODM.

Medicaid – As defined in OAC rule 5160-26-01, medical assistance as defined in ORC section 5162.01.

Medicaid Contracted Entities – Entities, such as the OhioRISE Plan, MCOs, the single pharmacy benefit manager (SPBM), and the Fiscal Intermediary that are under contract with ODM.

Medicaid Fraud Control Unit (MFCU) – Consistent with OAC rule 5160-26-01, the unit of the Ohio Attorney General's Office responsible for the investigation and prosecution of fraud and related offenses within Medicaid.

Medicaid School Program (MSP) – As defined in Chapter 5160-35 of OAC.

Medically Necessary or Medical Necessity – Has the same meaning as OAC rule 5160-1-01:

a. Medical necessity for individuals covered by early and periodic screening, diagnosis, and treatment (EPSDT) is defined as procedures, items, or services that prevent, diagnose, evaluate, correct, ameliorate, or treat an adverse health condition such as an illness, injury, disease, or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability.
b. Medical necessity for individuals not covered by EPSDT is defined as procedures, items, or services that prevent, diagnose, evaluate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability, and without which the person can be expected to suffer prolonged, increased, or new morbidity; impairment of function; dysfunction of a body organ or part; or significant pain and discomfort.
c. Conditions of medical necessity are met if all the following apply:
    i. Meets generally accepted standards of medical practice;
    ii. Clinically appropriate in its type, frequency, extent, duration, and delivery setting;
    iii. Appropriate to the adverse health condition for which it is provided and is expected to produce the desired outcome;

iv. Is the lowest cost alternative that effectively addresses and treats the medical problem;
v. Provides unique, essential, and appropriate information if it is used for diagnostic purposes; and
vi. Not provided primarily for the economic benefit of the provider nor for the convenience of the provider or anyone else other than the recipient.

d. The fact that a physician, dentist, or other licensed practitioner renders, prescribes, orders, certifies, recommends, approves, or submits a claim for a procedure, item, or service does not, in and of itself, make the procedure, item, or service medically necessary and does not guarantee payment for it.
e. The definition and conditions of medical necessity articulated in this rule apply throughout the entire Medicaid program. More specific criteria regarding the conditions of medical necessity for particular categories of service may be set forth within ODM coverage policies or rules.

Medicare – As defined in OAC rule 5160-26-01, the federally financed medical assistance program defined in 42 USC 1395.

Medication Therapy Management – A process that promotes safe and effective use of medications, including prescription and over-the counter drugs, vitamins, and herbal supplements.

Member – As defined in OAC rule 5160-26-01, a Medicaid eligible individual who has been assigned to the OhioRISE Plan for the purpose of receiving health care services.

Member Materials – Items developed by or on behalf of the OhioRISE Plan to fulfill OhioRISE Plan program requirements or to communicate to all members or a group of members. Member materials include member education, member appreciation, and member incentive program information. Member health education materials produced by a source other than the OhioRISE Plan, and which do not include any reference to the OhioRISE Plan are not considered to be member materials.

Merger – A transaction in which two companies join together to form a single entity, using both companies' assets or stock, or, for non-stock corporations (e.g., non-profit corporations), the conversion of memberships, sponsors, or their voting rights. Both companies cease to exist separately, and new stock is issued for the resulting organization or, for non-stock corporations (e.g., non-profit corporations), memberships or sponsors are combined, or their voting rights are transferred to the new corporation.

Misappropriation – Depriving, defrauding, or otherwise obtaining the money, or real or personal property (including medication) of a member by any means prohibited by law.

Mobile Response and Stabilization Services (MRSS) – As provided in OAC rule 5160-27-13, MRSS is a mobile response stabilization service for youth 20 years of age and under who are experiencing significant behavioral or emotional challenges and their families. The service may be delivered through a face-to-face mobile response to the young person’s home, school, a local emergency department (ED), or another location in the community, including a location preferred by the family.

The purpose of MRSS is to provide rapid community-based crisis assessment and stabilization to young people and their families and to build the skills needed to help maintain young people in their homes and communities whenever safe and possible. In addition to the direct provision of crisis intervention and stabilization services, MRSS providers link young people and their families to ongoing clinical and natural support and services through a facilitated Child and Family Team planning process.

MRSS consists of a series of four phases of services including: triage and initial mobile response; assessment and planning; stabilization; and service transition. MRSS provides young people and their caregivers with short-term, flexible services to assist in stabilizing young people in their community setting. Interventions are designed to maintain the young person in their current living arrangement and to stabilize behavioral health needs to improve functioning in all life domains.

Neglect – When there is a duty to do so, the failure to provide goods, services, and/or treatment necessary to assure the health, safety, and welfare of a member.

Network Provider – Consistent with 42 CFR 438.2, any provider, group of providers, or entity that has a network provider contract with the OhioRISE Plan and receives Medicaid funding directly or indirectly to order, refer, or render covered services as a result of ODM's provider agreement with the OhioRISE Plan. A network provider is not necessarily a subcontractor by virtue of the network provider contract.

Notice of Action – As defined in OAC rule 5160-26-08.4, the written notice the OhioRISE Plan must provide to members when an adverse benefit determination has occurred or will occur.

Oral Interpretation Services – Services provided to an eligible individual or member with limited English proficiency to ensure that the eligible individual or member receives OhioRISE information that is orally translated into their primary language.

ODM Approved Entity – For the purpose of this Agreement, an ODM Approved Entity is for Quality Improvement Training Requirements. Examples include the Institute for Healthcare Improvement, the Intermountain Healthcare Leadership Institute, the Cincinnati Children's Hospital, Anderson Center for Health System Excellence, the NC Center for Public Health Quality, the American Society for Quality's Learning Institute, the Deming Institute, and the National Association for Healthcare Quality.

Ohio Children's Initiative Child and Adolescent Needs and Strengths (CANS) – A multiple purpose information integration tool developed for children's services to support decision-making, including level of care and service planning, facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. CANS is designed to be the output of a functional assessment process. The Brief and Comprehensive CANS assessments are designed to be the output of a functional assessment process.

Pending Member – As defined in OAC rule 5160-26-01, an eligible individual who will be enrolled in the OhioRISE Plan but whose OhioRISE Plan membership is not yet effective.

Performance Improvement Project (PIP) – A type of quality improvement (QI) project in which the OhioRISE Plan works collaboratively with the ODM-contracted clinical lead, QI lead, and recruited practices to improve an outcome. The OhioRISE Plan will conduct one PIP per year in a topic chosen by ODM. PIPs are validated by ODM's contracted EQRO in accordance with 42 CFR 438.330.

Performance Measure – An assessment tool that aggregates data to assess the structure, processes, and outcomes of care within and between entities; typically, specifies a numerator (what/how/when), denominator (who/where/when), and exclusions (not).

Personal Identifiable Information (PII) - Any representation of information that permits the identity of an individual to whom the information applies to be reasonably inferred by either direct or indirect means.

Population Health – The health outcomes of a group of individuals, including the distribution of such outcomes within the group. Within Ohio Medicaid, these groups may be defined by health care service utilization, common diagnoses, physical or behavioral health need, demographic characteristics, geography, or social determinants (e.g., homelessness).

Population Health Management – An approach to maintain and improve physical and psychosocial well-being and address health disparities through cost-effective, person-centered health solutions that address members' health needs in multiple settings at all points along the continuum of care.

Post-Stabilization Care Services – As defined in OAC rule 5160-26-01, covered services related to an emergency medical condition that a treating provider views as medically necessary after an emergency medical condition has been stabilized in order to maintain the stabilized condition, or under the circumstances described in 42 CFR 422.113 to improve or resolve the member's condition.

Prepaid Inpatient Health Plan (PIHP) – As defined in 42 CFR 438.2, a PIHP is an entity that 1) provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates; 2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and 3) does not have a comprehensive risk contract.

Primary Care Provider (PCP) – As defined in OAC rule 5160-26-01, an individual physician (M.D. or D.O.), a physician group practice, an advanced practice registered nurse as defined in section 4723.01 of the Revised Code, an advanced practice nurse group practice within an acceptable specialty, or a physician assistant who meets the requirements of OAC rule 5160-4-03 contracting with an MCO to provide services as specified in OAC rule 5160-26-03.1. Acceptable PCP specialty types include family/general practice, internal medicine, pediatrics, and obstetrics/gynecology (OB/GYNs).

Protected Health Information (PHI) – Information received from or on behalf of ODM that meets the definition of PHI as defined by 45 CFR. 160.103.

Provider – As defined in OAC rule 5160-26-01, a hospital, health care facility, physician, dentist, pharmacy, or otherwise licensed or certified appropriate individual or entity that is authorized to or may be entitled to reimbursement for health care services rendered to an OhioRISE Plan member.

Provider Agreement – As defined in OAC rule 5160-26-01, a formal agreement between ODM and the OhioRISE Plan for the provision of medically necessary services to Medicaid members.

Provider Network or Network – Consistent with "Provider Panel" as defined in OAC rule 5160-26-01, the OhioRISE Plan's contracted providers available to the OhioRISE Plan's members.

Provider Claim Dispute Resolution – Established process for OhioRISE Plan network and out-of-network providers to challenge OhioRISE Plan claim payments or denials.

Provider Manual – A OhioRISE Plan specific document that serves as an overview of the OhioRISE Plan for providers that includes information such as prior authorization (PA) practices, appeals, etc. The Provider Manual serves as an overall guide for providers and explains the process of doing business with the OhioRISE Plan.

Provider-Preventable Condition – As defined in 42 CFR 447.26, a condition that meets the definition of a "health care-acquired condition" (a condition occurring in any inpatient hospital setting, identified as a health care-acquired condition by the Secretary under section 1886(d)(4)(D)(iv) of the Act for purposes

of the Medicare program identified in the Ohio Medicaid state plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Act; other than Deep Vein Thrombosis /Pulmonary Embolism as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients) or an "other provider-preventable condition" (a condition occurring in any health care setting) that meets the following criteria:

a. Is identified in the Ohio Medicaid state plan;
b. Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
c. Has a negative consequence for the beneficiary;
d. Is auditable;
e. Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Psychiatric Residential Treatment Facility (PRTF) – A facility that is not a hospital that provides intensive psychiatric treatment to youth under the age of 21, in accordance with Subpart D of 42 C.F.R. 441, Subpart G of 42 C.F.R. 483, and chapters 5160-59 and 5122-41 of the OAC.

Quality Assessment and Performance Improvement (QAPI) Program – A requirement by 42.CFR 438.330 that the OhioRISE Plan implement an ongoing quality assessment and performance improvement (QAPI) program for all services it furnishes to its members, ensuring the delivery of quality health care.

QAPI Evaluation Template – The ODM template that the OhioRISE Plan submit annually to demonstrate the content of their QAPI program and describe how they have executed and evaluated ODM's quality improvement requirements.

Quality Improvement Culture – Shared beliefs, perceptions, norms, values, and expectations of individuals and the organization regarding quality improvement (QI) and customer satisfaction. When a quality culture is achieved, all employees, from senior leadership to frontline staff, have infused QI into the way they do business daily. Employees continuously consider how processes can be improved, and QI is no longer seen as an additional task but a frame of mind in which the application of QI is second nature. The components of a sustainable QI culture include: leadership commitment, a QI infrastructure, employee empowerment, a customer (member, provider, stakeholder) focus, teamwork and collaboration, and a focus on continually learning and improving.

Quality Improvement Project (QIP) – Collaborative undertaking that uses rapid-cycle continuous quality improvement methods to identify and address root causes of poor outcomes which prioritize and test interventions, monitor intervention results, and sustain and scale up interventions found through testing to improve health outcomes, quality of life and satisfaction of providers and members. Typically, ODM initiated improvement projects involve entities at multiple levels within the health system, including health care providers, MCOs, the OhioRISE Plan, single pharmacy benefit manager (SPBM), and state and county entities.

Regional Mobile Response and Stabilization Services Providers (RMP)- Ohio's regional MRSS provider structure leverages regional and local resources to accelerate the expansion and sustainability of MRSS services. The Regional MRSS Provider (RMP) is responsible for the delivery of high quality in-person

MRSS services as defined in rule and practice standards for the entire regional catchment that they are assigned to. RMPs are selected through a state Request for Proposal (RFP) solicitation and are the only entity eligible to bill Medicaid for MRSS services. The RMP is responsible for providing the functions outlined in Ohio Administrative Code and practice standards for the entire assigned region.

Related Entity – Any related party to the OhioRISE Plan by common ownership or control under an oral or written arrangement to perform some of the administrative services under the OhioRISE Plan's contract with ODM. A related party includes but is not limited to agents, managing employees, individuals with an ownership or controlling interest in the contractor and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or individuals.

Reorganization – An arrangement where a company attempts to restructure its business to ensure it can continue operations. A company restructuring may work with its creditors to restate its assets and liabilities, which may be an attempt to avoid a bankruptcy.

Service Area – As defined in OAC 5160-26-01, the geographic area specified in the OhioRISE Plan's provider agreement where the OhioRISE Plan agrees to provide Medicaid services to members residing in those areas.

Single Funding Source Manager - Under contract with ODM, the Single Funding Source Manager pools and distributes Medicaid and non-Medicaid funds to Regional Mobile Response and Stabilization Services Providers.

Single Pharmacy Benefit Manager (SPBM) – The state pharmacy benefit manager selected under ORC section 5167.24 that is responsible for processing all pharmacy claims for OhioRISE Plan members.

Social Determinants of Health (SDOH) – The complex, integrated, and overlapping social and economic risk factors that impact health outcomes and health status.

Social Risk Factors – Economic and social conditions that may influence individual and group differences in health and health outcomes. These factors may include age, gender, income, race, ethnicity, nativity, language, sexual orientation, gender identity, disability, geographic location, and many others.

State Hearing – The process set forth in 42 CFR Part 431, Subpart E, and OAC section 5101:6.

Subcontract – As defined in OAC rule 5160-26-01, a written contract between the OhioRISE Plan and a third party, including the OhioRISE Plan's parent company or any subsidiary corporation owned by the OhioRISE Plan's parent company, or between the third party and a fourth party, or between any subsequent parties, to perform a specific part of the obligations specified under the OhioRISE Plan's provider agreement with ODM.

Subcontractor – As defined in OAC rule 5160-26-01, any party that has entered into a subcontract to perform a specific part of the obligations specified under the OhioRISE Plan's provider agreement with ODM. A network provider is not a subcontractor by virtue of the network provider contract with the OhioRISE Plan.

System of Care – A spectrum of effective, community-based services and supports for children and youth with or at risk for behavioralhealth or other challenges and their families that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their

cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.

Unexplained Death – A member death for which the circumstances or the cause of death are not related to any known medical condition of the member or someone's action or inaction may have caused or contributed to the member's death, including but not limited to inadequate oversight of medications or misuse of medications.

Validation – As defined in 42 CFR 438.320, the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

Value-Added Services – Consistent with 42 CFR 438.3(e)(1)(i), any services that the OhioRISE Plan voluntarily agrees to provide that are in addition to those covered under the Ohio Medicaid state plan, although the cost of these services cannot be included when determining payment to the OhioRISE Plan.

Warm Transfer – Process by which the person answering the original call stays on the phone with the caller while facilitating the transfer of the call to a third party, announces the caller and issue, and remains engaged as necessary to provide assistance.

Waste – As defined in OAC rule 5160-26-01, payment for or the attempt to obtain payment for items or services when there may be no intent to deceive or misrepresent, but poor or inefficient billing or treatment methods result in unnecessary costs.

Written Translation – Translation in writing of OhioRISE Plan documents and materials into the primary language of an eligible individual or member with limited English proficiency.

3. **Acronyms**

ABD	Aged, Blind, and Disabled
ADAMH	Alcohol, Drug Addiction, and Mental Health or County Board of Alcohol, Drug Addiction, and Mental Health
AI	Artificial Intelligence
AMA	American Medical Association
APM	Alternative Payment Model
APRN	Advanced Practice Registered Nurse
ASAM	American Society of Addiction Medicine
BDD	Board of Developmental Disabilities
CAHP	Consumer Assessment of Healthcare Providers
CANS	Ohio Children’s Initiative Child and Adolescent Needs and Strengths
CCE	Care Coordination Entity
CDJFS	County Department of Job and Family Services
CEO	Chief Executive Officer
CFCP	Child and Family-Centered Care Plan
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CFT	Child and Family Team
CHIP	Children's Health Insurance Program
CHW	Community Health Worker

CIO	Chief Information Officer
CBHC	Community Behavioral Health Center
CME	Care Management Entity
CMO	Chief Medical Officer
COA	Certificate of Authority
COE	Center of Excellence
CPC	Comprehensive Primary Care
CPSE	Claims Payment Systemic Error
CSP	Coordinated Services Program
CY	Calendar Year
DME	Durable Medical Equipment
DODD	Department of Developmental Disabilities
DYS	Ohio Department of Youth Services
EAPG	Enhanced Ambulatory Patient Grouping
eCQM	Electronic Clinical Quality Measure
EDI	Electronic Data Interchange
EHR	Electronic Health Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQRO	External Quality Review Organization
ESC	Educational Service Center
FCFC	Family and Children First Council
FDR	First Tier, Downstream, and Related Entities
FFS	Fee for Service
FQHC	Federally Qualified Health Center
FWA	Fraud, Waste, and Abuse
HCBS	Home and Community-Based Service
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HITECH	Health Information Technology for Economic and Clinical Health Act
ICF/IID	Intermediate Care Facility for Individuals with Intellectual Disabilities
IHBT	Intensive Home-Based Treatment
IHSP	Inpatient Hospital Services Plan
IMD	Institution for Mental Disease
IMS	Incident Management System
LISW	Licensed Independent Social Worker
LPCC	Licensed Professional Clinical Counselor
LSW	Licensed Social Worker
MAGI	Modified Adjusted Gross Income
MAT	Medication Assisted Treatment
MCO	Managed Care Organization
MFCU	Medicaid Fraud Control Unit
MHPAEA	Mental Health Parity and Addiction Equity Act
MISP	Maternal and Infant Support Program
ML	Machine Learning
MPS	Minimum Performance Standards
MRSS	Mobile Response and Stabilization Services
MSP	Medicaid School Program
NAIC	National Association of Insurance Commissioners

NCQA	National Committee for Quality Assurance
NPI	National Provider Identifier
OAC	Ohio Administrative Code
ODE	Ohio Department of Education
ODH	Ohio Department of Health
ODJFS	Ohio Department of Job and Family Services
ODRC	Ohio Department of Rehabilitation and Correction
OFCF	Ohio Family and Children First
OMHAS	Ohio Department of Mental Health and Addiction Services
OMES	Ohio Medicaid Enterprise System
ORC	Ohio Revised Code
ORP	Ordering, Referring, and Prescribing
PCP	Primary Care Provider
PCSA	Public Children Services Agency
PHI	Protected Health Information
PHMS	Population Health Management Strategy
PII	Personal Identifiable Information
PIP	Performance Improvement Project
PMPM	Per Member Per Month
PNM	Provider Network Management
PRTF	Psychiatric Residential Treatment Facility
QAPI	Quality Assessment and Performance Improvement
QI	Quality Improvement
RHC	Rural Health Clinic
RMP	Regional MRSS Providers
SDOH	Social Determinants of Health
SFTP	Secure File Transfer Protocol
SFY	State Fiscal Year
SIU	Special Investigative Unit
SPA	State Plan Amendment
SPBM	Single Pharmacy Benefit Manager
SSA	Social Security Act
SUD	Substance Use Disorder
TMR	Targeted Medication Review
TPL	Third Party Liability
TSS	Transitional Services and Supports
UM	Utilization Management
UPDL	Unified Preferred Drug List
US	United States
USC	United States Code
USCDI	United States Core Data for Interoperability

BASELINE PROVIDER AGREEMENT

This Provider Agreement (hereinafter "Agreement") is entered into this first day of July, 2024, at Columbus, Franklin County, Ohio, between the state of Ohio, the Ohio Department of Medicaid, (hereinafter referred to as ODM) whose principal office is located in the City of Columbus, County of Franklin, state of Ohio, and _____, OhioRISE Plan, an Ohio corporation, whose principal office is located in the city of _____, County of _____, state of Ohio.

The OhioRISE Plan is licensed as a Health Insuring Corporation by the state of Ohio, Department of Insurance (hereinafter ODI), pursuant to Chapter 1751 of the Ohio Revised Code (ORC) and is organized and must operate as prescribed by Chapter 5167 of the ORC, Chapter 5160-59 and, when applicable, 5160-26 of the Ohio Administrative Code (OAC), and other applicable portions of the OAC as amended from time to time. Upon request, the OhioRISE Plan must submit to ODM any data submitted to ODI to establish that the OhioRISE Plan has adequate provisions against the risk of insolvency as required under 42 Code of Federal Regulations (CFR) 438.116 and to ensure that neither members nor ODM shall be liable for any OhioRISE Plan's debts, including those that remain in the event of OhioRISE Plan's insolvency or the insolvency of any subcontractors.

The OhioRISE Plan is an entity eligible to enter into this Agreement in accordance with 42 CFR 438.3 as a prepaid inpatient health plan as described in 42 CFR 438.2 for the provision of services described in OAC 5160-59-03 for the Medicaid population described in OAC 5160-59-02 along with any other Medicaid eligible population authorized by the Centers for Medicare and Medicaid Services (CMS) and described in the Ohio Medicaid state plan.

ODM, as the single state agency designated to administer the Medicaid program under ORC section 5162.03 and Title XIX of the Social Security Act, desires to obtain the OhioRISE Plan's services for the benefit of certain Medicaid recipients. In doing so, the OhioRISE Plan has provided and must continue to provide proof of the OhioRISE Plan's capability to provide quality services efficiently, effectively, and economically during the term of this Agreement.

This Agreement is a contract between ODM and the undersigned OhioRISE Plan pursuant to the federal contracting provisions of 42 CFR 434.6 and 438.6 in which the OhioRISE Plan must provide or arrange for Medicaid services through the managed care program as provided in ORC Chapters 5164 and 5167 and OAC Chapter 5160-26 and 5160-59, assuming the risk of loss, and at all times complying with federal and state laws and regulations, federal and state Medicaid program requirements, and other requirements as specified by ODM. In accordance with 42 CFR 438.3(f)(1), this includes without limitation: Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990 as amended; and Section 1557 of the Patient Protection and Affordable Care Act.

ARTICLE I – GENERAL

A. ODM enters into this Agreement in reliance upon the OhioRISE Plan's representations that it has the necessary expertise, resources, and experience to perform its obligations hereunder, and the OhioRISE Plan represents and warrants that it does possess such necessary expertise and experience.

B. The OhioRISE Plan must communicate with ODM as necessary in order for the OhioRISE Plan to ensure its understanding of the responsibilities and satisfactory compliance with this Agreement.

C. The OhioRISE Plan must furnish the staff and services necessary for the satisfactory performance of the services as enumerated in this Agreement.

D. ODM may, as it deems appropriate, communicate specific instructions and requests to the OhioRISE Plan concerning the performance of the services described in this Agreement. The OhioRISE Plan must comply with such instructions and fulfill such requests within the timeframe designated by ODM and to the satisfaction of ODM. It is expressly understood by the parties that these instructions and requests are for the sole purpose of performing the specific tasks requested to ensure satisfactory completion of the services described in this Agreement and are not intended to amend or alter this Agreement or any part thereof.

E. Should any part of the scope of work under this Agreement relate to a state program that is no longer authorized by law (e.g., a state program that has been vacated by a court of law, for which CMS has withdrawn federal authority, or that is the subject of a legislative repeal), the OhioRISE Plan must do no work on that part after the effective date of the loss of program authority. ODM must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the OhioRISE Plan works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the OhioRISE Plan will not be paid for that work. If ODM paid the OhioRISE Plan in advance to work on a no-longer-authorized program or activity and under the terms of this Agreement the work was to be performed after the date the legal authority ended, the payment for that work should be returned to ODM. However, if the OhioRISE Plan worked on a program or activity prior to the date legal authority ended for that program or activity, and ODM included the cost of performing that work in its payments to the OhioRISE Plan, the OhioRISE Plan may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

ARTICLE II – TIME OF PERFORMANCE

A. Upon approval by the Director of ODM, this Agreement is in effect from the date executed through June 30, 2025, unless this Agreement is terminated pursuant to Article VIII of the Baseline Provider Agreement on or prior to the Agreement expiration date, or otherwise renewed or amended pursuant to Article IX of the Baseline Provider Agreement. Termination of this Agreement does not relieve the OhioRISE Plan of any ongoing obligations as set forth in this Agreement, including those obligations associated with the transition plan described in Appendix O, Plan Termination and Non-Renewal.

ARTICLE III – REIMBURSEMENT

A. ODM will compute capitation rates on an actuarially sound basis in accordance with 42 CFR 438.5. The capitation rates do not include any amount for risks assumed under any other existing agreement or contract, or any previous agreement or contract. ODM will review the capitation rates at least annually and the rates may be modified based on existing or anticipated actuarial factors and experience. Capitation rates can be prospectively and retrospectively adjusted.

B. Except for the non-risk payment arrangement as described in Appendix B, the amounts paid by ODM in accordance with this Agreement represent a full-risk arrangement and the total obligation of ODM to the OhioRISE Plan for the costs of medical care and services provided. Any savings or losses remaining after

costs have been deducted from the premium will be wholly retained by the OhioRISE Plan subject to any remittance as may be required by ODM in accordance with 42 CFR 438.8(j).

C. Capitation rates for the OhioRISE Program are anticipated to include a risk corridor as a shared risk mitigation mechanism. The risk corridor is being considered in recognition of claims cost uncertainty during the initial years of the OhioRISE Program. Such a risk corridor may be a temporary arrangement to be reevaluated for future rating periods. The risk corridor parameters for each contract year will be included in capitation rate certification materials.

D. In addition, ODM will consider implementing other risk mitigation techniques for the OhioRISE Program, including but not limited to risk pools for services or populations and Minimum Medical Loss Ratio (MLR) requirements.

E. ODM may establish financial incentive programs for the OhioRISE Plan based on performance.

ARTICLE IV – RELATIONSHIP OF PARTIES

A. ODM and the OhioRISE Plan agree that, during the term of this Agreement, the OhioRISE Plan must be engaged with ODM solely on an independent contractor basis, and neither the OhioRISE Plan nor its personnel may, at any time or for any purpose, be considered as agents, servants, or employees of ODM or the state of Ohio. The OhioRISE Plan is therefore responsible for all the OhioRISE Plan's business expenses, including but not limited to employees' wages and salaries, insurance of every type and description, and all business and personal taxes, including income and Social Security taxes and contributions for Workers' Compensation and Unemployment Compensation coverage, if any. Pursuant to ORC section 145.038, ODM must provide individuals and business entities that have fewer than five employees with the Independent Contractor Acknowledgment (Form PEDACKN). This form requires the OhioRISE Plan to acknowledge that ODM has notified the OhioRISE Plan that it has not been classified as a public employee and that no Ohio Public Employees Retirement System (OPERS) contributions will be made on behalf of the OhioRISE Plan, its employees, or its subcontractors for these services. If the OhioRISE Plan is a business entity with fewer than five employees, the OhioRISE Plan must ensure that each employee completes the PEDACKN form.

B. The OhioRISE Plan must comply with all applicable federal, state, and local laws, and any applicable Executive Orders in the conduct of the work hereunder. The Governor's Executive Orders may be found by accessing the following website: https://governor.ohio.gov/wps/portal/gov/governor/media/executive-orders.

C. ODM may take any action necessary to ensure that the OhioRISE Plan's work is in conformity with the terms and conditions of this Agreement.

D. Except as expressly provided herein, neither party has the right to bind or obligate the other party in any manner without the other party's prior written consent.

ARTICLE V – CONFLICT OF INTEREST; ETHICS LAWS

A. In accordance with 42 CFR 438.58, the safeguards specified in Section 27 of the Office of Federal Procurement Policy Act (41 USC 423), and other applicable federal requirements, an officer, member, or employee of the OhioRISE Plan, the Director of ODM, or other ODM employee who exercises any functions or responsibilities in connection with the review or approval of this Agreement or provision of services under this Agreement must not, prior to the completion of such services or reimbursement, acquire any

interest, personal or otherwise, direct or indirect, that is incompatible or in conflict with or would compromise in any manner or degree the discharge and fulfillment of their functions and responsibilities with respect to carrying out of such services. For purposes of this article, "members" does not include individuals whose sole connection with the OhioRISE Plan is the receipt of services through a health care program offered by the OhioRISE Plan.

B. The OhioRISE Plan represents, warrants, and certifies that the OhioRISE Plan and its employees engaged in the administration or performance of this Agreement are knowledgeable of and understand the Ohio Ethics and Conflicts of Interest laws, including those provisions found in ORC Chapters 102 and 2921, and Executive Order 2019-11D. The OhioRISE Plan further represents, warrants, and certifies that neither the OhioRISE Plan nor any of its employees will perform, cause, or omit any action in any way that is inconsistent with such laws and Executive Order. The Governor's Executive Orders may be found by accessing the following website: https://governor.ohio.gov/wps/portal/gov/governor/media/executive-orders.

C. The OhioRISE Plan hereby covenants that the OhioRISE Plan, its officers, members, and employees of the OhioRISE Plan must not, prior to the completion of the work under this Agreement, voluntarily acquire any interest, personal or otherwise, direct, or indirect that is incompatible or in conflict with or would compromise in any manner of degree the discharge and fulfillment of their functions and responsibilities under this Agreement. The OhioRISE Plan must periodically inquire of its officers, members, and employees concerning such interests. The OhioRISE Plan must have a conflict-of-interest policy that ensures its corporate independence and objectivity.

D. The OhioRISE Plan must ensure that any person who acquires an incompatible, compromising, or conflicting personal or business interest, on or after the effective date of this Agreement, or who involuntarily acquires any such incompatible or conflicting personal interest, immediately discloses their interest to ODM in writing. Thereafter, the OhioRISE Plan must ensure that they must not participate in any action affecting the services under this Agreement unless ODM determines in its sole discretion that, in the light of the personal interest disclosed, their participation in any such action would not be contrary to the public interest. The OhioRISE Plan must provide written disclosure of such interest to ODM.

E. The OhioRISE Plan must include language in all contracts and agreements that result from this Agreement to ensure the OhioRISE Plan is able to maintain adequate internal controls to detect and prevent conflicts of interest from occurring at all levels of the organization. Said language must make the OhioRISE Plan requirements under Article V of the Baseline Provider Agreement applicable to all contracts and agreements that result from this Agreement.

ARTICLE VI – NON-DISCRIMINATION OF EMPLOYMENT

A. The OhioRISE Plan must not discriminate in the performance or employment under this Agreement of an individual who is qualified and available to perform the services under this Agreement on the basis of race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, veteran status, military status, health status, genetic information, or ancestry. For purposes of this article, "members" does not include individuals whose sole connection with the OhioRISE Plan is the receipt of services through a health care program offered by the OhioRISE Plan. The OhioRISE Plan, its officers, employees, members, and subcontractors hereby affirm current and ongoing compliance with all federal civil rights laws, including:

1. Title VII of the Civil Rights Act of 1964 (Pub. L. 88-352);
2. Title VI of the Civil Rights Act of 1964 (42 USC 2000d, et seq.);

3. The Americans with Disabilities Act of 1990 (42 USC 12101, et seq.) and Section 504 of the Rehabilitation Act of 1973; and
4. The Age Discrimination Act of 1975 (42 USC 6101, et seq.).

B. The OhioRISE Plan must not, in any manner, discriminate against, intimidate, or retaliate against any employee hired for the performance or services under this Agreement based upon race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, veteran status, health status, genetic information, or ancestry.

C. The OhioRISE Plan must not participate in, condone, or tolerate any form of sexual harassment against any employee, subcontractor, or other person or entity with which it is associated in performance of this Agreement that is considered a form of sex discrimination prohibited by Title VII of the Civil Rights Act of 1964, ORC section 4112.02, OAC 123:1-49, the Anti-Discrimination Policy in State Government Executive Order 2019-05D, or state agency policy.

D. In addition to requirements imposed upon subcontractors in accordance with OAC Chapter 5160-26, the OhioRISE Plan must hold all subcontractors and persons acting on behalf of the OhioRISE Plan in the performance of services under this Agreement responsible for adhering to the requirements of paragraphs (A) through (C) above. The OhioRISE Plan must include the requirements of paragraphs (A) through (C) above in all contracts and agreements that result from this Agreement.

ARTICLE VII – RECORDS, DOCUMENTS, DATA, AND INFORMATION

A. The OhioRISE Plan must ensure that all records, documents, data, or other information produced or used by the OhioRISE Plan or any subcontractor under this Agreement are treated in accordance with OAC rule 5160-26-06 and must be provided to ODM or its designee at no cost if requested. The records, documents, data, and information must be provided by the OhioRISE Plan in a format solely determined by ODM, which may include the analysis of any data and documentation the OhioRISE Plan is required to maintain. The OhioRISE Plan must maintain an appropriate record system for services provided to members. The OhioRISE Plan must retain all records in accordance with 42 CFR 438.3(u) and comply with the audit and inspection rights of those records in accordance with 42 CFR 438.3(h).

   The OhioRISE Plan acknowledges that these records, including those of any subcontractors and other delegated entities, may be a part of any audit conducted by Ohio Auditor of State pursuant to ORC Chapter 117.

B. Upon request by ODM, the OhioRISE Plan must submit information related to OhioRISE Plan's current performance or operations not specifically covered under this Agreement, unless otherwise excluded by law.

C. The OhioRISE Plan must not withhold records, documents, data, or other information the OhioRISE Plan deems as proprietary from ODM. Proprietary information is information that: (a) if made public, would put the OhioRISE Plan at a disadvantage in the market place and trade of which the OhioRISE Plan is a part; and (b) meets the definition of "trade secret" as defined in ORC section 1333.61(D). The OhioRISE Plan must prominently mark the top or bottom of each individual record containing information the OhioRISE Plan deems proprietary as "proprietary," regardless of media type (e.g., CD-ROM, Excel file), prior to its release to ODM, unless otherwise specified by ODM. If the OhioRISE Plan fails to mark a record as proprietary, the OhioRISE Plan waives any claim that the record is proprietary and ODM may not hold the record

confidential. Upon request from ODM, the OhioRISE Plan must notify ODM in writing and within the timeframe specified by ODM of the specific proprietary information contained in the record, the nature of the proprietary information, the legal basis that supports that the information is proprietary, and the specific harm or injury that would result from the disclosure.

Except as stated in this Agreement, ODM will not share or otherwise disclose proprietary information received from the OhioRISE Plan to any third party without the express written authorization of the OhioRISE Plan. Notwithstanding the forgoing, ODM is permitted to share or disclose (without a subpoena, grand jury subpoena, or court order) proprietary information to CMS, the United States Department of Health and Human Services Office of Inspector General, the Ohio Auditor of State, the Ohio Attorney General (or other legal counsel representing ODM through the Ohio Attorney General), the Medicaid Fraud Control Unit (MFCU), and/or ODM-contracted entities who perform rate setting or other duties connected to the administration of the Ohio Medicaid program and who agree to be bound by the standards of confidentiality in this Agreement. In addition, notwithstanding the forgoing, ODM is also permitted to share or disclose proprietary information in response to court orders, subpoenas, and grand jury subpoenas.

When ODM determines that a court order, subpoena, or grand jury subpoena requires the disclosure of OhioRISE Plan proprietary information, ODM will promptly notify the OhioRISE Plan and will do so before any disclosure unless otherwise ordered by the court. If the OhioRISE Plan chooses to challenge any order, subpoena, or grand jury subpoena requiring disclosure of proprietary information submitted to ODM, or any legal action brought to compel disclosure under ORC section 149.43, the OhioRISE Plan must provide for the legal defense of all such proprietary information. The OhioRISE Plan is responsible for and must pay for all legal fees, expert and consulting fees, expenses, and costs related to this challenge against disclosure, regardless of whether those legal fees, expert and consulting fees, expenses, and costs are incurred by the OhioRISE Plan or by ODM. If the OhioRISE Plan fails to promptly notify ODM in writing that the OhioRISE Plan intends to legally defend against disclosure of proprietary information, that failure will be deemed to be a waiver of the proprietary nature of the information, and a waiver of any right of the OhioRISE Plan to proceed against ODM for violation of this Agreement or of any laws protecting proprietary information. Such failure will also be deemed a waiver of trade secret protection in that the OhioRISE Plan failed to make efforts that are reasonable under the circumstances to maintain the information's secrecy.

D. The OhioRISE Plan must not use any information, systems, or records made available to it for any purpose other than to fulfill the duties specified in this Agreement. The OhioRISE Plan must be bound by the same standards of confidentiality that apply to the employees of ODM and the state of Ohio, including without limitation the confidentiality requirements found in 42 CFR Part 431 Subpart F and ORC section 5160.45, as well as 42 CFR Part 2 and ORC section 5119.27, as applicable. The terms of this section must be included in any contracts and agreements executed by the OhioRISE Plan for services under this Agreement. The OhioRISE Plan must implement procedures to ensure that in the process of coordinating care, each member's privacy is protected consistent with the confidentiality requirements cited above, as well as those set forth in 45 CFR Part 160 and 164.

The OhioRISE Plan must allow ODM, CMS, the United States Department of Health and Human Services Office of the Inspector General, the Comptroller General, the Ohio Auditor of State, the Ohio Inspector General, or any of their designees of any of the foregoing to inspect and audit, at any time, any records or documents of the OhioRISE Plan or its subcontractors, and to inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this Article shall survive the termination of this Agreement and remain in effect for ten years from the termination or expiration of this Agreement or from the date of completion of any audit, whichever is later.

E. The OhioRISE Plan must retain all records relating to performance under or pertaining to this Agreement in accordance to the appropriate records retention schedule. Pursuant to 42 CFR 438.3(u) and 42 CFR 438.3(h), the appropriate records retention schedule for this Agreement is for a total period of ten years as are the audit and inspection rights for those records. For the initial three years of the retention period, the OhioRISE Plan must store records in a manner and place that provides readily available access. If any records are destroyed prior to the date as determined by the appropriate records retention schedule, the OhioRISE Plan must pay to ODM all damages, costs, and expenses incurred by ODM associated with any cause, action, or litigation arising from such destruction, during and after the effective dates of this Agreement.

F. The OhioRISE Plan must retain all records in accordance with ODM's notification of any litigation holds and actively participate in the discovery process if required to do so at no additional charge. Litigation holds may require the OhioRISE Plan to keep the records longer than the approved records retention schedule. ODM will notify the OhioRISE Plan when the litigation hold ends, and retention can resume based on the approved records retention schedule. If the OhioRISE Plan fails to retain the pertinent records after receiving a litigation hold from ODM, the OhioRISE Plan must pay to ODM all damages, costs, and expenses incurred by ODM associated with any cause, action, or litigation arising from such destruction.

G. The OhioRISE Plan must notify ODM of any legal matters and administrative proceedings, including but not limited to litigation and arbitration that involve or otherwise pertain to the activities performed pursuant to this Agreement and any third party. OhioRISE Plan's notification to ODM must be made within five business days from the OhioRISE Plan's receipt of legal or administrative matters related to this Agreement, or immediately when an interim order or an order of injunction has been issued. In the event that the OhioRISE Plan possesses or has access to information or documentation needed by ODM with regard to the above, the OhioRISE Plan must cooperate with ODM in gathering and promptly providing such information and documentation to the extent permissible under applicable law.

ARTICLE VIII – TERMINATION AND NON-RENEWAL

A. ODM may terminate this Agreement upon written notice pursuant to the applicable rules of the OAC. Any such termination will become effective at the end of the last calendar day of the month in which the termination is to take effect. The OhioRISE Plan must comply with the termination and non-renewal requirements as specified in Appendix O, Plan Termination and Non-Renewal.

B. Subsequent to receiving a notice of termination or non-renewal from ODM, the OhioRISE Plan, beginning on the effective date of the termination, must cease provision of services on the terminated activities under this Agreement, terminate all subcontracts relating to such terminated activities, take all necessary or appropriate steps to limit disbursements and minimize costs, and comply with the requirements specified in Appendix O, Plan Termination and Non-Renewal.

C. In the event of termination or non-renewal under this article, the OhioRISE Plan is entitled to request reconciliation of reimbursements through the final month for which the OhioRISE Plan provided services under this Agreement, in accordance with the reimbursement provisions of this Agreement. The OhioRISE Plan waives any right to, and must make no claim for, any additional compensation or liability of or against ODM resulting from such suspension or termination.

D. In the event of termination or non-renewal under this article, the OhioRISE Plan must transfer all data and records to ODM within the time period and in a file format as specified by ODM relating to cost, work

performed, supporting documentation for invoices submitted to ODM, and copies of all materials produced under or pertaining to this Agreement.

E. ODM may, in its sole discretion, terminate or decide not to renew this Agreement if the OhioRISE Plan or OhioRISE Plan's subcontractors violate or fail to comply with the provisions of this Agreement or other provisions of law or regulation governing the Medicaid program; or if the OhioRISE Plan or OhioRISE Plan's subcontractors are determined by any state or federal court to be liable for fraud or misrepresentation against the state of Ohio or any state agency including but not limited to ODM. In the event ODM proposes to terminate or not renew this Agreement, the provisions of applicable sections of the OAC with respect to ODM's termination or refusal to enter into a provider agreement apply, including the OhioRISE Plan's right to request an adjudication hearing under ORC Chapter 119.

F. When initiated by the OhioRISE Plan, the OhioRISE Plan's written notice of termination of or decision not to renew this Agreement must be received by ODM at least 240 calendar days in advance of the termination or renewal date, provided, however, that termination or non-renewal is effective at the end of the last calendar day of the applicable month. In the event of non-renewal of this Agreement with ODM by the OhioRISE Plan, if the OhioRISE Plan is unable to provide the required number of days of notice to ODM prior to the date when this Agreement expires, then this Agreement will be deemed extended to the last calendar day of the month that meets the required number of days from the date of the termination notice. Both parties must, for that time, continue to fulfill their duties and obligations as set forth herein.

G. The OhioRISE Plan understands that availability of funds to fulfill the terms of this Agreement is contingent on appropriations made by the Ohio General Assembly and the United States government for funding the Medicaid program. If sufficient funds are not available from the Ohio General Assembly or the United States government to make payments on behalf of a specific population (e.g., Aged, Blind, Disabled, Modified Adjusted Gross Income, or Adult Extension Group VIII-Expansion) to fulfill the terms of this Agreement, the obligations, duties, and responsibilities of the parties with respect to that population will be terminated, except as specified in Appendix O, Plan Termination and Non-Renewal, as of the date funding expires. If the Ohio General Assembly or the United States government fails at any time to provide sufficient funding for ODM or the state of Ohio to make payments due under this Agreement, this Agreement will terminate as of the date funding expires without further obligation of ODM or the state of Ohio.

ARTICLE IX – AMENDMENT AND RENEWAL

A. This Agreement, together with the Appendices and any other instruments to be executed and delivered pursuant to this Agreement, constitute the entire Agreement between the parties with respect to all matters herein. This Agreement may be amended only by a writing signed by both parties. Any written amendments to this Agreement must be prospective in nature. ODM, in its sole discretion, may amend this Agreement based upon the best interests of the program, its members, or the State. ODM will take into consideration the feedback of the OhioRISE Plan before implementing any amendment.

B. In the event that modification of this Agreement is necessary as a result of: (a) changes in state or federal law or regulations, an applicable waiver or state plan amendment, or the terms and conditions of any applicable federal waiver or state plan amendment; or (b) a decision by ODM to implement an incentive or other payment arrangement between ODM and the OhioRISE Plan under this Agreement in accordance with 42 CFR 438.6, ODM shall notify the OhioRISE Plan regarding such changes and this Agreement shall be automatically amended to conform to such changes without the necessity for executing written amendments pursuant to this article of the Baseline Provider Agreement.

C. This Agreement supersedes any and all previous agreements, whether written or oral, between the parties.

D. A waiver by any party of any breach or default by the other party under this Agreement must not constitute a continuing waiver by such party of any subsequent act in breach of or in default hereunder.

E. This Agreement may be renewed each fiscal year after June 30, 2025, upon satisfactory performance hereunder, appropriation of funds by the Ohio General Assembly, and at the sole discretion of ODM. ODM will issue a notice to the OhioRISE Plan if ODM decides to renew this Agreement. The OhioRISE Plan must not obligate resources in anticipation of a renewal until such notice is provided and includes direction to begin obligating resources to the renewal year.

ARTICLE X – LIMITATION OF LIABILITY

A. The OhioRISE Plan must (1) pay for the defense (if requested by ODM) of ODM and the state of Ohio and any of its agencies, and (2) indemnify and hold ODM, the state of Ohio, and any of its agencies harmless and immune from any and all claims for injury or damages resulting from the actions or omissions of the OhioRISE Plan in the fulfillment of this Agreement or arising from this Agreement that are attributable to the OhioRISE Plan's own actions or omissions, or of those of its trustees, officers, employees, members, agents, subcontractors, suppliers, third parties utilized by the OhioRISE Plan, or joint ventures. For purposes of this article, "members" does not include individuals whose sole connection with the OhioRISE Plan is the receipt of services through a health care program offered by the OhioRISE Plan. Such claims must include but are not limited to any claims by providers or Medicaid recipients, any claims made under the Fair Labor Standards Act or under any other federal or state law involving wages, overtime, or employment matters, and any claims involving patents, copyrights, trademarks, and applicable public records laws. The OhioRISE Plan is responsible for and must pay all legal fees, expert and consulting fees, expenses, and costs associated with defending ODM, the state of Ohio, and Ohio agencies against these claims, regardless whether those legal fees, costs or expenses are incurred by the OhioRISE Plan or the state of Ohio, ODM or other Ohio agencies. In any such litigation or claim, ODM, the state of Ohio, and its agencies have the right to choose their own legal counsel and any experts and consultants, subject only to the requirement that legal, expert, and consulting fees must be reasonable.

B. The OhioRISE Plan is liable for any loss of federal funds suffered by ODM for members resulting from specific, negligent acts or omissions of the OhioRISE Plan or its subcontractors during the term of this Agreement, including but not limited to the nonperformance of the duties and obligations under this Agreement.

C. In the event that, due to circumstances not reasonably within the control of the OhioRISE Plan or ODM, a major disaster, epidemic, complete or substantial destruction of facilities, war, riot, or civil insurrection occurs, neither ODM nor the OhioRISE Plan will have any liability or obligation on account of reasonable delay in the provision or the arrangement of covered services. So long as the OhioRISE Plan's Certificate of Authority remains in full force and effect, the OhioRISE Plan is liable for the covered services required to be provided or arranged for in accordance with this Agreement.

D. In no event will ODM be liable to the OhioRISE Plan for indirect, consequential, incidental, special, or punitive damages, business interruption, or lost profits.

ARTICLE XI – CHANGE IN ORGANIZATIONAL STRUCTURE

A. The OhioRISE Plan must notify and obtain written approval from ODM 180 calendar days prior to making any change in the OhioRISE Plan's organizational structure. For purposes of this Agreement, a change in organizational structure means a change in ownership, an acquisition, merger, or reorganization, as those terms are defined in this Agreement, as determined by ODM.

B. The OhioRISE Plan's request for approval must include an explanation of the type of entity or changes to the existing entity resulting from the proposed change in organizational structure, and any material changes to the OhioRISE Plan's operations to meet the requirements in this Agreement. The OhioRISE Plan must provide all information, data, and documents as directed by ODM to support a request to change the OhioRISE Plan's organizational structure.

C. ODM may deny the proposal if the change is determined by ODM to not be in the best interest of the state or Medicaid members. If ODM denies the proposal and the OhioRISE Plan moves forward with the change in organizational structure, ODM may terminate this Agreement with the OhioRISE Plan pursuant to Article VIII of the Baseline Provider Agreement.

ARTICLE XII – ASSIGNMENT

A. The OhioRISE Plan must not assign any interest in this Agreement and must not transfer any interest in the same (whether by assignment or novation) without the prior written approval of ODM and subject to such conditions and provisions as ODM may deem necessary. No such approval by ODM of any assignment will be deemed in any event or in any manner to provide for the incurrence of any obligation by ODM in addition to the total agreed-upon reimbursement in accordance with this Agreement. The OhioRISE Plan must submit any assignments of interest to ODM for ODM's approval 120 calendar days prior to the desired effective date. ODM must use reasonable efforts to respond to any such request for approval within the 120-calendar day period. Failure of ODM to act on the OhioRISE Plan's request for approval within the 120-calendar day period does not act as an approval of the request. ODM may require a receiving OhioRISE Plan to successfully complete a readiness review process before the transfer of obligations under this Agreement.

B. The OhioRISE Plan must not assign any interest in subcontracts of this Agreement and must not transfer any interest in the same (whether by assignment or novation) without the prior written approval of ODM and subject to such conditions and provisions as ODM may deem necessary. The OhioRISE Plan must submit any such assignments of subcontracts to ODM for ODM's approval 30 calendar days prior to the desired effective date. No such approval by ODM of any assignment will be deemed in any event or in any manner to provide for the incurrence of any obligation by ODM in addition to the total agreed-upon reimbursement in accordance with this Agreement.

ARTICLE XIII – CERTIFICATION MADE BY THE OhioRISE Plan

A. This Agreement is conditioned upon the full disclosure by the OhioRISE Plan to ODM of all information required for compliance with state and federal regulations.

B. The OhioRISE Plan certifies that no federal funds paid to the OhioRISE Plan through this or any other agreement with ODM will be or have been used to lobby Congress or any federal agency in connection with a particular contract, grant, cooperative agreement, or loan. The OhioRISE Plan further certifies its continuing compliance with applicable lobbying restrictions contained in 31 USC 1352 and 45 CFR Part 93. If

this Agreement exceeds $100,000, the OhioRISE Plan has executed the Disclosure of Lobbying Activities, Standard Form LLL, if required by federal regulations. This certification is material representation of fact upon which reliance was placed when this Agreement was entered into.

C. The OhioRISE Plan certifies that neither the OhioRISE Plan nor any principals of the OhioRISE Plan (e.g., a director, officer, partner, or person with beneficial ownership of more than 5% of the OhioRISE Plan's equity) is presently debarred, suspended, proposed for debarment, declared ineligible, or otherwise excluded from participation in transactions by any federal agency. The OhioRISE Plan also certifies that it is not debarred from consideration for contract awards by the Director of the Department of Administrative Services, pursuant to either ORC section 153.02 or ORC section 125.25. The OhioRISE Plan also certifies that the OhioRISE Plan has no employment, consulting, or any other arrangement with any such debarred or suspended person for the provision of items or services or services that are significant and material to the OhioRISE Plan's contractual obligation with ODM. This certification is a material representation of fact upon which reliance was placed when this Agreement was entered into. Federal financial participation (FFP) is not available for amounts expended for providers excluded by Medicare, Medicaid, or State Children's Health Insurance Program (SCHIP), except for emergency services. If it is ever determined that the OhioRISE Plan knowingly executed this certification erroneously, then, in addition to any other remedies, this Agreement will be terminated pursuant to Article VIII of the Baseline Provider Agreement, and ODM must advise the secretary of the appropriate federal agency of the knowingly erroneous certification.

D. The OhioRISE Plan certifies that the OhioRISE Plan is in compliance with all applicable federal and state laws, rules, and regulations governing fair labor and employment practices and is not on the most recent list established by the Secretary of State, pursuant to ORC section 121.23 that identifies the OhioRISE Plan as having more than one unfair labor practice contempt of court finding. This certification is a material representation of fact upon which reliance was placed when this Agreement was entered into.

E. The OhioRISE Plan must not discriminate against individuals who have or are participating in any work program administered by a County Department of Job and Family Services (CDJFS) under ORC Chapters 5101 or 5107.

F. The OhioRISE Plan certifies and affirms that, as applicable to the OhioRISE Plan, no party listed or described in Division (I) or (J) of ORC section 3517.13, who was in a listed position at the time of the contribution, has made as an individual, within the two previous calendar years, one or more contributions in excess of $1,000.00 to the present Governor or to the Governor's campaign committees during any time they were a candidate for office. If it is ever determined that the OhioRISE Plan's certification of this requirement is false or misleading, and not withstanding any criminal or civil liabilities imposed by law, the OhioRISE Plan must return to ODM all monies paid to the OhioRISE Plan under this Agreement. The provisions of this section must survive the expiration or termination of this Agreement.

G. The OhioRISE Plan must not promise or give to any ODM employee anything of value that is of such a character as to manifest a substantial and improper influence upon the employee with respect to their duties.

H. The OhioRISE Plan must comply with the false claims recovery requirements of 42 USC 1396a(a)(68) and to also comply with ORC section 5162.15.

I. The OhioRISE Plan must ensure that the OhioRISE Plan, its officers, employees, members, any subcontractors, and any independent contractors (including all field staff) associated with this Agreement comply with all state and federal laws regarding a smoke-free and drug-free workplace. The OhioRISE Plan

will make a good faith effort to ensure that all OhioRISE Plan's officers, employees, members, and subcontractors will not purchase, transfer, use, or possess illegal drugs or alcohol, or abuse prescribed drugs in any way while performing their duties under this Agreement.

J. The OhioRISE Plan certifies and confirms that any performance of experimental, developmental, or research work must provide for the rights of the federal government and the recipient in any resulting invention.

K. The OhioRISE Plan certifies and confirms that it must comply with all applicable standards, orders, or regulations of the Clean Air Act and Federal Water Pollution Control Act.

L. The OhioRISE Plan must comply with the Federal Acquisition Regulation (FAR) for Combating Trafficking in Persons, 48 CFR Part 22 Subpart 22.17, in which "the United States Government has adopted a zero-tolerance policy regarding trafficking in persons." The provisions found in 48 CFR Part 52 Subpart 52.2, specifically Subpart 52.222-50, are hereby incorporated into this Agreement by reference. ODM reserves the right to immediately and unilaterally terminate this Agreement if any provision in this section is violated and ODM may implement Section 106(g) of the Trafficking Victims Protection Act of 2000, as amended (22 USC 7104), see 2 CFR Part 175.

M. The OhioRISE Plan must comply with Executive Order 2019-12D. A copy of Executive Order 2019-12D can be found at https://governor.ohio.gov/wps/portal/gov/governor/media/executive-orders/2019-12d. This Executive Order prohibits the use of public funds to purchase services provided outside of the United States except under certain circumstances. Such services include the use of offshore programming or call centers. Additionally, the OhioRISE Plan shall not transfer personal health information to any location outside the United States or its territories. Pursuant to 42 CFR 438.602(i), no OhioRISE Plan claim paid to any provider, out-of-network provider, subcontractor, or financial institution located outside of the United States is considered in capitation rates. In conjunction with Executive Order 2019-12D, the OhioRISE Plan must comply with Executive Order 2022-02D. A copy of Executive Order 2022-02D can be found at https://governor.ohio.gov/media/executive-orders/executive-order-2022-02d. This executive order prohibits the purchases of services from or investments in Russian institutions or companies and requires service providers or prospective service providers to: affirm that they understand and will abide by the requirements of this Order; and disclose the principal location of business for the contractor and all subcontractors who are supplying services to the State under the proposed contracts.

N. The OhioRISE Plan certifies and confirms that the OhioRISE Plan must not boycott any jurisdiction with whom the state of Ohio can enjoy open trade and will not do so during the term of this Agreement. ODM reserves the right to terminate this Agreement immediately upon discovery of such a boycott.

O. The OhioRISE Plan must cooperate with ODM and any child support enforcement agency in ensuring that the OhioRISE Plan and its employees meet child support obligations and requirements established by state and federal law, including present and future compliance with any court or valid administrative order for the withholding of support issued pursuant to the applicable sections of ORC Chapters 3119, 3121, 3123, and 3125.

ARTICLE XIV – CONSTRUCTION

A. This Agreement is governed and will be construed and enforced in accordance with the laws and regulations of the state of Ohio and applicable federal statutes and regulations. The provisions of this Agreement are severable and independent, and if any such provision is determined to be unenforceable, in whole or in part,

the remaining provisions and any partially enforceable provision must, to the extent enforceable in any jurisdiction, nevertheless be binding and enforceable.

ARTICLE XV – INCORPORATION BY REFERENCE

A. The managed care and OhioRISE Program rules are located in OAC Chapter 5160-26 and OAC Chapter 5160-59 and are hereby incorporated by reference as part of this Agreement, having the full force and effect as if specifically restated herein. The OhioRISE Plan must subscribe to the appropriate distribution lists for notification of all OAC rule clearances, and final rules published with medical assistance letters (MALs), Medicaid handbook transmittal letters (MHTLs), and other transmittal letters affecting managed care program requirements. The OhioRISE Plan is solely responsible for submitting its names and email addresses to the appropriate distribution lists and for ensuring the validity of any email addresses maintained on those distribution lists. Email distribution lists include RuleWatch Ohio at https://www.rulewatchohio.gov/home?1; and ODM Rule Notification at https://medicaid.ohio.gov/wps/portal/gov/medicaid/stakeholders-and-partners/legal-and-contracts/legal-and-contracts.

B. Appendices A through P and any additional appendices are hereby incorporated by reference as part of this Agreement having the full force and effect as if specifically restated herein. Appendix O, Plan Termination and Non-Renewal, and any other applicable obligations set forth in this Agreement will survive the termination or non-renewal of this Agreement.

C. Documents incorporated by reference in this Agreement have the full force and effect as if specifically restated herein. The OhioRISE Plan must comply with all requirements set forth in these sources, as well as any updates thereto. The OhioRISE Plan is responsible for ensuring that its subcontractors and providers are notified when ODM makes modifications to these documents and that its subcontractors and providers comply with the requirements.

D. In accordance with the terms and conditions of Request for Application (RFA) Number ODMR-2021-0025, the OhioRISE Plan is bound by the responses the OhioRISE Plan has submitted through that process. Accordingly, the OhioRISE Plan's responses to RFA Number ODMR-2021-0025 are incorporated by reference in this Agreement and have the full force and effect as if specifically restated herein.

E. In the event of inconsistency or ambiguity between the provisions of OAC Chapter 5160-26 and this Agreement, the provisions of OAC Chapter 5160-59 will be determinative of the obligations of the parties unless such inconsistency or ambiguity is the result of changes in federal or state law, as provided in Article IX of the Baseline Provider Agreement, in which case such federal or state law will be determinative of the obligations of the parties. In the event OAC Chapter 5160-26 is silent with respect to any ambiguity or inconsistency, this Agreement (including Appendices) will be determinative of the obligations of the parties other than as specifically provided in federal or state law. In the event that a dispute arises that is not addressed in any of the aforementioned documents, the parties must make every reasonable effort to resolve the dispute, in keeping with the objectives of this Agreement and the budgetary and statutory constraints of ODM.

ARTICLE XVI – NOTICES

A. All notices, consents, and communications between the parties under this Agreement must be given in writing, must be deemed to be given upon receipt thereof, and must be sent to the addresses first set forth below.

ARTICLE XVII – HEADINGS

A. The headings in this Agreement have been inserted for convenient reference only and must not be considered in any questions of interpretation or construction of this Agreement.

B. The parties have executed this Agreement the date first written above. This Agreement is hereby accepted and considered binding in accordance with the terms and conditions set forth in the preceding statements.

AETNA BETTER HEALTH, INC.:

BY: _____ DATE: _____

MARTHA TAYLOR, PRESIDENT & CEO

7400 West Campus Road, Suite 200, New Albany, OH 43054

THE OHIO DEPARTMENT OF MEDICAID:

BY: _____ DATE: _____

MAUREEN M. CORCORAN, DIRECTOR

50 West Town Street, Suite 400, Columbus, Ohio 43215

APPENDIX A – GENERAL REQUIREMENTS

1. General Administrative Requirements

a. Inclusive Agreement

i. The OhioRISE Plan acknowledges and agrees that the RFA Number ODMR-2021-0025, all attachments, written addenda to the RFA, the OhioRISE Plan's accepted proposal, the questions and answers posted during the inquiry period of the RFA Number ODMR-2021-0025 are hereby incorporated into this Agreement.

b. Certificate of Authority

i. The OhioRISE Plan must submit a current copy of its Certificate of Authority (COA) to the Ohio Department of Medicaid (ODM) within 30 calendar days of issuance by the Ohio Department of Insurance (ODI).

c. National Committee for Quality Assurance Review

i. In accordance with 42 CFR 438.332, the OhioRISE Plan is required to inform ODM if it has been accredited by a private independent accrediting entity, including the National Committee for Quality Assurance (NCQA). The OhioRISE Plan must authorize the accrediting entity to provide ODM with a copy of its most recent accreditation review, including accreditation status, survey type and level (as applicable); accreditation results including recommended actions or improvements, corrective action plans, and summaries of findings; and expiration date of the accreditation. The OhioRISE Plan must submit the aforementioned documents as specified in Appendix P, Chart of Deliverables.

ii. The entity contracting with ODM as the OhioRISE Plan must complete a National Committee for Quality Assurance (NCQA) review of ODM-selected NCQA health plan accreditation standards within 21 months of the effective date of the contract, or no later than March 31, 2024, for the OhioRISE Plan's Ohio Medicaid line of business.

iii. The OhioRISE Plan must achieve and maintain an acceptable NCQA score of 80% for each standard category included in the review – i.e., Quality Improvement, Population Health Management, Network Management, Utilization Management, and Member Experience. If the OhioRISE Plan receives an NCQA review score of 79% or lower on a standards category the OhioRISE Plan will be subject to sanctions as noted in Appendix N, Compliance Actions.

iv. ODM will assess OhioRISE Plan compliance based on the OhioRISE Plan's NCQA review cycle.

v. For the purposes of determining whether the OhioRISE Plan meets the minimum review score requirement, ODM will only accept the use of the NCQA Corporate Survey Process to the extent deemed allowable by NCQA.

vi. Upon ODM's request, the OhioRISE Plan must provide requested documents related to the NCQA review and scoring within the timeframe specified by ODM.

d. Model Agreements with MCOs and SPBM

i. As part of OhioRISE Plan readiness activities, under ODM's direction, the OhioRISE Plan must work in partnership with ODM, the Managed Care Organizations (MCOs), the single pharmacy benefit manager (SPBM) and other ODM-contracted MCOs to develop model written agreements that memorialize the respective expectations and the coordination between the OhioRISE Plan, the MCOs, and the SPBM. The OhioRISE Plan must execute an agreement with each MCO and with the SPBM and comply with its written agreements with each MCO and the SPBM.

1. The content of the written agreements must include:

a. A primary point of contact to represent each entity in the cross-coordination, communication, and collaboration will be identified;

b. Operationalization detail of the respective roles and responsibilities of the parties, including processes to triage, track, and address shared grievances;

c. Collaborative communication and coordination protocols, including development and coordination across OhioRISE Plan, SPBM, and MCOs for shared stakeholder outreach and communication strategies, and streamlining/standardization of processes to minimize administrative burden for providers;

d. Data and information exchange requirements and timeframes;

e. Confidentiality and privacy requirements; and

f. Problem resolution protocols.

ii. The OhioRISE Plan, in collaboration with ODM, the MCOs, and SPBM, must renew and amend the model agreement on an annual basis or more frequently, as needed.

e. OhioRISE Implementation and Plan Readiness Review Activities

i. In accordance with 42 CFR 438.66(d), the OhioRISE Plan must participate in ODM-led readiness reviews for ODM to assess the OhioRISE Plan's readiness and ability to provide services consistent with the requirements in this Agreement. The OhioRISE Plan must also participate in ODM-led implementation activities. OhioRISE Plan implementation and readiness includes activities associated with the coordination and interfaces between the OhioRISE Plan, ODM, OMES, the MCOs, and the SPBM.

ii. The OhioRISE Plan must fully partner, support, and cooperate in implementation and readiness review activities as directed by ODM. The OhioRISE Plan must respond to ODM requests related to implementation and readiness promptly (i.e., within the timeframe specified by ODM). Such requests may include but are not limited to operations, information technology, data, communications, or any other area of responsibility under this Agreement.

iii. The OhioRISE Plan must demonstrate to ODM's satisfaction that it is able to meet the requirements in this Agreement prior to the effective date of this Agreement.

iv. The ODM-led readiness review will assess the OhioRISE Plan's readiness to begin serving members under this Agreement. Readiness review activities may include but are not limited to desk and on-site review of documents provided by the OhioRISE Plan, a walk-through of the OhioRISE Plan's operations, system demonstrations (including systems connectivity testing), and interviews with ODM-specified OhioRISE Plan staff. The scope of the review may include any of the requirements specified in this Agreement as determined by ODM.

v. At any time during implementation and/or readiness, ODM, in its sole discretion, may do any of the following:

1. Issue a letter of findings and, if needed, task the OhioRISE Plan for a corrective action plan or issue a directed corrective action plan. The OhioRISE Plan must implement corrective action and demonstrate the OhioRISE Plan's ability to meet the requirements in this Agreement to ODM's satisfaction. The OhioRISE Plan must complete the corrective action within the timeframes provided by ODM.

2. Impose financial sanctions or other remedies at the discretion of ODM;

3. Terminate this Agreement; or

4. Take any other compliance action or remedy at the sole discretion of ODM.

vi. ODM shall not assign members nor make payment to the OhioRISE Plan until ODM has determined that the OhioRISE Plan is able to meet the requirements of this Agreement.

vii. The OhioRISE Plan understands and agrees that prioritizing implementation and readiness is essential to the success of this program. The OhioRISE Plan agrees to release, waive, forego, and not commence or engage in any action or omission that will or could delay, hinder, contradict, or prejudice the implementation of this Agreement, the Ohio Medicaid managed care program, or any of its program components. This release and waiver includes but is not limited to commencing or engaging in any legal action against ODM. The OhioRISE Plan releases and waives any right to sue ODM and its employees, officers, and agents for any and all claims at any time during implementation and readiness. The OhioRISE Plan agrees that this waiver and release, as well as all other provisions of this Agreement, are legally enforceable and binding.

viii. During the course of this Agreement, the OhioRISE Plan must participate in ODM-conducted readiness reviews prior to OhioRISE Plan implementation of significant operational or program changes (e.g., service changes, IT system modifications), as determined by ODM. At ODM's sole discretion, ODM may retain expert consultants at the OhioRISE Plan's expense to verify readiness of significant OhioRISE Plan-initiated operational or program changes. The OhioRISE Plan must demonstrate to ODM's satisfaction that the OhioRISE Plan will continue to be able to meet the requirements in this Agreement prior to implementing the change.

f. OhioRISE CME Manual

i. The OhioRise CME Manual provides guidance to the OhioRISE Plan on how to complete certain program components. The OhioRise Plan will comply with processes set forth in the OhioRise CME Manual.

g. Local Presence

i. Administrative Office

1. The OhioRISE Plan must maintain an administrative office located in Ohio at all times during the life of this Agreement.

2. Upon ODM's request, the OhioRISE Plan must provide ODM with private, on-site space to allow ODM to perform on-site reviews, audits, or other oversight activities.

ii. Utilization Management and Care Coordination

1. The OhioRISE Plan's Utilization Management (UM) and care coordination staff will need a thorough understanding of local communities as well as work collaboratively with members' Child and Family Teams (CFTs), therefore the following staff and functions must be located in Ohio:

a. All staff participating in UM functions, including care plan development and review, authorizations, discharge planning, CFT liaison, and medical/clinical staff peer-to-peer consultation.

b. All OhioRISE Plan and CME care coordination staff and functions, including for members assigned to Tiers 1, 2, and 3.

iii. Out-of-State Functions

1. For functions that the OhioRISE Plan is not required to perform in the state of Ohio (e.g., claims processing), the OhioRISE Plan must maintain a list of the functions and where they are located. The OhioRISE Plan must notify and obtain ODM's approval prior to moving those functions, whether they are performed inside or outside of the state. The OhioRISE Plan notification must occur prior to implementation and include a transition and implementation plan.

2. OhioRISE Plan must bear any ODM costs (including travel and subcontractor cost) associated with ODM conducted on-site audits, readiness review, or other oversight activities for out-of-state OhioRISE Plan functions.

h. Contract Communications

i. Key Contacts

1. The OhioRISE Plan must designate a primary contact person for this Agreement, the OhioRISE Plan Contract Administrator, as described below in this appendix, who must dedicate a majority of their time to the OhioRISE product line and coordinate overall communication between ODM and the OhioRISE Plan. The OhioRISE Plan Contract Administrator must ensure the timeliness, accuracy,

completeness, and responsiveness of all OhioRISE Plan communications and submissions to ODM.

2. The OhioRISE Plan must designate and identify contact staff for specific program areas upon ODM request.

3. ODM will identify contact staff for the OhioRISE Plan, including an ODM Contract Administrator.

ii. Communication Process

1. The OhioRISE Plan must take all necessary and appropriate steps to ensure all OhioRISE Plan staff are aware of, and follow, the following communication process:

   a. Unless otherwise directed by ODM, the OhioRISE Plan must copy the ODM-provided regulatory email address on all submissions and communications to ODM.

   b. Unless otherwise directed by ODM, the OhioRISE Plan must copy or direct contract related communications to the ODM Contract Administrator. The OhioRISE Plan must direct communications related to stakeholder engagement to ODM's External Affairs Administrator until further notice.

   c. The OhioRISE Plan is prohibited from contacting entities that contract or subcontract with ODM, unless necessary to fulfill the requirements under this Agreement or when specifically instructed by ODM. However, ODM reserves the right to contact the subcontractor directly at its discretion.

   d. Under the terms of this Agreement, the OhioRISE Plan must meet all program requirements, regardless of delegation of functions.

   e. To ensure that the OhioRISE Plan is meeting its obligations in accordance with this Agreement, the OhioRISE Plan must notify the ODM Contract Administrator within one business hour of the OhioRISE Plan's receipt of a legislative or awareness of any media that raises a pattern of concern regarding the OhioRISE Plan's provision of services, ongoing provider relations issues, or a matter of significant concern to the community at large. This provision shall not be relied upon by the OhioRISE Plan to deny or delay responding to the inquiry. As necessary and appropriate, ODM will facilitate and/or require a response to the underlying issue or issues in a matter designed to meet the mission and goals of this Agreement (see Introduction). In the case of an inquiry made pursuant to sections 103.412 and 103.413 of the Ohio Revised Code, the OhioRISE Plan need not provide notification unless authorized by the individual making the inquiry.

f. Events of a potentially concerning nature may include, but are not limited to, those that involve:

i. An individual who is a member of the OhioRISE Plan; or

ii. A provider serving a member of the OhioRISE Plan; or

iii. An employee of a CME or the OhioRISE Plan.

iii. Timeframes for Responding to Requests for Information

1. Timeframes for responding to requests for information unless otherwise stated in this Agreement or in the request for information from ODM, the OhioRISE Plan must respond to requests for information within the following timeframes (included examples are non-exhaustive):

a. Within 24 hours for requests for information regarding OhioRISE Program eligibility, assessment, member access to services, and enrollment processes;

b. Within the same day or 24 hours, as identified by ODM, for requests regarding member health, safety, and welfare;

c. Within 3-5 business days for inquiries related to state hearings, legislative, and non-urgent information seeking requests;

d. Within five business days for requests regarding members received through HealthTrack, including provider or member billing inquiries, or constituent inquiries received through external business relations; and

e. Ten business days for requests regarding policy research queries, coding, rate change inquiries, and all other requests for information unless otherwise stated in the request.

2. Prior to the expiration of the allotted timeframe, the OhioRISE Plan may request an extension of the timeframe for responding to a request for information from ODM when necessary. Requests for extension are subject to the approval by ODM.

iv. Electronic Communications

1. The OhioRISE Plan must use Transport Layer Security for all email communication between ODM and the OhioRISE Plan. The OhioRISE Plan's email gateway must be able to support the sending and receiving of large email files using Transport Layer Security, and the OhioRISE Plan's gateway must be able to enforce the sending and receiving of email via Transport Layer Security.

v. Meeting Attendance

1. The OhioRISE Plan must prepare for and send appropriate staff representatives to participate in all meetings and events when ODM requires OhioRISE Plan

attendance and participation. Meetings may include but are not limited to technical assistance sessions, performance and compliance, systems configuration, provider network decisions, and policy and program development.

2. The OhioRISE Plan must not record meetings or calls with or where ODM is present or participating without ODM's express prior written approval. The word "record" has its commonly understood meaning and includes, for example and without limitation, inscribing or capturing words, statements, conversations, discussions, meetings, presentations, and phone calls using electronic or digital means or methods.

3. The OhioRISE Plan must send staff who are appropriately qualified and authorized to take actions or make decisions in the topic area. It is insufficient to send solely the OhioRISE Plan's Contract Administrator to meetings and events that require specific subject matter expertise and authority (e.g., discussion of clinical topics, quality topics, program integrity, or claims).

vi. Program Input from the OhioRISE Plan

1. The OhioRISE Plan must respond on a timely basis to Ohio Medicaid managed care program, including OhioRISE program, input opportunities, including but not limited to:

a. Review and comment on the capitation rate-setting timeline, proposed rates, proposed changes to the OAC program rules, and proposed amendments to this Agreement;

b. Commenting on Ohio Medicaid program policy and procedural changes and, whenever possible, offer sufficient time for comment and implementation; and

c. Revising OhioRISE Plan's program updates and discuss program issues with ODM staff.

vii. Performance and Compliance Feedback

1. ODM will regularly provide information to the OhioRISE Plan regarding different aspects of the OhioRISE Plan's performance, including information on OhioRISE Plan-specific and statewide external quality review organization surveys, focused clinical quality of care studies, member satisfaction surveys, and provider profiles.

i. Program Modifications

i. The OhioRISE Plan must implement program modifications as soon as reasonably possible, but no later than the required effective date, in response to changes to this Agreement and state and federal laws and regulations.

2. Eligibility, Enrollment, Transfers, and Enrollment Termination

a. OhioRISE Eligibility and Enrollment

i. Pursuant to OAC rules 5160-59-02 and 5160-59-02.1, the OhioRISE Plan must comply with eligibility and enrollment requirements.

ii. The OhioRISE Plan must pay for all medically necessary services covered under this Agreement provided to members starting on the date of enrollment (as described in paragraph C of Ohio Administrative code 5160-59-02) into the OhioRISE Plan and while the member is enrolled in the OhioRISE Plan.

b. OhioRISE 1915(c) Waiver Eligibility and Enrollment

i. Pursuant to OAC rule 5160-59-04, the OhioRISE Plan must comply with eligibility and enrollment requirements for the OhioRISE 1915(c) waiver.

ii. The OhioRISE Plan must pay for all medically necessary services covered under this Agreement provided to members starting on the date of enrollment into the OhioRISE Plan and the OhioRISE 1915(c) waiver and while the member is enrolled in the OhioRISE Plan and OhioRISE 1915(c) waiver.

iii. The OhioRISE Plan must ensure CMEs perform 1915(c) waiver Inpatient Psychiatric Level of Care assessments for the purposes of initial and ongoing waiver eligibility determination by ODM as described in OAC rule 5160-59-04.

iv. The OhioRISE Plan must ensure annual redetermination and accompanying Inpatient Psychiatric Level of Care assessments described in OAC rule 5160-59-04 are completed in a timely manner. New level of care assessments must be completed within 365 days of the previous level of care assessment for continued enrollment on the waiver.

c. OhioRISE Membership

i. ODM will enroll individuals who meet the eligibility criteria in the following rules into the OhioRISE Program:

1. OhioRISE eligibility and enrollment pursuant to OAC rule 5160-59-02.

2. OhioRISE first day eligibility and enrollment pursuant to OAC rule 5160-59-02.1 .

3. OhioRISE home and community-based services waiver eligibility and enrollment pursuant to OAC rule 5160-59-04.

ii. ODM, at its discretion, may include additional children and youth in the OhioRISE Plan membership.

d. OhioRISE Plan Membership Acceptance, Documentation, and Reconciliation

i. Medicaid Consumer Hotline Contractor

1. The OhioRISE Plan must provide ODM prior-approved OhioRISE Plan's materials and must provide directories to the Medicaid Consumer Hotline contractor for distribution to eligible individuals.

ii. Monthly Remittance Advice

1. The HIPAA 820 monthly remittance advice contains the following: a capitation payment for each member listed on the HIPAA 834F monthly enrollment file, a capitation payment/recoupment for changes listed in the HIPAA 834C daily enrollment file, any other capitation payment/recoupment, and delivery payment/recoupment from the previous calendar month.

iii. Enrollment and Monthly Capitation Reconciliation

1. The OhioRISE Plan must maintain the integrity of its membership data through processing and loading of data contained for each member in the daily HIPAA 834C enrollment files and reconciling the daily changes with the HIPAA 834F monthly enrollment file.

2. The OhioRISE Plan must report discrepancies between the HIPAA 834C daily enrollment files and HIPAA 834F monthly enrollment file that have a negative impact on a member's access to care to ODM within one business day. The OhioRISE Plan must submit reconciliation for any discrepancies of enrollment(s)/disenrollment(s) contained on the HIPAA 834 files and HIPAA 820 monthly remittance advice, for the associated HIPAA 834 files, to ODM no later than 60 calendar days after the issuance of the HIPAA 820 monthly remittance advice. The OhioRISE Plan must report discrepancies and reconciliation requests.

3. The OhioRISE Plan must submit all reconciliation requests in the format specified by ODM.

4. ODM may reject reconciliation requests submitted by the OhioRISE Plan after the initial 60 calendar day due date. ODM may process OhioRISE Plan reconciliation requests submitted after the initial 60 calendar day due date at ODM's sole discretion.

5. ODM will not accept OhioRISE Plan's reconciliation requests for enrollment or payment beyond the last day of the 18th month after the capitation/enrollment month.

6. ODM will process reconciliations for ODM recoupment of capitation payments.

7. The OhioRISE Plan must submit monthly waiver enrollment information (OhioRISE 1915(c) Waiver Monthly Enrollment Report) to ODM as specified in Appendix P, Chart of Deliverables. The report must identify any OhioRISE member for whom an active waiver span is indicated on the 834 file for any waiver other than the OhioRISE 1915(c) waiver for purposes of reconciling existing waiver enrollees to the OhioRISE 1915(c) waiver. The OhioRISE Plan

must participate in a waiver enrollment reconciliation process to ensure the number of allocated waiver slots has not been exceeded.

iv. Change in Member Circumstance

1. In accordance with 42 CFR 438.608, the OhioRISE Plan must notify ODM no later than 30 calendar days after being notified of the date of death of a member.

2. The OhioRISE Plan must notify ODM within one business day of becoming aware of changes in the member's address, phone number, email address, or other relevant contact information.

3. The OhioRISE Plan's notifications must follow ODM prescribed submission guidelines and be provided in the format prescribed by ODM.

v. Enrollment into the OhioRISE Plan due to an Inpatient Behavioral Health Stay

1. The OhioRISE Plan will notify the inpatient behavioral health facility that it is responsible for coverage of the stay within one business day of being notified by the MCO, and work with the facility and the member's MCO (as applicable) to facilitate discharge planning and authorize services as needed.

2. If a member is admitted for a behavioral health inpatient hospital stay prior to the first day of Medicaid eligibility and retroactive eligibility does not apply, the OhioRISE Plan is responsible for reimbursement of the inpatient hospital claim for the days the member is enrolled in the OhioRISE Plan. The days prior to Medicaid eligibility would be considered non-covered days, and the claim should be processed for payment based upon partial eligibility.

vi. Termination of Enrollment

1. Pursuant to OAC rule OAC 5160-59-02, the OhioRISE Plan must comply with Ohio Medicaid OhioRISE Plan's termination of enrollment requirements.

vii. OhioRISE Plan-Initiated Disenrollment Requests

1. The OhioRISE Plan may make a disenrollment request if there is evidence to support that the member no longer meets the threshold score on the CANS assessment (or other assessment) as established by ODM. The OhioRISE Plan must submit disenrollment requests on the first business day of the month in the format specified by ODM. Upon verification by ODM that the member no longer meets the threshold score, the member will be disenrolled on the last day of the month the request was submitted.. Disenrollment request submitted after the first day of the month may not be verified for disenrollment to be effective the end of the following month.

2. The OhioRISE Plan may make a disenrollment request if the member is approaching age 21 and is not inpatient in a psychiatric residential treatment facility or in a PRTF. Disenrollment request must be submitted by the first business day of the month of the month the member's 21st birthday in a format

specified by ODM. Upon verification by ODM, the member will be disenrolled on the last day of the month following the member's 21st birthday.

3. The OhioRISE Plan must monitor OhioRISE 1915(c) waiver enrolled members who are temporarily residing in an institution. If a waiver-enrolled member resides in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) for more than 90 consecutive days, the OhioRISE Plan will initiate disenrollment from the OhioRISE waiver. When the OhioRISE Plan expects a member's institutional stay at a facility other than an ICF/IID will exceed 90 consecutive days, the OhioRISE Plan must assess the youth for potential disenrollment from the OhioRISE waiver approximately 60 days after admission. When the youth resides in an institutional facility other than an ICF/IID for longer than 180 consecutive days, the OhioRISE plan will initiate disenrollment from the OhioRISE waiver approximately 150 days after admission.

4. The OhioRISE Plan must submit a request for disenrollment from the OhioRISE 1915(c) waiver to ODM as soon as ineligibility is determined, but no later than 30 days prior to the 1915(c) level of care redetermination date:

    a. If the OhioRISE Plan becomes aware that 1915(c) waiver services are no longer needed;

    b. If the OhioRISE Plan becomes aware that the member no longer meets waiver eligibility criteria outlined in OAC 5160-59-04, including but not limited to, no longer being eligible for the waiver based on a Waiver CANS assessment; or

    c. If the 1915(c) waiver level of care redetermination is not completed by the waiver level of care redetermination date.

viii. Member Initiated Disenrollments

1. The OhioRISE Plan must assist any member requesting disenrollment from the OhioRISE Plan by initiating a referral to the CANS assessment (or other assessment) as established by ODM to determine if they no longer meet the threshold score.

2. The OhioRISE Plan will receive Just Cause requests via an ODM approved system.

    a. The OhioRISE Plan is responsible for outreaching to members and providers and taking the necessary action to address the issue or concern in the Just Cause request.

    b. The OhioRISE Plan will document updates and results to the individual request in the ODM approved system.

    c. The OhioRISE Plan will participate in Just Cause related state hearings with ODM.

ix. Pending Member

1. If a pending member (i.e., a member who meets criteria for OhioRISE enrollment prior to their membership effective date or a member identified as meeting first day eligibility per OAC rule 5160-59-02.1) contacts the OhioRISE Plan, the OhioRISE Plan must provide any membership information requested, including how to access services as an OhioRISE Plan's member and assistance in determining whether the eligible individual's current services require prior authorization.

2. The OhioRISE Plan must ensure any care coordination (e.g., prescheduled services, transition of care) information provided by the pending member is logged in the OhioRISE Plan's system and forwarded to the appropriate OhioRISE Plan's staff for processing as required.

3. The OhioRISE Plan may confirm any information provided on the Consumer Contact Record, or data provided by ODM, at the time the pending member contacts the OhioRISE Plan. Such communication does not constitute confirmation of membership. Upon receipt of the Consumer Contact Record, data provided by ODM, or the HIPAA 834, the OhioRISE Plan may contact a pending member to confirm information provided on the Consumer Contact Record, data provided by ODM, the CANS assessment, or the HIPAA 834, assist with care coordination and transition of care, and inquire if the pending member has any membership questions.

4. The OhioRISE plan may contact pending members identified by ODM as meeting first day eligibility per OAC rule 5160-59-02.1 to begin care coordination and transition of care activities.

x. Direct Member Reimbursement

1. Pursuant to OAC rule 5160-1-60.2, the OhioRISE Plan must comply with requirements for direct reimbursement for out-of-pocket expenses incurred by members for covered services during approved eligibility periods.

2. If a member properly submits an ODM-approved direct reimbursement packet, the OhioRISE Plan must accept the ODM-approved direct reimbursement packet and complete the direct reimbursement process.

3. If a member makes first contact with the OhioRISE Plan regarding direct reimbursement, the OhioRISE Plan must complete the direct reimbursement process but may use the OhioRISE Plan’s own direct reimbursement process and documents.

3. Privacy Compliance Requirements

a. General

i. The OhioRISE Plan must safeguard confidential information in accordance with state and federal requirements, including but not limited to: the HIPAA of 1996 (Public Law 104-191); 45 CFR parts 160 and 164, 42 CFR 431, Subpart F; 42 CFR Part 2; 42 CFR Part 457;

42 CFR Part 438; *the Family Educational Rights and Privacy Act (20 U.S.C. § 1232g; 34 CFR Part 99);* and, ORC sections 5101.26, 5101.27, and 5160.45 through 5160.481.

1. Information disclosed to the OhioRISE Plan may include records protected by 42 CFR Part 2. 42 CFR Part 2 prohibits unauthorized disclosure of these records.

ii. The OhioRISE Plan acknowledges that ODM is a Covered Entity under HIPAA.

iii. The OhioRISE Plan must make protected health information (PHI) in a designated record set available to ODM as necessary to satisfy Medicaid's obligations under 45 CFR 164.524.

iv. The OhioRISE Plan must maintain and make available the information required to provide an accounting of disclosures as necessary to satisfy ODM's obligations under 45 CFR 164.528.

b. Data Security Agreement with Board of Pharmacy

i. Pursuant to ORC section 5167.14, the OhioRISE Plan must enter into a data security agreement with the state of Ohio's Board of Pharmacy that governs the OhioRISE Plan's use of the Board's drug database established and maintained under ORC section 4729.75.

c. Reporting of Disclosures

i. The OhioRISE Plan must promptly report to ODM any inappropriate use or disclosure of PHI not in accordance with this Agreement or applicable law, including a breach of unsecured PHI as required by 45 CFR 164.410 and any security incident of which the OhioRISE Plan has knowledge or reasonably should have knowledge under the circumstances. If the OhioRISE Plan determines, pursuant to 45 CFR 164.402, that any inappropriate use or disclosure of PHI does not require breach notification, then the OhioRISE Plan shall make any documentation related to such determination available to ODM upon request. In addition, as specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must submit an annual report (Protected Health Information Breach Report) to ODM regarding the number of breaches of PHI and specify how many breaches were reported to U.S. Department of Health and Human Services as required by 45 CFR 164.408(b) and (c).

d. Mitigation Procedures

i. The OhioRISE Plan must coordinate with ODM to determine specific actions that will be required of the OhioRISE Plan or its subcontractors for mitigation, to the extent practical, of any breach. These actions must include notification to the appropriate individuals, entities, or other authorities. Notification or communication to any media outlet must be approved, in writing, by ODM prior to any such communication being released. The OhioRISE Plan must report all of its mitigation activity to ODM and must preserve all relevant records and evidence.

e. Incidental Costs

i. The OhioRISE Plan must bear the sole expense of all costs to mitigate any harmful effect of any breaches or security incidents that were caused by the OhioRISE Plan, or its subcontractors in violation of the terms of this Agreement. These costs include but are not limited to the cost of investigation, remediation, and assistance to the affected members, entities, or other authorities.

f. System Access Requests

i. The OhioRISE Plan must follow ODM access processes to obtain, maintain, and remove access to all state systems.

ii. The OhioRISE Plan must immediately notify ODM when an individual with access to a state system leaves employment.

iii. The OhioRISE Plan must cooperate with ODM access audits.

4. Member Requirements

a. Availability of services.

i. In accordance with 42 CFR 438.206(c), the OhioRISE Plan must address health care disparities and ensure equitable access to and the delivery of services to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

ii. "Equitable access" for purposes of this Agreement means meeting the standards as defined by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (https://www.thinkculturalhealth.hhs.gov/clas).

iii. In accordance with 42 CFR 438.206(c)(3), the OhioRISE Plan must ensure that the OhioRISE Plan, its subcontractors, and network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical or behavioral health disabilities.

iv. The OhioRISE Plan's population health improvement efforts, including population-specific efforts designed to optimize access and outcomes for all members must align with the requirements in Appendix C, Population Health and Quality.

v. The OhioRISE Plan must participate in ODM's population-specific and community initiatives as requested by ODM.

b. Member Information

i. The OhioRISE plan shall comply with applicable federal and state laws regarding persons with limited English proficiency (LEP) and persons with disabilities, including Title VI of the Civil Rights Act of 1964, Titles II and III of the Americans with Disabilities Act, the Section 504 of the Rehabilitation Act of 1973, and section 1557 of the Patient Protection and Affordable Care Act.

ii. The OhioRISE Plan must comply with the following information requirements for eligible individuals and members, in accordance with 42 CFR §438.10 and OAC rules 5160-59-01.1, 5160-59-03.1, 5160-26-05, and 5160-26-05.1:

1. Oral Interpretation

a. The OhioRISE Plan must make oral interpretation in all languages and sign language available to eligible individuals and members at no expense.

2. Written Materials

a. The OhioRISE Plan must make written materials that are critical to obtaining services available to its members. Such materials include, at a minimum, HIPAA privacy notices, provider directories, member handbooks, care coordination materials provided to the member, grievance and appeal notices, denial and termination notices, and any other materials identified by ODM.

b. The OhioRISE Plan's written materials must include taglines to the extent required by federal law in the prevalent non-English languages and in conspicuously visible font size explaining the availability of written translations or oral interpretation free of charge to understand the information provided.

c. The OhioRISE Plan must make all written member materials available in alternative formats and provide auxiliary aids and services when requested at no expense to eligible individuals and members.

i. Alternative formats must include but are not limited to Braille, large print, and audio, as determined by the need of the individual member.

ii. The OhioRISE Plan's provision of alternative formats and auxiliary aids and services must take into consideration the special needs of eligible individuals or members with disabilities or limited English proficiency.

d. The OhioRISE Plan's written materials must include the toll-free and TeleTYpe/ Telecommunications Device for the Deaf (TTY/TDD) telephone number of the OhioRISE Plan's member services line, and information that explains how to request auxiliary aids and services, including the provision of materials in alternative formats.

e. The OhioRISE Plan must notify all eligible individuals and members that information is available in alternative formats and that auxiliary aids and services are available at no charge.

f. The OhioRISE Plan must ensure that all member materials are clearly legible, and use person-centered, trauma-informed, and easily understood language and format.

i. The OhioRISE Plan must write member materials at or below a sixth grade reading level, unless otherwise approved by ODM.

ii. If the OhioRISE Plan must include medical terminology that is not understandable from a layperson perspective, the OhioRISE Plan must offer the member an opportunity to speak to an OhioRISE Plan's representative to explain the information.

iii. The OhioRISE Plan must provide written member materials in at least 12-point font by March 1, 2023.

iv. The determination of whether the OhioRISE Plan's materials comply with member material requirements is in the sole discretion of ODM.

3. Contracting for Translation, Oral Interpretation, and Sign Language

a. If, in accordance with OAC rule 5160-26-05.1, the OhioRISE Plan is financially responsible for providing oral translation, oral interpretation, or sign language services to OhioRISE enrolled members while receiving services from a network provider, the OhioRISE Plan must give preference to contracting with local agencies to provide such services.

b. The OhioRISE Plan must receive ODM's approval prior to executing a sole source contract with an entity to provide such services.

c. In addition to the requirements in OAC rule 5160-26-05.1, the OhioRISE Plan must make translation services available to OhioRISE 1915(c) waiver applicants at the time of initial application for assistance of potentially eligible members.

4. Special Communication Needs

a. The OhioRISE Plan must collect and use information regarding :

i. The special communication needs of all OhioRISE Plan's members (e.g., those with Limited English Proficiency, limited reading proficiency, visual impairment, and hearing impairment, and those in need of auxiliary aids and services); and

ii. The provision of related services (e.g., OhioRISE Program materials in alternate format, oral interpretation, oral translation services, written translations of OhioRISE Program materials, sign language services, and other auxiliary aids and services).

b. The OhioRISE Plan's database must include all OhioRISE Plan's member primary language information, as well as all other special communication needs information for OhioRISE Plan's members, as indicated above, when identified by any source, including ODM, the SPBM, the MCOs, the ODM's consumer hotline, OhioRISE Plan's staff, providers, and members. Unless otherwise specified by a member, the OhioRISE Plan shall ensure that the special communication needs identified by a member (for example, large print) are applied to subsequent communications with the member so that a member does not have to repeatedly request the accommodation.

c. This information regarding special communication needs must be readily available to OhioRISE Plan's staff and must be used in coordinating communication and services to members.

d. The OhioRISE Plan must share information on member-specific communication needs with its providers, including CMEs, subcontractors, and Third-Party Administrators as applicable.

e. Upon ODM's request, the OhioRISE Plan must submit information regarding the OhioRISE Plan's members with special communication needs to ODM. Such information may include but is not limited to individual member names, their specific communication need, and any provision of special services to members (i.e., those special services arranged by the OhioRISE Plan as well as those services reported to the OhioRISE Plan that were arranged by the provider, including the CMEs).

f. If members of the OhioRISE Plan are also members of a MCO Plan, then the OhioRISE Plan and the MCO Plan may exchange information, upon request, regarding the special communication needs of these members to ensure that each plan has updated and complete information.

g. The OhioRISE Plan and the SPBM may exchange information, upon request, regarding the special communication needs of OhioRISE members.

c. Member Services

i. Member Services Telephone System

1. The OhioRISE Plan must develop and implement member services call center policies and procedures that address staffing, training, hours of operation, access and response standards, transfers/referrals, including referrals from all sources, monitoring of calls via recording or other means, translation/interpretation, and compliance with standards.

2. The OhioRISE Plan must provide member services to members through a toll-free telephone system.

3. The OhioRISE Plan's member services telephone system must have services available to assist:

    a. Members who are hard of hearing (i.e., TTY/TDY); and

    b. Members with limited English proficiency in the primary language of the member.

4. The OhioRISE Plan must have the capability for ODM or its designee to monitor calls remotely.

5. The OhioRISE Plan must have the capability to capture "audio signatures" for any required forms or requests that require a member's signature.

6. The OhioRISE Plan must measure and monitor the accuracy of responses provided by OhioRISE Plan's call center staff and take corrective action as necessary to ensure the accuracy of responses by staff.

ii. Member Services Responsibilities

1. The OhioRISE Plan's member services program must assist members, and as applicable, eligible individuals seeking information about OhioRISE Program's membership, with the following:

    a. The services and supports available through the OhioRISE Program;

    b. Eligibility requirements and processes for the OhioRISE Program;

    c. Methods of accessing the CANS;

    d. Accessing Medicaid-covered services;

    e. Obtaining or understanding information on the OhioRISE Plan's policies and procedures;

    f. Understanding the scope of the role of the OhioRISE Plan compared to the role of the MCO;

    g. Understanding the requirements and benefits of the OhioRISE Program;

    h. Resolving of concerns, questions, and problems;

    i. Filing of grievances and appeals as specified in OAC rule 5160-26-08.4;

    j. Obtaining information on state hearing rights;

    k. Appealing to or filing directly with the U.S. Department of Health and Human Services Office of Civil Rights any complaints of discrimination on the basis of race, color, national origin, age, or disability in the receipt of health services;

    l. Appealing to or filing directly with the ODM Office of Civil Rights any complaints of discrimination on the basis of race, color, religion, gender,

gender identity, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, health status, or need for health services in the receipt of health services; and

m. Accessing sign language, oral interpretation, and auxiliary aids and services.

i. The OhioRISE Plan must ensure these services are provided at no cost to the eligible individual or member.

ii. The OhioRISE Plan must designate a staff person to coordinate and document the provision of these services.

2. In the event the OhioRISE Plan's member services center receives a call during normal business hours about a matter that is the responsibility of the SPBM or an MCO, the OhioRISE Plan must directly transfer the call to the member services center of the SPBM or the MCO, which has enrolled the member, and make a warm transfer. If the call is received after hours or the contact is made other than by phone (e.g., email or fax), the OhioRISE Plan must provide the relevant information to the SPBM or the MCO as expeditiously as possible, but no more than one business day from receipt of the contact.

iii. Member Services Hours of Operation

1. The OhioRISE Plan must ensure member services staff are available nationwide to provide assistance to members through the toll-free call-in system at all times during the hours of 7:00 am to 8:00 pm Eastern Time, Monday through Friday, except on the following major holidays: New Year's Day, Martin Luther King Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day.

2. The OhioRISE Plan may select two additional optional closure days, which may be used separately or in combination with any of the major holiday closures but may not both be used within the same closure period. Before announcing any optional closure dates to members or staff, the OhioRISE Plan must receive ODM prior approval that verifies that the optional closure days meet the specified criteria.

3. If a major holiday falls on a Saturday, the OhioRISE Plan may close its member services line on the immediately preceding Friday.

4. If a major holiday falls on a Sunday, the OhioRISE Plan may close its member services line on the immediately following Monday.

5. The OhioRISE Plan must specify member services closure days in the OhioRISE Plan's member handbook, member newsletter, or other written communication to the OhioRISE Plan's members at least 30 calendar days in advance of the closure.

6. The OhioRISE Plan must have an after-hours system to route emergent and crisis behavioral health calls directly to Ohio Department of Mental Health and Addiction Services' (OMHAS') statewide crisis line, 988, outside of the OhioRISE Plan's member services hours of operation.

iv. Medical Advice Line

1. The OhioRISE Plan is not required to operate its own Medical Advice Line.

2. The OhioRISE Plan must be able to refer and provide a direct transfer for a member to the member's MCO's Medical Advice Line or to their MCO's customer service office.

v. Member Call Center Performance Standards

1. The OhioRISE Plan must meet or exceed the following call center standards:

a. Average speed of answer: Ninety percent of calls are to be answered by a live call center representative within thirty seconds. Answered means for each caller who elects to speak to a live call center representative;

b. Abandonment rate: Five percent or less of incoming calls that are abandoned while waiting for a live call center representative. ODM considers a call to be abandoned if:

i. The caller chooses to disconnect after thirty seconds and prior to being connected to a live call center representative or voice mail;

ii. The caller elects an IVR option and is not permitted to access that option and disconnects (by the caller or system); or

iii. The system disconnects the call while the caller is waiting for a live call center representative.

c. Hold time: Total on hold time not to exceed sixty seconds. Hold time refers to anytime the caller is placed on hold by a live call center representative. This could include placing a caller on hold for the following:

i. The call center representative to review documentation; or

ii. Transfer the call to another call center representative, manager, or department.

d. Inquiry response time: All inquiries that require a call back must be returned within 1 business day of receipt; and

e. First call resolution: Seventy percent of incoming calls are resolved, closed, or completed on initial contact (i.e. does not require the caller to call back or the call center representative to call the caller back).

2. The OhioRISE Plan must self-report its monthly performance on these five standards for its member services and 24/7 hour toll-free call-in systems to ODM (Member Services Call Center Report) as specified in Appendix P, Chart of Deliverables.

3. The OhioRISE Plan must have a separate telephone line and phone number for this Agreement.

4. The OhioRISE Plan must report performance standards more frequently, if required by ODM.

5. The OhioRISE Plan must comply with any changes or updates to Utilization Review Accreditation Commission call center standards.

d. Member Rights

i. In accordance with 42 CFR 438.100 and OAC rule 5160-26-08.3, the OhioRISE Plan must comply with all federal and state laws that pertain to member rights and ensure that its employees and contractors adhere to such laws when furnishing services to its members under this Agreement.

ii. The OhioRISE Plan must include language in its contracts requiring subcontractors and network providers to adhere to federal and state laws pertaining to member rights when providing services to members.

e. Member Safeguards

i. The OhioRISE Plan shall develop and implement safeguards, systems, and processes that detect, prevent, and mitigate harm and/or risk factors that could impact a member's health, safety, or welfare.

ii. When the OhioRISE Plan identifies or becomes aware of risk factors, it must put in place services and supports to mitigate and address the identified issues as expeditiously as the situation warrants.

iii. The OhioRISE Plan must ensure that an Individual Crisis and Safety Plan is completed for every OhioRISE member with the care coordination status of active. The Individual Crisis and Safety Plan must include individualized, trauma-informed, interventions and de-escalation strategies designed with the goal of preventing the use of restraints, seclusion, or restrictive interventions. For a member who poses a risk to the health, safety, or welfare of the member or others, the Individual Crisis and Safety Plan must clearly indicate such risks and identify the interventions recommended by the care coordinator and reviewed by the OhioRISE Plan to address such risks to ensure the health, safety, and/or welfare of the member and others.

1. The OhioRISE Plan's process for development and implementation of an Individual Crisis and Safety Plan must be in accordance with ODM's specifications.

2. The OhioRISE Plan must document in the clinical record the member's Individual Crisis and Safety Plan, any refusal of the member to sign the Individual Crisis and

Safety Plan, and/or lack of adherence by the member to the agreed upon actions or interventions.

iv. ODM or its designee will conduct administrative reviews, in-home checks, and/or other oversight activities to ensure a member's health, safety, and welfare.

v. The OhioRISE Plan's failure to meet member safeguard requirements that places a member at risk for a negative health outcome or jeopardizes the member's health, safety, or welfare will result in the assessment of sanctions as specified in Appendix N, Compliance Actions.

vi. The OhioRISE Plan must review and approve the Individual Crisis and Safety Plan. The Individual Crisis and Safety Plan may reference a restraint, seclusion or restrictive measure that was recommended and approved by a qualified and licensed behavioral health professional as part of their treatment plan. This should be used as a last resort for OhioRISE members so as not to subject children to re-traumatization or harm. If the OhioRISE member has a restraint, seclusion or restrictive measure within a licensed provider treatment plan, that treatment plan must be included as supporting documentation with the member's Individual Crisis and Safety Plan. The OhioRISE Plan should ensure that the qualified behavioral health professional who recommended and approved the restraint, seclusion or restrictive measure is included as a participant on the member's CFT. The OhioRISE plan must review within the CFT meeting that all providers use a trauma-informed approach. The review includes consideration of de-escalation strategies, and also the circumstances of when a qualified behavioral health professional has identified the potential need in which the use of restraints, restrictive measures, or seclusions may be considered to ensure the safety of the member and others. The OhioRISE Plan's review and approval process must ensure that to the extent possible, restraints, restrictive measures, or seclusions are identified as last resort measures when less restrictive measures, such as verbal redirection/prompting and behavioral management strategies, are ineffective in ensuring the health, safety and welfare of the member and others. When an Individual Crisis and Safety Plan is submitted without restrictive interventions, the OhioRISE Plan will review and accept it.

vii. The OhioRISE Plan must identify any unapproved or inappropriate use of restraints, restrictive measures, or seclusions and report case-specific information through the IMS. The OhioRISE Plan must analyze restraint, restrictive measure, and seclusion data and take appropriate follow-up to address identified trends and patterns to support improvement strategies. OhioRISE follow-up may include but is not limited to requiring additional training of OhioRISE Plan or provider staff, changes in protocols, identifying recommended changes of rules to ODM. The OhioRISE Plan must use case-specific information in IMS and its analysis to address case-specific concerns by following up with the entity authorizing the restraint, restrictive measure, or seclusion and the member's team.

viii. The OhioRISE Plan must report data to ODM regarding the members for whom an approved restrictive intervention, restraint, and/or seclusion is used, and the entity authorizing the restraint, restrictive measure, or seclusion. The OhioRISE Plan must submit a report to ODM for OhioRISE 1915(c) waiver members for whom a restrictive intervention, restraint, and/or seclusion is used (OhioRISE 1915 (c) Restrictive

Intervention, Restraint and/or Seclusion report), identifying the authorizing entity, as specified in Appendix P, Chart of Deliverables.

f. Advance Directives

   i. The OhioRISE Plan must maintain written policies and procedures that meet the requirements for advance directives, as set forth in 42 CFR Part 489 Subpart I.

g. OhioRISE Program Member and Family Advisory Council

   i. The OhioRISE Plan must convene an OhioRISE Program Member and Family Advisory Council (council) at least quarterly. The OhioRISE Plan must offer meeting attendance in person, by phone, or virtually.

   ii. The OhioRISE Plan, through council support and activities, must engage members and their families or caregivers in such a way as to elicit meaningful input into the OhioRISE Plan's population health and quality improvement strategies, and address strengths and challenges of these strategies with serving members.

   iii. The Member and Family Advisory Council must serve in an advisory capacity to ODM, and other child-serving agencies.

   iv. The OhioRISE Program Member and Family Advisory Council must participate in OhioRISE Plan and ODM quality assurance processes, including:

      1. Providing input and recommendations to the quality improvement activities of the OhioRISE Plan;

      2. Receiving and reviewing quality assurance reports from the OhioRISE Plan on a regular basis and make recommendations to improve service quality and outcomes;

      3. Participating in cross-system planning at the state level;

      4. Participating in state coordination activities;

      5. Identifying training and technical assistance needs in coordination with the Centers of Excellence (COEs) and ODM;

      6. Proposing quality improvement issues and projects to the OhioRISE Plan resulting from the efforts of the OhioRISE Program council, as applicable (The OhioRISE Plan's quality team will receive and evaluate the proposed projects, and if indicated, incorporate any resulting action into the OhioRISE Plan's quality plan);

      7. Reviewing quality performance and improvement analyses from the OhioRISE Plan and provide input on high priority issues for OhioRISE Plan and ODM consideration to improve the system serving OhioRISE Plan's members and their families. These will include but not be limited to the following:

a. Reviewing reports on quality-of-care elements (e.g., youth and family satisfaction with services, providers, and quality of life improvement measures) gathered from members of the OhioRISE Plan;

b. Reviewing reports related to CME performance, quality, and outcomes; and

c. Reviewing reports related to System of Care interface between MCOs, CMEs, OhioRISE Plan, community providers, and social determinants of health (SDOH) resources.

8. Providing input to the OhioRISE Plan regarding the development, implementation, and outcomes of a publicly available report card for providers serving members, grading them in areas such as ongoing engagement with youth and families, quality of service, overall progress experienced by members, and quality of life improvements;

9. Providing specific input to improve and enhance outreach to members and their families to educate them with regard to available services, in particular care coordination; mobile response; and how youth and families can access and advocate for services, support, guidance, and connection to other supportive family resources, as needed.

v. The OhioRISE Plan, with council input and recommendations, must develop policies and procedures for the inclusion of family voice that demonstrate at least quarterly accommodation to working families and schooling children, youth, and young adults.

vi. The OhioRISE Plan must ensure that the composition of the council is diverse and representative of the OhioRISE Plan's current membership throughout the state with respect to the members' race, ethnic background, primary language, age, Medicaid eligibility category (e.g., Medicaid Adjusted Gross Income [MAGI]; Aged, Blind, and Disabled; Adoption Assistance; Foster Care; Supplemental Security Income), and health status.

vii. As new populations are enrolled in managed care, the OhioRISE Plan must actively ensure the council's membership reflects the diversity of its enrolled population.

viii. The OhioRISE Plan must report the following to ODM as specified in Appendix P, Chart of Deliverables:

1. A list of attending members during the prior quarter for the council;

2. Meeting dates, agenda, and the minutes from the council meeting that occurred during the prior quarter;

3. Improvement recommendations developed by the council; and

4. The OhioRISE Plan's response to or implementation of the council's improvement recommendations.

ix. The OhioRISE Plan is encouraged to establish other processes, in addition to the Member and Family Advisory Council, to seek input on priorities and improvement opportunities, share findings and lessons learned from members and their families, child-serving state and local entities, Medicaid contracted entities, and others as directed by ODM consistent with expectations for cross-system collaboration.

5. Grievance and Appeal System

a. General

i. The OhioRISE Plan must develop and implement written policies and procedures for a grievance and appeal system for members in compliance with the requirements of OAC rule 5160-26-08.4 and 42 CFR 438 Subpart F.

ii. The OhioRISE Plan must use the ODM standardized appeal form to document member appeals. While the OhioRISE Plan may offer the ODM standardized appeal form for member use (e.g., as an attachment to a notice of appeal or as a form available on the OhioRISE Plan's website), the OhioRISE Plan must not reject an appeal on the basis that the member did not use or complete the ODM standardized appeal form and must document the member appeal onto the ODM standardized appeal form.

iii. The OhioRISE Plan's policies and procedures must include the process by which members may file grievances and appeals with the OhioRISE Plan, and a process by which members may access the state's fair hearing system through the Ohio Department of Job and Family Services Bureau of State Hearings.

iv. The OhioRISE Plan must include the participation of individuals authorized by the OhioRISE Plan to require corrective action in the OhioRISE Plan's grievance and appeal processes.

v. The OhioRISE Plan must use information from grievances, appeals, and state hearings to inform improvements to the OhioRISE Plan's operations and service delivery system.

vi. In the event the OhioRISE Plan receives a grievance, appeal, or state hearing request related to a decision or matter that is the responsibility of the SPBM or MCO, the OhioRISE Plan must forward the grievance, appeal, or state hearing request to the appropriate entity:

1. Immediately, for grievances that involve a member's emergent or urgent need to access health care, or for expedited appeals; and

2. Within one business day from receipt for all other types of grievances, appeals, or state hearing requests.

3. In addition to forwarding the grievance, appeal or state hearing request to the appropriate entity within the aforementioned timeframes, on a rolling basis, the OhioRISE Plan must also report the grievance, appeal or state hearing request to ODM using a template provided by ODM.

b. State Hearing Process

i. The OhioRISE Plan must develop and implement written policies and procedures that ensure the OhioRISE Plan's compliance with the state hearing provisions pursuant to division 5101:6 of the Administrative Code.

ii. The OhioRISE Plan must submit its state hearing policies and procedures for review and approval by ODM upon ODM's request.

iii. When the OhioRISE Plan is notified by the Bureau of State Hearings that a member has requested a state hearing, the OhioRISE Plan must review the state hearing request and within two business days of receipt of the Bureau of State Hearings notice, confirm via email to State_Hearings_Scheduling@jfs.ohio.gov one of the following:

1. The OhioRISE Plan has no record that the member has requested an OhioRISE Plan appeal pertaining to the state hearing request.

    a. In this event, the OhioRISE Plan must attempt to contact the member to initiate the OhioRISE Plan's appeal process unless the timeframe for a member to file an appeal with the OhioRISE Plan is exhausted in accordance with OAC rule 5160-26-08.4.

2. The OhioRISE Plan made an adverse appeal resolution pertaining to the state hearing request, whether or not the appeal was expedited, and attach a copy of the State Hearing Notice issued to the member.

3. The OhioRISE Plan made a decision to authorize the services pertaining to the state hearing request and identify the date the member and provider were notified of the authorization.

4. The OhioRISE Plan has not yet made a decision on the appeal request pertaining to the state hearing request, identify the date the OhioRISE Plan received the appeal request, and identify the date the OhioRISE Plan must currently issue a timely appeal resolution.

c. Grievances, Appeals, and State Hearings Logs and Record-Keeping

i. The OhioRISE Plan must log and keep records of grievances, appeals, and state hearings documenting OhioRISE Plan's performance of all state and federal requirements (e.g., timely acknowledgement, continuation of benefits when applicable) that in accordance with 42 CFR 438.416 must include:

1. The name of the member for whom the appeal, grievance, or state hearing was filed;

2. The date the appeal, grievance, or state hearing was received;

3. A general description of the reason for the appeal, grievance, or state hearing;

4. The date of each review or, if applicable, review meeting;

5. If applicable, the resolution of the appeal, grievance, or state hearing; and

6. If applicable, the date of the resolution.

d. Grievance and Appeal System Reporting

i. The OhioRISE Plan must submit the Grievance and Appeal Activity Report to ODM as specified in Appendix P, Chart of Deliverables. The OhioRISE Plan must submit appeal and grievance activity at least monthly in an electronic data file format pursuant to the *ODM Appeal File and Submission Specifications and ODM Grievance File and Submission Specifications*.

ii. The OhioRISE Plan must submit the Monthly Grievance and Appeal System Report to ODM as specified in Appendix P, Chart of Deliverables. The OhioRISE Plan must submit grievance, appeal, and state hearing information as required in *ODM's Grievance, Appeal, and Service Authorization Reporting Specifications Manual*. As part of the OhioRISE Plan's report submission, the OhioRISE Plan must include the analysis of individual and aggregate outliers and trends and identify the OhioRISE Plan's actions taken in response.

6. Provider Requirements

a. Provider Services

i. General

1. The OhioRISE Plan must comply with provider services requirements pursuant to OAC rule 5160-26-05.1.

2. The OhioRISE Plan must provide assistance to providers through a toll-free call-in system.

3. The OhioRISE Plan must have the capability to capture "audio signatures" for any required forms or requests that require the provider's signature.

4. The OhioRISE Plan must use information from provider services interactions to inform improvements to the OhioRISE Plan's operations and service delivery system.

5. In the event the OhioRISE Plan's provider services center receives a call during normal business hours about a matter that is the responsibility of the SPBM or MCO, the OhioRISE Plan must provide the caller the appropriate contact information and transfer the caller to the SPBM's or MCO's provider services center. If the call is received after hours or the contact is made other than by phone (e.g., email or fax), the OhioRISE Plan must provide the relevant information to the SPBM or MCO as expeditiously as possible, but no more than one business day from receipt of the contact.

ii. Provider Services Hours of Operation

1. The OhioRISE Plan must ensure provider services staff are available nationwide to provide assistance to providers through the toll-free call-in system at all times during the hours of 7:00 am to 8:00 pm Eastern Time, Monday through Friday, except on the following major holidays: New Year's Day, Martin Luther King Day,

Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day.

2. The OhioRISE Plan may select two additional optional closure days, which may be used separately or in combination with any of the major holiday closures, but may not both be used within the same closure period. Before announcing any optional closure dates to providers or staff, the OhioRISE Plan must receive ODM's prior approval that verifies that the optional closure days meet the specified criteria.

3. If a major holiday falls on a Saturday, the OhioRISE Plan may close its provider services line on the immediately preceding Friday.

4. If a major holiday falls on a Sunday, the OhioRISE Plan may close its provider services line on the immediately following Monday.

5. The OhioRISE Plan must specify provider services closure days in the OhioRISE Plan's provider manual, provider portal, and website at least 30 calendar days in advance of the closure.

6. The OhioRISE Plan must request and obtain prior approval from ODM of any extended hours of operation of the provider services line outside the required days and time specified above.

7. The OhioRISE Plan must transfer providers directly to the respective MCO through a warm handoff for questions tied to MCO covered benefits, contracting, etc.

iii. Provider Call Center Performance Standards

1. The OhioRISE plan must meet or exceed the following provider call center standards:

   a. Average speed of answer: Ninety percent of calls are to be answered by a live call center representative within thirty seconds. Answered means for each caller who elects to speak to a live call center representative;

   b. Abandonment rate: Five percent or less of incoming calls that are abandoned while waiting for a live call center representative. ODM considers a call to be abandoned if:

      i. The caller chooses to disconnect after thirty seconds and prior to being connected to a live call center representative or voice mail; or

      ii. The caller elects an IVR option and is not permitted to access that option and disconnects (by the caller or system); or

iii. The system disconnects the call while the caller is waiting for a live call center representative.

c. Hold time: Total on hold time not to exceed sixty seconds. Hold time refers to anytime the caller is placed on hold by a live call center representative. This could include placing a caller on hold for the following:

i. The call center representative to review documentation; or

ii. To transfer the call to another call center representative, manager, or department;

2. The OhioRISE Plan must self-report provider call center performance (Provider Call Center Report) as specified in Appendix P, Chart of Deliverables, in the standards identified above for its Provider Call Center.

3. The OhioRISE Plan must have a separate telephone line and phone number for its provider call center under this Agreement. The OhioRISE Plan must separately report call center performance for member services and provider services.

4. The OhioRISE Plan must report performance standards more frequently by provider type, if required by ODM.

iv. Provider Representatives

1. The OhioRISE Plan must designate and make available provider representatives across all areas of the state with the training and knowledge to promptly and accurately respond to inquiries and resolve problems raised by providers of all types.

v. Provider Training

1. The OhioRISE Plan must ensure providers and subcontractors receive training on applicable program requirements and all necessary OhioRISE Plan's operational requirements.

2. The OhioRISE Plan must maintain a calendar and records of its provider and subcontractor required trainings.

3. The OhioRISE Plan must ensure that individuals who oversee and deliver training must have demonstrable experience and expertise in the topic for which they are providing training.

4. The OhioRISE Plan must maintain records of training that occur along with an attendee listing for each training. Upon ODM request, the OhioRISE Plan must provide evidence of provider and subcontractor completion of OhioRISE Plan-required training.

5. The OhioRISE Plan must require providers to attend ODM-delivered provider training, as mandated by ODM.

6. The OhioRISE Plan must make upcoming provider trainings publicly available, including on its website, and must maintain records of past training and related information.

b. Provider Feedback

   i. The OhioRISE Plan must have the administrative capacity to monitor individual providers on the provider's adherence to evidence-based practice guidelines, positive and negative care variances from standard clinical pathways, and the direct impact on treatment outcomes and costs of care.

   ii. The OhioRISE Plan must use this information to guide OhioRISE Plan's activities, such as performance improvement projects for providers that include incentive programs, or the development of quality improvement programs.

   iii. The OhioRISE Plan must collaborate with ODM and the MCOs on prescriber engagement strategies to educate and monitor the OhioRISE Plan's network providers regarding compliance with ODM's preferred drug list, prior authorization requirements, billing requirements, and appropriate prescribing practices.

c. Notification of OhioRISE Plan's Policy Changes

   i. In instances when the OhioRISE Plan must provide notice to a provider regarding a change in policy as specified in this Agreement, the OhioRISE Plan must provide direct communication (e.g., email, letter, in-person meeting) to any applicable provider association(s) at least 30 calendar days prior to implementation.

d. Provider Manual

   i. The OhioRISE Plan must customize, distribute, and maintain a provider manual, using an ODM-provided template and required model provider manual language.

   ii. The OhioRISE Plan must submit the provider manual to ODM for review and approval prior to distribution.

   iii. The OhioRISE Plan must issue bulletins as needed to incorporate any necessary changes to the provider manual and must review the entire provider manual at least annually.

   iv. The OhioRISE Plan must post the provider manual on its website.

e. PRTF Program Manual

   i. The OhioRISE Plan must customize, distribute, and maintain a PRTF program manual.

   ii. The OhioRISE Plan must submit the PRTF program manual to ODM for review and approval prior to distribution.

iii. The OhioRISE Plan will work with ODM to revise and maintain the PRTF Program manual.

iv. The OhioRISE Plan must post the PRTF program manual on its website.

f. Billing Guides

i. The following principles must be incorporated into the creation and use of the OhioRISE Plan's billing guides. The OhioRISE Plan must:

1. Collaborate with ODM to minimize the complexity of conducting business with the State Medicaid agency.

2. Utilize the Provider Master File to adjudicate claims. The OhioRISE Plan must use this information to minimize the impact on provider billing requirements and reduce provider denials and resubmissions.

3. Follow the X12/TR3 industry standard when implementing changes.

4. Follow Council for Affordable Quality Healthcare, Inc. (CAQH) Committee on Operating Rules for Information Exchange (CORE) mandated timeframes with specific claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) on the 835 transaction of the outcome. The OhioRISE Plan must inform the providers of the outcome on the encounter submissions to ODM.

5. Participate in any meetings, workgroups, or other activities related to billing guides as directed by ODM. The OhioRISE Plan must notify ODM for review and approval prior to implementation of any changes to billing guide policies or procedures.

g. Information for ODM-Designated Providers

i. The OhioRISE Plan must share specific information with CMEs, MRSS (including referrals from MRSS for children who may be eligible for the OhioRISE Program due to a crisis), Intensive Home-Based Treatment providers, federally qualified health centers (FQHCs)/rural health clinics (RHCs), PRTFs, hospitals offering inpatient psychiatric and/or inpatient substance use disorder services, and other behavioral health providers identified in Appendix B, Coverage and Services.

ii. The information must be shared within the timeframe established by ODM after the OhioRISE Plan has been awarded a Medicaid provider agreement and annually thereafter.

1. At a minimum, the information must include the following:

a. The information's purpose;

b. Claims submission information, including the OhioRISE Plan's Medicaid provider number (this information must only be provided to non-panel federally qualified health centers [FQHCs] and rural health clinics [RHCs]). Claims submission information must include 30 calendar day

advance notice to providers of any new edits or system changes related to claims adjudication or payment processing;

c. The OhioRISE Plan's prior authorization and referral procedures;

d. A picture of the MCO-issued and ODM-issued member ID card containing information about OhioRISE Plan assignment (front and back);

e. Contact numbers for obtaining information for eligibility verification, claims processing, referrals, prior authorization, post-stabilization care services; and

f. A listing of the OhioRISE Plan's providers.

h. Provider Claim Resolution

i. Provider Claim Inquiry Resolution

1. Provider claim inquiries include any questions about claims received by the provider call center that are resolved on the initial phone call.

2. The OhioRISE Plan must establish and maintain a provider claim inquiry resolution process for its network and out-of-network providers.

3. The OhioRISE Plan must ensure that staff who review, investigate, and resolve a claim inquiry have the appropriate experience and knowledge for that type of inquiry and have access to all needed information and systems.

4. As a part of the provider claim inquiry resolution process, the OhioRISE Plan must:

a. Allow providers to file a claim inquiry within 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later

b. If additional time is needed to resolve a claim inquiry beyond the initial phone call, the OhioRISE Plan must escalate it to the provider claim dispute resolution and follow those requirements.

c. Thoroughly investigate each provider claim inquiry using applicable statutory, regulatory, and contractual provisions, collecting all pertinent facts from all parties and applying the OhioRISE Plan’s written policies and procedures;

ii. Provider Claim Inquiry Resolution Tracking and Reporting

1. The OhioRISE Plan must develop and use a system to capture, track, and report the status and resolution of all provider claim inquiries.

a. Upon request, the OhioRISE Plan must submit any system documentation and additional data requests within 7 business days.

2. The OhioRISE Plan must evaluate the effectiveness of the claim inquiry resolution system and identify opportunities to improve the provider experience.

3. The OhioRISE Plan must use information collected from the claim inquiry process to determine if there are claims payment systemic errors (CPSEs) and if improvements are needed to any of their processes.

4. The OhioRISE Plan must submit the Provider Claim Inquiry Report to ODM as specified in Appendix P, Chart of Deliverables, including but not limited to information regarding number and types of inquiries by provider type.

    a. Raw data for each inquiry must be included on a tab of the monthly report submitted to ODM. At a minimum, the following should be included:

        i. Inquiry Category;

        ii. Claim Number;

        iii. Received Date; and

        iv. Provider Type.

iii. Provider Claim Dispute Resolution Process

1. Provider claim disputes include any level of dissatisfaction with claims determination such as reconsiderations, appeals, and escalated provider claim inquiries. While these disputes can come in through any avenue (e.g., provider call center, provider advocates, OhioRISE Plan's provider portal), they do not include inquiries that come through ODM's ProviderWeb portal (HealthTrack).

2. The OhioRISE Plan must establish and maintain a provider claim dispute resolution process for its network and out-of-network providers to dispute adverse claims payment decisions made by the OhioRISE Plan.

3. The OhioRISE Plan must ensure that staff who review, investigate, and resolve a claim dispute have the appropriate experience and knowledge for that type of dispute and have access to all needed information and systems.

4. As a part of the provider claim dispute resolution process, the OhioRISE Plan must:

    a. Allow providers to file a claim dispute within 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later;

    b. Allow providers to submit claim disputes verbally or in writing, including through the provider portal;

c. Convert a verbal dispute to writing and include a tracking number for the provider;

d. Within five business days of receipt of a dispute, notify the provider (verbally or in writing) that the dispute has been received;

e. Thoroughly investigate each provider claim dispute using applicable statutory, regulatory, and contractual provisions, collecting all pertinent facts from all parties and applying the OhioRISE Plan's written policies and procedures;

f. Resolve and provide written notice to the provider of the disposition of all claim disputes resulting from the OhioRISE Plan's decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity within 30 business days of the receipt of the dispute.

g. Resolve and provide written notice to the provider of the disposition of all claim disputes, except for claim disputes resulting from the OhioRISE Plan's decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity, within 15 business days of receipt of the dispute.

h. If additional time is needed to resolve a claim dispute beyond 15 business days, the OhioRISE Plan must provide a status update to the provider on the 15th business day from receiving the claim dispute. For claim disputes not related to medical necessity, the OhioRISE Plan must provide an update to the provider every five business days beginning on the 15th business day until the claim dispute is resolved.

i. When required, the written notice must include:

    i. The nature of the dispute;

    ii. The claim dispute tracking number;

    iii. A summary of the pertinent facts and claim detail for claim related disputes;

    iv. The specific statutory, regulatory, contractual, or policy references that support the resolution;

    v. If applicable, CPSE details, including CPSE ID and location of the CPSE report; and

    vi. Next steps if the provider disagrees with the resolution including the opportunity for external medical review if the claim denial was due to lack of medical necessity.

j. Reprocess and pay disputed claims, when the resolution determines they were paid/denied incorrectly, within 30 calendar days of the

written notice of the resolution unless a system fix is needed then additional time is allotted; and

k. Automatically apply the corrective action or claims resolution to correctly adjudicate all other provider claims affected by the same issue.

iv. Provider Claim Dispute Resolution Tracking and Reporting

1. The OhioRISE Plan must develop and use a system to capture, track, and report the status and resolution of all provider claim disputes, including all associated documentation.

    a. The OhioRISE Plan must provide ODM view-only access to its provider claim dispute tracking system.

    b. Upon request, the OhioRISE Plan must submit any system documentation and additional data requests within 7 business days.

2. ODM Provider Relations must be granted access to the MCO's provider claim dispute system where all disputes are captured.

3. The OhioRISE Plan must evaluate the effectiveness of the claim dispute resolution system and identify opportunities to improve the provider experience.

4. The OhioRISE Plan must use information collected from the claim dispute process to determine if there are claims payment systemic errors (CPSEs) and if improvements are needed to any of its processes.

5. The OhioRISE Plan must submit the Provider Claim Dispute Report to ODM as specified in Appendix P, Chart of Deliverables, including but not limited to information regarding number and types of disputes, by provider type, time to resolution, identified trends, and program improvements.

    a. Raw data for each dispute must be included on a tab of the monthly report submitted to ODM. At a minimum, the following should be included:

        i. Dispute Category

        ii. Claim Number

        iii. Received Date

        iv. Avenue of submission (e.g., phone, mail, email, provider portal)

        v. Provider Type

        vi. Resolution Date

i. External Medical Review

i. The OhioRISE Plan must offer an external medical review to a provider who is unsatisfied with the OhioRISE Plan's decision to deny, limit, reduce, suspend, or terminate a covered service (i.e., those specified in Appendix B, Coverage and Services) for lack of medical necessity. Denials for lack of medical necessity include, but are not limited to:

    1. Denials, limitations, reductions, suspensions, or terminations that required clinical documentation or medical record review in making the decision to deny (includes pre-service, concurrent, and retrospective reviews);

    2. Denials, limitations, reductions, suspensions, or terminations that involved clinical judgement or medical decision-making (i.e., request was referred to a licensed practitioner for review);and

    3. Denials, limitations, reductions, suspensions, or terminations based on not meeting a clinical standard or medical necessity requirement (e.g., InterQual®, MCG®, ASAM, or OAC rule 5160-1-01, including EPSDT criteria).

ii. Decisions subject to external review include an adverse benefit determination in response to a service authorization request or claim payment denials that are due to lack of medical necessity. Service authorization requests and claim payments that are denied for reasons other than the lack of medical necessity correctly by the OhioRISE Plan are not subject to external medical review.

iii. The OhioRISE Plan must require the provider to first appeal the decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity using the OhioRISE Plan's internal provider appeals process as specified in ORC 5160.34(B)(12) or provider claim dispute resolution process before the provider requests external medical review.

    1. If after a provider requests an external medical review and the OhioRISE Plan and provider disagree that the OhioRISE Plan's decision is subject to an external medical review, ODM or its designee will determine if an external medical review is available for the provider in accordance with this Agreement.

    2. The OhioRISE Plan must allow a provider to request an external medical review if the OhioRISE Plan does not issue its response to the provider's internal appeal of the OhioRISE Plan's decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity within the required timeframes specified in ORC 5160.34(B)(12) for service authorizations or within 30 business days for provider claim disputes.

iv. The OhioRISE Plan must use the entity identified by ODM to perform the external medical review, and must pay for the cost of each review using an ODM-developed fee schedule.

v. The OhioRISE Plan must ensure that the external medical review process does not interfere with the provider's right to request a peer-to-peer review, a member's right to request an appeal or state hearing, or the timeliness of appeal and/or state hearing resolutions.

vi. The OhioRISE Plan must include the following information to providers for decisions subject to external medical review:

1. Information on the provider appeal process, including timelines for the OhioRise Plan to issue its appeal decision;

2. Notification of the provider's right to request an external medical review following the OhioRISE Plan's provider appeal decision or claims dispute resolution;

3. Information about the provider's ability to request external medical review within 30 calendar days after the provider's receipt of the OhioRISE Plan's provider appeal decision or claim dispute resolution and how to do so; and

4. Notification that the external medical review is available at no cost to the provider.

vii. The OhioRISE Plan must transmit all information relevant to the external medical review request to the ODM-identified external medical review entity within five business days for standard requests and one business day for expedited requests of when the external medical review entity requests information related to the provider's request for an external medical review, unless the OhioRISE Plan decides to reverse its decision as specified in this Agreement. Relevant information includes the provider's request for authorization, request for external medical review, and all medical records, other documents and records, and additional evidence considered, relied upon, or generated by the OhioRISE Plan in connection with the medical necessity determination.

viii. The OhioRISE Plan may review the relevant information submitted by the provider with an external medical review request prior to transmitting the OhioRISE Plan's information to the entity identified by ODM to perform the external medical review and decide to reverse the original coverage decision in part or in whole. If the OhioRISE Plan decides to reverse its original decision, in part or in whole, based on the review of relevant information submitted by the provider, the OhioRISE Plan must issue a written decision to the provider within 72 hours and notify the external medical review entity. If the OhioRISE Plan decides to reverse its decision in part, the OhioRISE Plan must forward the part that is unfavorable to the provider for an external medical review.

ix. If the decision from the external medical review entity reverses the OhioRISE Plan's coverage decision in part or in whole, the external medical review decision is final and binding on the OhioRISE Plan.

x. The OhioRISE Plan must comply with the written decision from the entity identified by ODM to perform the external medical reviews.

xi. For reversed service authorization decisions, the OhioRISE Plan must authorize the services promptly and as expeditiously as the member's behavioral health condition requires, but no later than 72 hours from when the OhioRISE Plan receives the external medical review decision.

xii. For reversed decisions associated solely with provider payment (i.e., the service was already provided to the member), the OhioRISE Plan must pay for the disputed services within the timeframes established for claims payment in Appendix L, Payment and Financial Performance.

xiii. The OhioRISE Plan must develop and use a system to capture and track the status and resolution of all external medical review, including external medical review volume and trends. The OhioRISE Plan must provide external medical review information to ODM upon request.

xiv. The OhioRISE Plan must periodically evaluate the effectiveness of the external medical review process and identify opportunities to improve the provider experience.

xv. The OhioRISE Plan must use information collected from the external medical review process to improve service authorization decision-making.

j. Provider Web Portal Complaints

i. The OhioRISE Plan must check ODM's Provider Web portal (hereinafter referred to as Healthtrack) complaint inbox daily for updates and new complaints assigned to it.

1. The OhioRISE Plan must acknowledge receipt of a HealthTrack complaint within five business days of the date the complaint was submitted by:

a. Conducting outreach to the provider through an in-person visit, a phone call, or an email. If attempting to make contact via phone and the appropriate person is unavailable, the OhioRISE Plan must leave a voicemail. Outreach must include that the complaint was received and that the OhioRISE Plan will respond by the assigned due date; and

b. Documenting the OhioRISE Plan's initial contact with the provider in Healthtrack within six business days of the submission of the complaint to include the following information:

i. The dates that outreach was made to the provider (a future date of contact will not be accepted);

ii. A call reference number if applicable;

iii. The methods of contact;

iv. The person that made the contact; and

v. The name of the individuals contacted.

2. The OhioRISE Plan must perform internal research, contact the provider, and present its findings to the provider within 15 business days.

a. Provider contact must include:

i. Outreach Monday through Friday between the hours of 8:00 am and 5:00 pm Eastern Time;

ii. The assigned OhioRISE Plan's provider representative's contact information;

iii. The Healthtrack complaint number or call reference number; and

iv. The OhioRISE Plan's findings, including all relevant information, to ensure the provider is educated on how to access all supporting policies or procedures.

b. If the provider is non-responsive, prior to closure of the complaint, the OhioRISE Plan must make a minimum of three outreach attempts to the provider by the OhioRISE Plan.

c. The OhioRISE Plan must document the following in HealthTrack by the assigned due date:

i. The date or dates that the OhioRISE Plan contact was made or attempted with the provider (a future date of contact will not be accepted);

ii. The method or methods of contact;

iii. The name of the individual or individuals contacted;

iv. The findings shared with the provider;

v. The policies and procedures to support the findings; and

vi. The root cause analysis or CPSE details. If already reported to ODM as a CPSE then the OhioRISE Plan must include the report month and row number.

d. If the OhioRISE Plan requires additional time to research a provider complaint, the OhioRISE Plan must:

i. Contact the provider, advise the provider of the delay in response, and indicate that the OhioRISE Plan will ask ODM to grant an extension. ODM will not grant the OhioRISE Plan an extension if the request does not include evidence that the OhioRISE Plan contacted the provider; and

ii. Document the OhioRISE Plan's outreach to the provider in Healthtrack, including the date of the provider contact, the name(s) of the individual(s) contacted, the requested extension date, and the justification for the delay in resolution.

e. ODM may shorten the timeframe for the OhioRISE Plan to address a complaint. If ODM shortens the timeframe, ODM will advise the OhioRISE Plan by entering a comment in Healthtrack.

k. Provider Advisory Council

i. The OhioRISE Plan must establish a provider advisory council.

ii. The OhioRISE Plan must hold provider advisory council meetings no less than on a quarterly basis. The OhioRISE Plan must offer meeting attendance in person, by phone, or virtually.

iii. The OhioRISE Plan must ensure that the provider advisory council is composed of a wide array of provider types, including CMEs, behavioral health providers, and SUD providers, as well as those predominantly serving minorities, LGBTQ youth, people with disabilities, or other populations disadvantaged by social determinants of health (SDOH).

iv. The purpose of the provider advisory council is for the OhioRISE Plan to gather input, discuss and learn about issues affecting providers, identify challenges and barriers, problem-solve, share information, and collectively find ways to improve and strengthen the health care service delivery system.

v. The OhioRISE Plan's provider advisory council must be chaired by the OhioRISE Plan's Administrator/Chief Executive Officer (CEO)/Chief Operating Officer (COO) or designee.

vi. The OhioRISE Plan must invite ODM to attend provider advisory council meetings and provide an agenda to ODM in advance of the meetings.

vii. The OhioRISE Plan must invite other child serving system agency representatives to the advisory council meetings to ensure representation for multi-system youth.

viii. The OhioRISE Plan must report on its provider advisory council activities (Provider Advisory Council Activity Report) as specified in Appendix P, Chart of Deliverables, including meeting dates, provider advisory council attendees, provider advisory council recommendations, and OhioRISE Plan's responses or follow-up activities to provider advisory council recommendations.

7. OhioRISE Plan's Website Requirements

a. General

i. The OhioRISE Plan must ensure its website is Americans with Disabilities Act Section 508 compliant, is accessible to individuals with limited English proficiency, and meets health equity requirements.

ii. The OhioRISE Plan must ensure that the appropriate safeguards are in place for any website functions that allow approved users to access member information (e.g., eligibility verification, authorization, claims).

iii. The OhioRISE Plan must have a mobile version of OhioRISE Plan's website content.

iv. The OhioRISE Plan must ensure that all information is located on the OhioRISE Plan's website in a manner that allows members and providers to navigate to it easily from the OhioRISE Plan's home page.

v. The OhioRISE Plan must coordinate with ODM and ODM-contracted managed care entities at ODM's direction to create standardized website functions and formats for key elements.

vi. The OhioRISE Plan must indicate it serves the entire state.

vii. As specified in Appendix F, Provider Network, the OhioRISE Plan's website must have a link to ODM's online provider directory and may have its own internet-based, mobile enabled internet-based provider directory that allows members to electronically search for providers.

    1. The OhioRISE Plan must make upcoming provider trainings publicly available on their website for easy accessibility.

viii. The OhioRISE Plan's website must have a link to ODM's Preferred Drug List and a link to the SPBM's website and provide information about how members can access pharmacy services, including how to request prior authorization, how to access the pharmacy provider directory (via link to ODM's provider directory), and the SPBM's toll-free call member services call center.

ix. The OhioRISE Plan's website must have links to all MCE websites operating in the State and a description of the MCEs' responsibilities.

x. The OhioRISE Plan's website must have links to the ODM webpage.

xi. The OhioRISE Plan website must have links regarding eligibility criteria for OhioRISE enrollment, process for requesting enrollment into the OhioRISE Program, including information on obtaining a CANS assessment.

xii. The OhioRISE Plan must post on its website the OhioRISE Plan's criteria for medical necessity determinations for services requiring authorization. In accordance with 42 CFR 438.915(a), the OhioRISE Plan must provide a hard copy of the OhioRISE Plan's medical necessity criteria to providers and members upon request.

xiii. The OhioRISE Plan must post information on its website to support members and their families/caregivers to understand and access behavioral health services, including:

    1. Systems of Care values and goals;

    2. The roles of the OhioRISE Plan, CMEs, and care coordinators;

    3. Where and how to access services, including emergency and crisis services, and a description of covered services;

    4. The family's/caregiver's role in the assessment, treatment, and support for members with mental health or substance use disorders, with a focus on member goals and strengths-based approaches; and

5. General information on the managing mental and substance use disorders; family- and person-centered and youth- and young adult-driven approaches; types of providers and services; and evidence-based and promising practices managed under the OhioRISE Plan.

xiv. The OhioRISE Plan must receive prior written approval from ODM before adding any information to its website that would require ODM's prior approval in hard copy form (e.g., member handbook information).

xv. The OhioRISE Plan must include additional information on its website as determined necessary by ODM.

b. Online Member Website

i. Member Information

1. The OhioRISE Plan must update the member website regularly to include the most current ODM-approved materials.

2. The OhioRISE Plan member website must also include the following information that must be accessible to members and the general public without any log-in restriction:

a. OhioRISE Plan contact information, including the OhioRISE Plan's toll-free member services phone number, service hours, and closure dates;

b. General information about how to request interpreter, translation, or auxiliary aids and services;

c. The ODM-approved OhioRISE Plan member handbook, OhioRISE 1915(c) waiver handbook, Quick Guide, SPBM/MCO pharmacy information, (as applicable to the phase of Next Generation implementation), recent newsletters, and announcements. The OhioRISE Plan's online version of its member handbook must offer hyperlinks from the table of contents to applicable section or topic;

d. A link to ODM's online provider directory);

e. The OhioRISE Plan's own internet-based, mobile enabled provider directory, if the OhioRISE Plan has opted to provide one as referenced in this appendix;

f. A section for member forms, including the following:

i. Change of address (County);

ii. Grievance and appeal form;

iii. Authorized representative;

iv. Advanced Directive; and

v. Any other forms the OhioRISE Plan requires the member to complete.

g. A list of services requiring prior authorization;

h. A 30-calendar days' advance notice of changes to the list of all services requiring prior authorization. The OhioRISE Plan must provide a hard copy of the notification of any prior authorization changes upon request;

i. The toll-free telephone statewide number for crisis behavioral health calls; and

j. Contact information for the MCOs and links to the MCO's websites to schedule non-emergency transportation assistance, including an explanation of the available services and to contact MCO member services for transportation services complaints, or OhioRISE Plan/CME care coordination for assistance with any transportation barriers.

3. The OhioRISE Plan must ensure that toll-free member services, 24/7 call-in systems, statewide and local behavioral health crisis response, and the MCO's transportation scheduling telephone numbers are easily identified on either the OhioRISE Plan's website home page or a page that is a direct link from a contact button on the home page.

ii. Secure Member Portal

1. The OhioRISE Plan must develop a secure member portal that allows members to perform the following functions:

a. Submit questions, comments, grievances and appeals, and receive a response, giving the member the option of requesting a response by return email or phone call;

b. Submit changes of member name, address, and phone number for the OhioRISE Plan to provide that information to the County; and

c. Request a change in behavioral health provider, including the member's CME.

2. The OhioRISE Plan must respond to questions or comments received from members within one business day from receipt.

3. The OhioRISE Plan must develop a secure member portal that allows members to access the following information:

a. The member's Medicaid redetermination date;

b. Authorized services;

c. The member's current care coordinator;

d. The data specified in 42 CFR 438.242 and 42 CFR 431.60;

e. Explanation of benefits for MCO, SPBM, and OhioRISE claims;

f. Community resources; and

g. Other Information that the OhioRISE Plan determines would be helpful to encourage the member to engage in their own health care.

c. Online Provider Website

i. Secure Provider Portal

1. The OhioRISE Plan must have a secure website for network providers through which providers can perform the following functions:

a. Access relevant member information to:

i. View member eligibility and enrollment;

ii. Confirm member primary language information and any other special communication needs;

iii. Access to child- and family-centered care plans for OhioRISE Plan's members; and

iv. Access claims and utilization history.

b. File and track the status of pending provider claim disputes and external medical reviews.

2. The OhioRISE Plan's secure provider portal must comply with all state and federal requirements relating to PHI, including compliance with 45 CFR Parts 160 and 164 (the HIPAA Security and Privacy Rule) and 42 CFR Part 2.

3. The OhioRISE Plan must obtain, maintain, and track all applicable authorizations and consent forms related to the secure provider portal. In the event a member revokes or limits their authorization or consent, the OhioRISE Plan must exclude the revoked or limited PHI from being shared via the secured provider portal unless otherwise permitted by law.

ii. Publicly Available Provider Page

1. The OhioRISE Plan must ensure that its provider page includes, at a minimum, the following information that the OhioRISE Plan must make accessible to providers and the general public without any log-in restrictions:

a. OhioRISE Plan's provider services contact information for provider issues;

b. The OhioRISE Plan's provider manual as described in this appendix;

c. Links to policies and prominent alerts that notify providers of changes to OhioRISE Plan's coverage processes and policies:

    i. The OhioRISE Plan must provide notice of changes to OhioRISE Plan's coverage requirements and services requiring prior authorization via its website at least 30 calendar days in advance.

    ii. Pursuant to ORC section 5160.34, the OhioRISE Plan must notify providers, via email or standard mail, the specific location of coverage and prior authorization requirement changes on the website 30 calendar days prior to the implementation of the changes.

d. The OhioRISE Plan's policies and procedures for all providers (in and out-of-network providers) to seek payment of claims for emergency, post-stabilization, and any other services authorized by the OhioRISE Plan;

e. ODM-provided provider instruction regarding the need to submit claims and prior authorization requests through the OMES Portal;

f. New edits or system changes related to claims adjudication or payment processing;

g. The OhioRISE Plan's documentation requirements for prior authorization and details about Medicaid programs and the OhioRISE Plan's services requiring prior authorization pursuant to ORC section 5160.34;

h. A sample network provider agreement by provider type; and

i. Links to Medicaid managed care and OhioRISE requirements in the Ohio Administrative Code and Ohio Revised Code.

8. Staffing Requirements

a. General Requirements

    i. The OhioRISE Plan must employ the identified qualified key and organizational staff, sufficient in number, to meet performance and compliance expectations as set forth in this Agreement.

    ii. The OhioRISE Plan must provide ODM with an Organizational and Functional Chart that identifies key staff, organizational staff, and reporting lines as specified in the Appendix P, Chart of Deliverables. This chart must also include work telephone numbers and email addresses for all key staff.

    iii. The OhioRISE Plan must ensure ODM-identified key and organizational staff are in place within the timeframe established by ODM as part of the readiness review requirements in this appendix.

1. The OhioRISE Plan must ensure sufficient staff are available with appropriate training and experience beginning within 30 days of contract execution to successfully begin implementation of the requirements of the agreement. Staff may include a combination of employed and contracted staff, and temporary national staff prior to employment of the required Ohio-based staff described in this section. Temporary national staff must be replaced with required Ohio-based staff within the timeframe established by ODM as part of the readiness review requirements in this appendix

iv. The OhioRISE Plan must have Ohio-based staff available 24/7 to work with ODM and other entities as identified by ODM on urgent issue resolutions. The OhioRISE Plan must have sufficient staff to meet the needs of ODM and its members. Urgent issues resolutions include but are not limited to immediate health, safety, or welfare concerns for members and public emergency events.

1. The OhioRISE Plan must ensure that these staff have access to identify members who may be at risk, their current health status and services, and the authority to initiate new placements or services to ensure limited disruption of care and services.

2. The OhioRISE Plan must notify ODM of the names and contact information, as well as any changes thereto, for these staff.

b. Key Staffing Requirements

i. All OhioRISE Plan's key staff must be full time and based (working) in the state of Ohio, unless otherwise indicated in this Agreement. OhioRISE Plan's key staff, including staff performing key staff functions on an interim basis, must be approved by ODM.

ii. An OhioRISE Plan's key staff member must only occupy one of the key positions listed below unless the OhioRISE Plan receives prior written approval from ODM allowing the key staff to occupy more than one key position.

iii. Key staff must be dedicated to the OhioRISE Plan and may not share roles or responsibilities with an Ohio Medicaid MCO and/or MyCare Ohio Plan unless specifically indicated in the position requirements in this Agreement.

1. Any position that may be shared between the OhioRISE Plan and an affiliated Ohio Medicaid and/or MyCare Ohio Plan may be a part time position if the selected OhioRISE Plan is unaffiliated with an Ohio Medicaid MCO and/or MyCare Ohio Plan, subject to ODM's review and approval.

2. The OhioRISE Plan's Organization and Functional Chart must indicate any shared or part-time positions and must be reviewed and approved by ODM.

iv. The OhioRISE Plan must notify ODM in writing of interim and permanent replacements for key staff.

1. OhioRISE Plan's notification must include the name of interim or permanent staff fulfilling the position responsibilities, and the individual's experience and

credentials demonstrating minimum key staff requirements under this Agreement are met, and the individual's contact information.

2. The OhioRISE Plan is prohibited from using interim staff to fill a key position for longer than six months, unless approved in writing by ODM.

c. Key Staff

i. Administrator/Chief Executive Officer/Chief Operating Officer

1. The Administrator/Chief Executive Officer (CEO)/Chief Operating Officer (COO) must fulfill the responsibilities of the position to oversee the entire operation of the OhioRISE Plan and have clear local authority over the general administration and implementation of all requirements set forth in this Agreement. The Administrator/CEO/COO must have at least five years of experience with children's behavioral health services and devote full time/40 hours per week to the OhioRISE Plan's operations to ensure adherence to program requirements and timely responses to ODM.

2. The Administrator/CEO/COO may not be shared with or report to the CEO of an Ohio Medicaid MCO and/or MyCare vendor and must be authorized and empowered to represent the OhioRISE Plan in all matters pertaining to this Agreement.

ii. Chief Medical Officer

1. The Chief Medical Officer (CMO) must be a physician with a current, unencumbered license through the Ohio State Medical Board and have at least five years of experience with children's behavioral health services. A physician who is a Board-Certified Child and Adolescent Psychiatrist is preferred. The CMO shall devote a minimum of 32 hours per week to the OhioRISE Plan's operations to ensure clinical oversight and consultation and shall be a member of the OhioRISE Plan's executive team.

2. The responsibilities of the Medical Director/CMO include but are not limited to:

a. Ensuring that the OhioRISE Plan makes timely medical decisions, including after-hours consultation as needed;

b. Leading all major clinical, population health management, and quality improvement components of the OhioRISE Plan;

c. Developing, implementing, and interpreting medical policies and procedures, including service authorization, claims review, discharge planning, and medical reviews performed through the OhioRISE Plan's grievance and appeal system;

d. Leading the administration of all medical management activities of the OhioRISE Plan;

e. Serving as the chair or co-chair of the Utilization Management committee and of the OhioRISE Plan's internal quality improvement committee;

f. Play a lead role in monitoring the overall safety of members with complex and or comorbid medical conditions;

g. Coordinating with the MCOs' care coordination staff and providers on medical services not included in the OhioRISE Plan's service array, early and periodic screening, diagnostic and treatment (EPSDT), receipt of maternal and postpartum care, family planning, and preventative health strategies;

h. Serving as a key clinical lead in developing and implementing evidence-based clinical policies and practices;

i. Participating in regulatory/accreditation reviews;

j. Working with MCO's clinical leadership as needed for integration of all health care needs and services for OhioRISE Plan's members; and

k. Assuming key role in quality improvement initiatives, care coordination activities, and member safety activities (i.e., incident management).

iii. Behavioral Health Clinical Director

1. The Behavioral Health (BH) Clinical Director who possesses an independent, current, and unrestricted Ohio license to provide behavioral health services in the state of Ohio (MD, DO, RN with Advance Practice Registered Nurse [APRN] licensure, psychologist, licensed independent social worker [LISW], professional clinical counselor [LPCC], independent marriage and family therapist [LIMFT]) with a minimum of five years of experience in the provision and supervision of treatment service for mental illness and substance use disorders for children and adolescents. The BH Clinical Director must have specialty experience with children and adolescents with complex behavioral health needs, multi-system experience, and understanding of managed care.

2. The BH Clinical Director shall demonstrate knowledge and understanding of Ohio's overall behavioral health system that includes mental health, alcohol and drug addiction; developmental disabilities services; child welfare system; juvenile justice system; as well as Family and Children First Councils. The responsibilities of the BH Clinical Director include but are not limited to:

a. Providing daily operational activities of BH services across the full spectrum of care to members, inclusive of mental health and substance abuse services;

b. Ensuring access to behavioral health services;

c. Serve as a key clinical lead in developing and implementing evidence-based clinical policies and practices at both the OhioRISE Plan and the

clinical practice levels. This will necessarily require the integration of relevant pharmacy and social data to inform clinical policies and practices;

d. Promoting preventive BH strategies;

e. Identifying and coordinating assistance for member needs specific to BH;

f. Participating in management and program improvement activities with other key staff for enhanced integration with primary care and coordination of BH services and achievement of outcomes; and

g. Working with MCO clinical leadership as needed for integration of all health care needs and services for OhioRISE Plan's members.

3. Other duties and responsibilities of the BH Clinical Director staff must include:

a. Engaging in oversight and quality improvement activities associated with case management activities;

b. Providing guidance to BH network development recruitment, and value-based contracting, including CMEs in conjunction with OhioRISE Plan's provider relations, COE(s), and ODM;

c. Assisting in the review of utilization data to identify variances in patterns, and providing feedback and education to OhioRISE Plan's staff and providers as appropriate;

d. Representing the OhioRISE Plan as the BH clinical liaison to members, providers, and ODM; and

e. Ensuring whole person care by fully integrating physical and behavioral health throughout the care continuum and actively managing transitions of care.

iv. Chief Financial Officer

1. The Chief Financial Officer (CFO) must oversee the OhioRISE Plan's budget and accounting systems and operations. The CFO must have access to an actuary and is responsible for ensuring that the OhioRISE Plan meets ODM requirements for financial performance and reporting. The CFO may be a shared position with an Ohio Medicaid MCO and/or MyCare Ohio Plan.

v. Pharmacy Director

1. The OhioRISE Plan must have a Pharmacy Director who is a registered pharmacist in the state of Ohio with experience in state and federally funded health care programs, preferably with pharmacy benefit management experience. This may be a part-time position. The Pharmacy Director may be a shared position with an Ohio Medicaid MCO and/or MyCare Ohio Plan.

2. The primary roles and responsibilities of the Pharmacy Director include:

    a. Overseeing the OhioRISE Plan's responsibilities related to pharmacy benefits;

    b. Coordinating with the SPBM;

    c. Coordinating with ODM to provide input in the review of new drugs to market, changes to ODM's Preferred Drug List and ODM's/SPBM's/MCO's prior authorization criteria for pharmacy benefits;

    d. Consultation, coordination, and training for medication issues relevant to children for CMEs and prescribers in the OhioRISE Plan or MCO provider networks;

    e. Monitoring, managing, and coordinating the care of the OhioRISE Plan's members as it relates to utilization of prescription drugs (e.g., Coordinated Services Program, use of antipsychotics in children); and

    f. Participating in the Pharmacy and Therapeutics Committee, the Drug Utilization Review Committee, the Drug Utilization Review Board, and any other committee or board as requested by ODM.

vi. Population Health Director

1. The Population Health Director must:

    a. Hold a master's degree or other advanced degree in nursing, social work, health services research, health policy, information technology, or other relevant field;

    b. Have at least five years of progressively responsible professional experience in population health, service coordination, ambulatory care, community public health, case or care management, or coordinating care across multiple settings and with multiple providers;

    c. Have specialty experience with children and adolescents with complex behavioral health needs, experience with multi-system involved children and youth, experience with addressing health equity and race equity issues, and understanding of the different systems that serve children and youth; and

    d. Report directly to the OhioRISE Plan's Medical Director/CMO or Administrator/CEO/COO.

2. The primary roles and responsibilities of the Population Health Director are to:

    a. Oversee OhioRISE Plan support of system-wide and MCO population health initiatives based on a deep understanding of scientific population health principles;

b. Coordinate with ODM, MCOs, and other state child-serving agencies to design, implement, coordinate, and evaluate population health initiatives focused on the behavioral health of high-risk children and youth;

c. Sponsor and champion OhioRISE Plan and system-wide initiatives, including cultivating the support necessary to achieve the desired operational objectives for each initiative;

d. Liaison with ODM, MCOs, the SPBM, and other ODM contracted MCOs on population health activities;

e. Develop and implement operational plans that address the market opportunities/challenges and align with the established population health goals; and

f. Provide leadership for programmatic initiatives to reduce health disparities and address SDOH.

vii. Quality Improvement Director

1. The Quality Improvement (QI) Director must:

a. Be an Ohio-licensed registered nurse, physician, or physician's assistant, or be certified as a Certified Professional in Health Care Quality by the National Association for Healthcare Quality (NAHQ), Certified Quality Improvement Associate by the American Society for Quality, or Certified in Health Care Quality and Management (CHCQM) by the American Board of Quality Assurance and Utilization Review Providers prior to employment or within six months of the date of hire;

b. A minimum of two years' experience in a senior QI role in child/adolescent behavioral health managed care is required;

c. Have experience in quality management and quality improvement as specified in 42 CFR 438.206 through 438.370; and

d. Report directly to the Medical Director/CMO.

2. The primary functions of the QI Director are to:

a. Develop and manage the OhioRISE Plan's portfolio of improvement projects, including ensuring impact at a population level and identifying and prioritizing initiatives to align with ODM's Quality Strategy;

b. Oversee OhioRISE Plan's improvement teams and coordinate QI training for OhioRISE Plan's staff;

c. Reinforce the application of QI tools and methods within OhioRISE Plan's improvement projects and initiatives;

d. Ensure that learning from all improvement projects and initiatives are shared with ODM and ODM's contracted managed care entities; and

e. Coordinate with MCOs on Healthcare Effectiveness Data and Information Set (HEDIS) measures, including ensuring timely and accurate collection and exchange of data and collaboration on HEDIS outcome improvement initiatives.

viii. Care Coordination Director

1. The Care Coordination Director must be Ohio-licensed as a registered nurse, independent social worker, psychologist, professional clinical counselor, independent marriage and family therapist, independent chemical dependency counselor, or school psychologist in good standing, preferably with a designation as a Certified Case Manager from the Commission for Case Manager Certification. The Care Coordination Director must have experience in the activities of care management as specified in 42 CFR 438.208. The Care Coordination Director must have at least three years' experience providing direct behavioral health care coordination or oversight for children and adolescents with complex behavioral health needs, and must report through the Medical Director/CMO or BH Clinical Director. Additionally, the Care Coordination Director must have specialty experience with children and adolescents with complex behavioral health needs, and understanding of managed care and other child-serving systems, including child welfare, juvenile justice, and developmental disabilities.

2. The primary functions of the Care Coordination Director position are to:

a. Oversee the day-to-day operational activities of the Care Coordination Program Description in accordance with state guidelines and as set forth in the Care Coordination Plan described in Appendix D, Care Coordination. The Care Coordination Director is responsible for ensuring the functioning of care coordination activities across the continuum of care (assessing, planning, implementing, coordinating, monitoring, and evaluating);

b. Ensure access to primary care, behavioral health, and coordination of health care services for all members;

c. Serve as the OhioRISE Plan's primary point of contact for the MCOs on care coordination;

d. Develop and support the care coordination roles and responsibilities of the CMEs, in conjunction with OhioRISE Plan's clinical and provider leadership, COE(s) and ODM guidance;

e. Provide clinical leadership, in conjunction with the CMO, BH Clinical Director and Utilization Management Director, for assisting OhioRISE Plan and CME care coordinators with responsibilities to support and

develop CFT members' understanding of service and placement recommendations based on member need;

f. Develop and implement processes and resources for providing support to members who opt out of care coordination;

g. Know which members are participating in the Medicaid School Program and what school-based services they are receiving through the MSP;

h. Serve as the OhioRISE Plan primary point of contact for the MSP.

i. Coordinate services furnished to the member with the services the member receives from any other health care entity; and

j. Ensure care coordination and disease management is part of population health and quality improvement activities, when appropriate.

ix. Utilization Management Director

1. The Utilization Management Director must:

a. Be an Ohio-licensed registered nurse, APRN, licensed independent behavioral health clinician (MD, DO, RN with Advance Practice Registered Nurse [APRN] licensure, psychologist, licensed independent social worker [LISW], professional clinical counselor [LPCC], independent marriage and family therapist [LIMFT]) with a current unencumbered license through the Ohio State Medical Board with experience in the activities of utilization management, in accordance with 42 CFR 438.210. The Utilization Management Director must have at least three years' experience providing direct behavioral health care coordination or oversight for children and adolescents with complex behavioral health needs;

b. Preferably be certified as a Certified Professional in Health Care Quality by the NAHQ or CHCQM by the American Board of Quality Assurance and Utilization Review Providers; and

c. Report through the Medical Director/CMO.

d. The Utilization Management director can be located out of state if prior approved by ODM. Upon ODM approval, any out of state Utilization Management Director hire must meet Ohio licensing requirements within 6 months of hire.

2. The Utilization Management Director's primary responsibilities are to:

a. Oversee the day-to-day operational activities of the Utilization Management Program in accordance with state guidelines;

b. Develop written policies and procedures regarding authorization of services and monitor to ensure that these are followed;

c. Ensure the consistent application of review criteria for authorization decisions;

d. Collaborate with OhioRISE Plan's clinical leadership to implement the Utilization Management Program in a manner reflective of the roles and responsibilities of the CFT;

e. Ensure that decisions to deny or reduce the amount of services are made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease;

f. Ensure OhioRISE Plan's Notices of Adverse Action are provided in accordance with 42 CFR 438.404;

g. Ensure that all authorization decisions are made within the specified allowable timeframes; and

h. Evaluate under and over utilization information for impact on member quality of care and outcomes, including access to care.

x. Provider Network Director

1. The Provider Network Director acts as the primary point of accountability to ODM to address escalated provider issues and is responsible for network development, network sufficiency, and network reporting functions.

2. The primary functions of the Provider Network Director are to:

a. Meet provider services requirements under this Agreement;

b. Provide provider education and develop and deliver provider training;

c. Ensure network adequacy and appointment access, including development of network resources for identified unmet needs;

d. Ensure that contracted providers impacted by population health initiatives, such as quality improvement projects, are included on project teams to identify provider perceived barriers and provide input on design and intervention test that may impact providers;

e. Ensure that contracted provider perspectives and feedback are included in evaluations of improvement initiative successes;

f. Collaborate with other ODM-contracted managed care entities to simplify provider requirements and remove administrative barriers;

g. Serve as the point of communication and coordination with the COE(s); and

h. Develop and implement the OhioRISE Plan's provider claim dispute resolution process as described in this appendix.

xi. Claims and Encounter Administrator

1. The Claims and Encounter Administrator is responsible for ensuring prompt and accurate provider claims processing and accurate and timely encounter reporting to ODM. Sufficient staffing under this position must be in place to ensure all claims and encounter contract requirements are met.

    a. The Claims and Encounter Administrator responsibilities may be shared with an Ohio Medicaid MCO and/or MyCare Ohio Plan, and the OhioRISE Plan's Organization and Functional Chart must indicate how claims and encounter responsibilities will be shared across organizations.

    b. If the OhioRISE Plan is not affiliated with an Ohio Medicaid MCO and/or MyCare Ohio Plan, the Claims and Encounter Administrator must be a full-time position.

2. The primary functions of the Claims and Encounter Administrator are to:

    a. Develop and implement claims processing systems capable of paying claims in accordance with state and federal requirements, including resubmissions and overall adjudication of claims;

    b. Develop processes for cost avoidance;

    c. Ensure minimization of claims recoupments;

    d. Ensure claims processing timelines are met; and

    e. Ensure ODM encounter reporting requirements are met, including sufficient staff to ensure the submission of timely, accurate, and complete encounter data to ODM.

xii. Chief Information Officer

1. The Chief Information Officer (CIO) must be able to complete all required work under this Agreement and authorized to prioritize change orders and allocate the resources necessary to develop and maintain an information system that meets the performance expectations under this Agreement. The CIO may be a shared position with an Ohio Medicaid MCO and/or MyCare Ohio Plan.

2. The CIO must have the necessary training and experience in information systems, data processing, and data reporting to oversee all information systems functions supporting this Agreement.

3. The primary functions of the CIO are to:

    a. Ensure that multiple OhioRISE Plan's data systems are able to connect and coordinate so that fields housed in one system (e.g., updated contact information) can readily inform other systems;

b. Ensure that information related to data systems, analytical methods, and analysis results is communicated in a way that allows optimal usage by all OhioRISE Plan's programmatic areas;

c. Ensure that program areas are aware of, and understand how to use data resources (e.g., files received from ODM, Health Information Exchanges, Electronic Health Records and data from OhioRISE Plan's contractors) and integrate those resources with programmatic data when necessary;

d. Ensure that member and provider facing websites and portals are easily navigable by the general public, members, providers, and other authorized participants in the CFT process by obtaining and incorporating feedback from these stakeholders;

e. Ensure that Information Technology projects are implemented timely and correctly, as specified by ODM;

f. Coordinate with other ODM-contracted MCOs, SPBM, ODM-contracted FI, PNM, SI, and EDI vendors, and ODM to create a seamless view of the Ohio Medicaid interface with the public, members, and providers, resulting in all members interacting with Ohio Medicaid having a uniform way to access information;

g. Responsible for working with providers, particularly CMEs, to connect with and exchange information from OhioRISE systems to facilitate care coordination and efficient use of resources; and

h. Support program areas to integrate information contained within multiple data systems for use in improvement activities.

i. Ensures appropriate resources from parent company and OhioRISE Plan are engaged to fulfill ODM system requirements within the timelines specified by ODM, including providing the parent company with sufficient advance notice of the requirements to ensure that they understand the requirements and can allocate resources, as needed, to assist in fulfilling the requirements.

xiii. Grievance and Appeal Director

1. The Grievance and Appeal Director may be a shared position with an Ohio Medicaid MCO and/or MyCare Ohio Plan.

2. The primary functions of the Grievance and Appeal Director are to:

a. Establish and implement a grievance and appeals system pursuant to OAC rule 5160-26-08.4 and in accordance with 42 CFR Part 438, Subpart F;

b. Ensure the OhioRISE Plan's grievance and appeals system functions in two ways:

i. As an essential process to remediate member access to care and quality concerns; and

ii. As a source of information that serves as indicators of heath care system issues and concerns.

c. Share and review grievance and appeal system data with other operational areas, such as population health/quality management, utilization management, network management, member services, and program integrity to collectively develop and monitor interventions to correct system deficiencies.

xiv. Member Services Director

1. The Member Services Director is responsible for coordinating communications with members, resolving member inquiries and problems, and meeting member service requirements as required in this Agreement. The Member Services Director may be a shared position with an Ohio Medicaid MCO and/or MyCare Ohio Plan. The Member Services Director must also:

a. Ensure that members impacted by population health initiatives, such as quality improvement projects, are included on the project team to identify member perceived barriers and to assist with the design and testing of interventions impacting members;

b. Ensure that member perspectives and feedback are included in evaluations of improvement initiative success; and

c. Ensure that pertinent knowledge obtained through the OhioRISE Plan's population health improvement initiatives is incorporated into member services.

xv. Family Engagement Director

1. The Family Engagement Director is a member of the Senior Management team and is involved across OhioRISE Plan's functions, principally, utilization management, care coordination, quality monitoring, population health, and outreach/enrollment.

2. The Family Engagement Director must have personal experience parenting a child or youth with significant behavioral health challenges or co-occurring disorders.

3. The primary functions of the Family Engagement Director are to:

a. Work with OhioRISE Plan's senior management team members, ODM, CMEs, providers, other child-serving systems, the Member and Family Advisory Council, family-run organizations, and a diverse group of stakeholders to support the design, implementation, evaluation, and expansion of culturally competent, family-driven and youth-guided

practice and principles that support families, children, and youth who are being served through the OhioRISE Plan;

b. Keep informed of national, regional, and local trends and developments and supports the OhioRISE Plan to be a leader in implementation of culturally competent, family-driven public sector behavioral health care, through participation in strategic planning sessions and networking with experts in these fields, internal and external;

c. Draw on their own personal experience of:

    i. Parenting a child or youth with significant behavioral health challenges or co-occurring disorders;

    ii. Negotiating services and supports for their child and family; and

    iii. Being knowledgeable in key resources for children, youth, and families in the State.

d. Assist with new member outreach and orientation, including, assisting:

    i. Members to learn to navigate the behavioral health care delivery system, community resources, transportation, and effectively use behavioral health plan benefits;

    ii. Families to understand the treatment process and service choices for their children and providing education to families who have questions, concerns, or specific needs related to behavioral health; and

    iii. Families to understand the roles of the OhioRISE Plan, CMEs, and providers, as well as their relationship to Ohio Department of Job and Family Services (ODJFS), OMHAS, DYS, and the MCOs.

e. Ensure culturally competent, family-driven principles are woven throughout all communications and outreach approaches and materials;

f. Work with OhioRISE Plan's senior management staff in the development of training curricula, educational materials, program standards, program descriptions, and expected outcomes for OhioRISE Plan-funded services;

g. Collaborate with COE(s) as needed for provider development and training to support families, children and youth being served by the OhioRISE Plan;

h. Conduct member and family focus groups to determine strengths and opportunities for improvement in OhioRISE Plan, CME, and provider functions;

i. Lead roundtables, forums, and other meetings, as assigned;

j. Ensure input into quality improvement from the OhioRISE Program Member and Family Advisory Council;

k. Work with Provider Network Development staff to support the alignment of the provider network with culturally competent, family-driven principles, including:

    i. Ensuring input from the Member and Family Advisory Council into Provider Development issues; and

    ii. Assisting with developing ongoing training programs for OhioRISE Plan's staff, as well as for staff at network provider agencies, including online training modules, conferences, etc.

l. Provide input into UM policies and practices from the perspective of culturally competent, family-driven care;

m. Serve as a resource for families to help explain UM policies and practices;

n. Make UM staff aware of UM related issues identified through focus groups and other input from families and work with UM staff to resolve these issues;

o. Develop and maintain strategies to garner stakeholder, community, member, and family feedback to identify key issues and inform/refine overall population health strategy;

p. Disseminate information at conferences and other meetings of professional communities to family-run organizations and other stakeholders through exhibits and presentations;

q. Develop strong relationships with stakeholders and act as spokesperson for families, parents, and youth as needed;

r. Support population health objectives by assisting with outreach to and obtaining input from populations experiencing disparities in access to care or disproportional service use;

s. Speak at local and regional conferences showcasing the OhioRISE Plan's work to promote culturally competent, family-driven care, and population health objectives and support OhioRISE Plan's major campaigns such as children's mental health awareness;

t. Assist families with understanding care coordination tiers and provide assistance, as needed, for families transitioning from or between tiers, including conducting member and family focus groups to determine strengths and opportunities for improvements at CMEs and with tiers;

u. Work with OhioRISE Plan's staff care coordinators to perform data collection and analysis of trends;

v. Provide support to family peer specialists working for agencies in the OhioRISE Plan's network;

w. Sponsor periodic conference calls for peer specialists, for training. support, and peer exchange;

x. Serve as liaison with parent-run and consumer organizations and provider agencies regarding efforts to expand the use of peer specialists, achieve family-driven and youth-guided care, and support resiliency-oriented programs; and

y. Act as liaison with advocacy organizations regarding peer support training and implementation initiatives.

xvi. Youth Engagement Director

1. The Youth Engagement Director is responsible for facilitating and coordinating a robust youth engagement strategy for the OhioRISE Plan, with a particular focus on young people who are experiencing or have experienced behavioral health challenges as well as those who have been impacted by foster care, juvenile justice, or homelessness. The Youth Engagement Specialist should have direct lived experience with behavioral health challenges.

2. The primary functions of the Youth Engagement Director are to:

a. Work closely with OhioRISE Plan's senior management team members, ODM, COE, CMEs, providers and other child-serving systems, and the Member and Family Advisory Council to assist in the development, evaluation, and improvement of services to ensure adherence to the OhioRISE Program's mission and values of authentic youth engagement, building community, equitable practices that promote race equity, diversity and inclusion, and strengths-based, youth-guided practice;

b. Develop and provide support to a Youth subgroup of the OhioRISE Program Member and Family Advisory Council, including outreach to recruit young people to the subgroup with lived experience in behavioral health, foster care, juvenile justice, or who are experiencing homelessness to participate in opportunities to inform OhioRISE Plan's operations, population health strategies, and quality improvement;

c. Conduct orientation, as well as initial and ongoing training for young people on various topics;

d. Provide ongoing support, guidance, and coaching to young people engaged in opportunities and programming, including life domain development, conflict resolution, emotional and moral support, and coordinating transportation as needed;

e. Provide ongoing input, information, and materials (as requested) that support internal and external communication efforts about youth-guided care;

f. Support young people as they advocate to ensure that the unique needs of young people are a priority for the systems designed to support them and in the broader community;

g. Participate in the continuous quality improvement and data-driven decision-making processes to assess efficacy of programming and drive programmatic refinements;

h. Ensure adherence to data collection requirements relevant to youth; and

i. Provide ancillary support for other OhioRISE Plan's projects by coordinating with and supporting colleagues as needed or requested.

xvii. Chief Compliance Officer

1. The Chief Compliance Officer is responsible for developing and implementing a compliance program and policies and procedures designed to ensure compliance with the requirements in this Agreement. The Chief Compliance Officer may be a shared position with an Ohio Medicaid MCO and/or MyCare Ohio Plan.

2. The Chief Compliance Officer must report to the Administrator/CEO/COO and the OhioRISE Plan's Board of Directors, and must be solely dedicated to ensuring OhioRISE Plan compliance with this Agreement.

xviii. Lead Investigator (Special Investigative Unit)

1. The Lead Investigator must hold either:

a. A bachelor's degree with a minimum of two years of experience in the health care field working in fraud, waste, and abuse investigations and audits; or

b. An associate's degree, with a minimum of four years of experience working in health care fraud, waste, and abuse investigations and audits; or

c. Experience and training/certifications commensurate with position requirements in lieu of formal educational requirements for the Lead SIU Investigator position may be considered. ODM will determine whether a potential Lead investigator’s experience and certifications are acceptable when the stated educational requirements are not met, on a case-by-case basis.

2. The Lead Investigator must be proficient in their ability to understand and analyze health care claims and coding, and must be solely dedicated to Special Investigative Unit (SIU) responsibilities required under this Agreement.

3. The Lead Investigator may be a shared position with an Ohio Medicaid MCO and/or MyCare Ohio Plan.

4. The primary responsibilities of the Lead Investigator are to:

    a. Identify risk, and guard against, fraud, waste, and abuse throughout the OhioRISE Plan's service delivery system;

    b. Actively monitor for aberrant providers;

    c. Refer potential fraud, waste, and abuse to ODM as required in Appendix G, Program Integrity, in a timely manner; and

    d. Actively participate in any meetings identified by ODM, including but not limited to Managed Care Program Integrity Group meetings, the Biweekly Home Health Care Fraud Referral meeting, and quarterly Special Investigation Unit lead meetings.

xix. OhioRISE Plan's Contract Administrator

1. The OhioRISE Plan Contract Administrator must serve as the primary point-of-contact for all OhioRISE Plan's operational issues.

2. The primary functions of the OhioRISE Plan's Contract Administrator include but are not limited to:

    a. Coordinating the tracking and submission of all contract deliverables;

    b. Fielding and coordinating responses to ODM inquiries;

    c. Coordinating, preparing for, and facilitating random and periodic audits and site visits; and

    d. Serving as the OhioRISE Plan's contract transition coordinator for transitions resulting from OhioRISE Plan's termination or non-renewal, as identified in Appendix O, OhioRISE Plan's Terminations and Non-Renewals, that includes:

        i. Coordinating the development and submission of the OhioRISE Plan's transition plan to ODM;

        ii. Coordinating the tracking and submission of all transition-related reports and deliverables;

        iii. Coordinating OhioRISE Plan's representation and attendance for ODM-identified transition meetings;

        iv. Coordination and overseeing all member transition activities to ensure the safe, timely, and orderly transition of members and their care; and

        v. Coordinating the development and submission of OhioRISE Plan's transition plan updates and the final report to ODM.

xx. Transition of Care Coordinator

1. The Transition of Care Coordinator is a full-time position and will serve as the primary point of contact with MCOs and with state agency staff for planning, managing, and troubleshooting transition issues as members' transition from MCOs into the OhioRISE Plan or back to the MCOs. The position reports to the Director of Care Coordination and must serve as the OhioRISE Plan's primary point of contact for planning and managing all member transitions of care as identified in Appendix D, Care Coordination, and transitions resulting from OhioRISE Plan's enrollments and disenrollments. The Transition of Care Coordinator must meet the following minimum qualifications:

    a. Have a minimum of two years' experience managing or coordinating children's mental health, child welfare, developmental disabilities, juvenile justice, or a related public sector human services or behavioral health care field, providing community-based services to children and youth and their family/caregivers;

    b. Have background and experience in one or more of the following areas of expertise: family systems; community systems, and resources; case management; child and family counseling/therapy; child protection; or child development;

    c. Be clinically and culturally competent/responsive with training and experience necessary to manage complex cases in the community across child-serving systems.

2. The primary functions of the OhioRISE Plan's Transition of Care Coordinator include but are not limited to:

    a. Development of OhioRISE Plan's policies and procedures for successful transition of members to and from MCOs in alignment with state requirements;

    b. Primary point of contact for OhioRISE Plan's staff, ODM, MCO representatives, and other state agency staff for transition of care issues; and

    c. Interface with Regional Coordinators to ensure member transitions of care include local resources and input as needed.

d. OhioRISE Plan's Organizational Staff

i. Provider Services Representatives

1. The OhioRISE Plan must have Provider Services Representatives sufficient in number to meet the standards set forth in this Agreement.

    a. Provider Services Representatives are responsible for ensuring providers receive prompt resolution to provider issues, including problems with claims payments, prior authorizations, and referrals.

b. Provider Services Representatives must be regionally based and familiar with the communities and providers serving that region.

c. Provider Services Representatives may be shared positions with an Ohio Medicaid MCO and/or MyCare vendor.

d. At least one full time Provider Services Representative must be dedicated to OhioRISE Plan's functions, if the OhioRISE Plan is affiliated with an Ohio Medicaid MCO and/or MyCare Ohio Plan.

ii. Regional Coordinators

1. The OhioRISE Plan must have Regional Coordinators who develop and execute OhioRISE Plan's engagement activities in priority communities. Regional coordinators must have at least two years' experience in a setting that includes services or management of multi-system youth, work with local/community systems of care, and knowledge of Ohio's child-serving systems.

2. The primary responsibilities of Regional Coordinators are to:

a. Serve as the OhioRISE Plan's primary points of contact for ODM-approved improvement efforts involving community-based organizations and requiring community outreach and active involvement in priority communities (e.g., juvenile detention diversion initiatives or reduction in efforts to reduce out–of-home placements);

b. Serve as the OhioRISE Plan's dedicated contact for county or local child serving agencies. Attend or oversee OhioRISE Plan attendance at community events in priority communities (e.g., trainings; County Alcohol Drug and Mental Health Boards [ADAMH], Boards of Developmental Disability, PCSA, Family and Children First Councils, Juvenile Courts, and School District meetings; and racism dialogues);

c. Provide in-person communication with ODM or other state agency funded community-based organizations in order to bolster the presence of the OhioRISE Plan itself as a collaborative and trusted partner of the community-based organization and as a supporter of the ODM initiative;

d. Coordinate training for county or local child-serving entities regarding the roles and responsibilities of the OhioRISE Plan and the CMEs;

e. Collaborate with the CMEs to identify service and resource gaps in local communities and assist state and local child-serving agencies in addressing those gaps;

f. Collaborate with MCO's Regional Coordinators to collectively strategize and address community concerns;

g. Coordinate the tracking and submission of process measures, as needed, related to OhioRISE Plan's improvement efforts in communities (e.g., reductions in out-of-home placements);

h. Promote the referral of members to community-based organizations when services are provided that will promote better outcomes;

i. Respond to ODM inquiries related to OhioRISE Plan's community engagement activities; and

j. Build alliances with family- and youth-run organizations to strengthen family and youth voice in OhioRISE Plan's operations.

iii. Special Investigative Unit Staff

1. The OhioRISE Plan must maintain adequate staffing and resources for its Special Investigative Unit (SIU) that includes, at a minimum, one SIU staff person per 60,000 members.

2. The OhioRISE Plan's proposed SIU staffing must be included in the OhioRISE Plan's fraud, waste, and abuse plan described in Appendix G, Program Integrity.

a. The Lead Investigator may also serve the Special Investigation Unit staff resources on a full or part-time basis depending on OhioRISE Plan's membership levels and required time to fulfill leadership responsibilities.

b. Proposed SIU staffing, including total full-time equivalents, are subject to ODM review and approval annually based on the OhioRISE Plan's fraud, waste, and abuse plan.

3. The OhioRISE Plan must ensure that all SIU staff investigators meet the following qualifications:

a. A minimum of two years in a health care field working on fraud, waste, and abuse investigations and audits;

b. A bachelor's degree, or an associate's degree with an additional two years working on health care fraud, waste, and abuse investigations and audits;

c. The ability to understand and analyze health care claims and coding.

iv. Population Health Staffing

1. In addition to senior clinical leadership, the OhioRISE Plan must employ sufficient population health staffing to improve population health outcomes, including the creation of new processes and procedures through iterative testing and evaluation that, at a minimum, incorporates insights from data, research, members, and providers.

a. Population Health staff may be shared positions with an Ohio Medicaid MCO and/or MyCare Ohio Plan.

b. At least one full time Population Health staff must be dedicated to OhioRISE Plan's functions, if the OhioRISE Plan is affiliated with an Ohio Medicaid MCO and/or MyCare Ohio Plan.

2. The OhioRISE Plan's population health staff must understand and execute their role in responding quickly and agilely to the needs of internal (i.e., OhioRISE Plan's staff) and external stakeholders (e.g., ODM).

3. The OhioRISE Plan's population health staffing must include community initiative staff, and staff in the fields of analytics, statistics, and informatics.

v. Member Services Staffing

1. OhioRISE Plan's member services staffing must be sufficient to designate at least one full-time member relations staff position to serve as the contact to address barriers identified by members during quality improvement projects aimed at improving member outcomes.

2. Member services staff may be shared positions with an Ohio Medicaid MCO and/or MyCare Ohio Plan.

3. At least one full time member services staff must be dedicated to OhioRISE Plan's functions, if the OhioRISE Plan is affiliated with an Ohio Medicaid MCO and/or MyCare Ohio Plan.

vi. Utilization Management Staff

1. The OhioRISE Plan must ensure that all staff involved in reviewing, evaluating information for service planning, authorization, or other UM functions meets the following minimum qualifications:

a. Be clinically licensed with a specialty in mental health, SUD, or child or youth services;

b. Have a minimum of two years' experience in children's behavioral health, child welfare, developmental disabilities, juvenile justice, or a related public sector human services or behavioral health care field, providing community-based services to children and youth, and their family/caregivers;

c. Have background and experience in one or more of the following areas of expertise: family systems, community systems and resources, case management, child and family counseling/therapy, child protection, or child development;

d. Be clinically and culturally competent/responsive with training and experience necessary to manage complex cases in the community across child-serving systems; and

e. Be trained to screen and assess crisis or emergency calls and assess the caller's degree of acuity/severity and clinical necessity for treatment based on ODM approved criteria.

2. The OhioRISE Plan must not use generalists to review and make prior authorization decisions for specialty services (e.g., child behavioral health services or services for substance use disorders).

a. UM staff may be shared positions with an Ohio Medicaid MCO and/or MyCare Ohio Plan.

b. At least one full time UM staff must be dedicated to OhioRISE Plan's functions, if the OhioRISE Plan is affiliated with an Ohio Medicaid MCO and/or MyCare Ohio Plan.

vii. Care Coordination Staff

1. The OhioRISE Plan must employ a sufficient number of care coordination staff to support the care coordination and population health needs of its members as specified in Appendix D, Care Coordination.

2. The OhioRISE Plan shall ensure that OhioRISE Plan's care coordinators meet the following minimum qualifications:

a. Have a minimum of two years' experience in children's mental health, child welfare, developmental disabilities, juvenile justice, or a related public sector human services or behavioral health care field, providing community-based services to children and youth, and their family/caregivers;

b. Have background and experience in one or more of the following areas of expertise: family systems, community systems and resources, case management, child and family counseling/therapy, child protection, or child development; and

c. Be clinically and culturally competent/responsive with training and experience necessary to manage complex cases in the community across child-serving systems.

viii. Other Organizational Staff

1. The OhioRISE Plan must employ sufficient organizational staff and appropriately utilize staffing resources to comply with this Agreement. ODM will evaluate staffing adequacy based on the OhioRISE Plan's ability to achieve compliance with this Agreement.

e. OhioRISE Plan's Staff Training Requirements

i. The OhioRISE Plan must ensure staff have appropriate education and experience, and provide staff training and orientation to enable staff fulfill the requirements of this Agreement.

ii. The OhioRISE Plan must ensure staff receive training on applicable program requirements commensurate with position responsibilities.

iii. The OhioRISE Plan must ensure staff receive training on characteristics of their members (multi-system youth) and best practices (including strategies to address trauma) for addressing the behavioral health needs of this population.

iv. The OhioRISE Plan must ensure staff receive training on the role of child welfare caseworkers, legal mandates, especially for youth in custody, and training on courts and juvenile corrections system.

v. The OhioRISE Plan must use the most appropriate training methods, which may include instructor-lead and web-based trainings.

vi. The OhioRISE Plan must submit an OhioRISE Plan's Staff Training Plan, including the topics and frequency of training, to ODM for prior review and approval as specified in Appendix P, Chart of Deliverables. At a minimum, the OhioRISE Plan's training must include:

1. Orientation to Ohio Medicaid managed care program, including roles and responsibilities of the MCOs, CCEs, the OhioRISE Program, SPBM, COE(s) and CMEs;

2. Training on health and race equity and implicit bias;

3. Training on the identification and report of fraud, waste, and abuse;

4. "Question, persuade, and refer" training for all care management staff;

5. Training on trauma-informed approaches, and

6. Any additional training topics as directed by ODM.

vii. The OhioRISE Plan must ensure that individuals who develop and deliver training have demonstrable experience and expertise in the topic for which they are providing training.

viii. When a position's role includes the application of clinical criteria, medical necessity criteria, or similar guidelines or criteria that requires the use of clinical judgement, the OhioRISE Plan must include:

1. An inter-rater reliability component to the training;

2. Minimum threshold of satisfactory scoring in inter-rater reliability prior to assumption of duties; and

3. No less than annual refresher training, including meeting or exceeding scoring threshold on inter-rater reliability.

9. Subcontractual Relationships and Delegation

a. General Requirements

i. The OhioRISE Plan may delegate administrative responsibilities subject to the requirements in this section.

ii. Unless otherwise specified by ODM, administrative services of a first tier, downstream, or related (FDR) entity include care coordination, marketing, utilization management, quality improvement, enrollment, disenrollment, membership functions, claims administration, provider network management, and coordination of benefits.

iii. For any other administrative functions not listed above that could impact a member's health, safety, welfare, or access to covered services, the OhioRISE Plan must contact ODM to request a determination of whether the function may be included as an administrative service that complies with the provisions listed herein.

iv. The OhioRISE Plan must not publish a delegated entity's general call center number.

v. For purposes of this Agreement, parties to administrative services arrangements and related terms are defined as follows:

1. "First tier entity" means any party that enters into a written arrangement, acceptable to ODM, with the OhioRISE Plan to provide administrative services for Ohio Medicaid-eligible individuals.

2. "Downstream entity" means any party that enters into a written arrangement, acceptable to ODM, with a first tier or related entity or below the level of a first tier or related entity to provide administrative services for Ohio Medicaid-eligible individuals. These arrangements continue down to the level of the ultimate provider of the administrative services.

3. "Related entity" means any related party to the OhioRISE Plan by common ownership or control under an oral or written arrangement to perform some of the administrative services under the OhioRISE Plan's contract with ODM. A related party includes but is not limited to agents, managing employees, individuals with an ownership or controlling interest in the OhioRISE Plan and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or individuals.

4. "FDR" is the collective term for first tier, downstream, and related entities.

5. "FDR agreement" is the written agreement between the OhioRISE Plan and an FDR to delegate administrative responsibilities or service.

b. First Tier, Downstream, and Related Entities Agreements

i. If the OhioRISE Plan delegates administrative responsibilities or services under this Agreement to any first tier, downstream, and related entities (FDR), the OhioRISE Plan must ensure it has an FDR agreement with the FDR to perform administrative services on the OhioRISE Plan's behalf.

ii. The following requirements apply to all FDR agreements.

1. The OhioRISE Plan must evaluate the FDR's ability to perform the administrative services before executing or renewing any FDR agreement.

2. The OhioRISE Plan must notify ODM of a proposed new FDR agreement,amendment, or termination at least 45 calendar days prior to the execution or termination of the FDR agreement. For new or amended FDR agreements, the OhioRISE Plan must use the ODM approved notification process so that ODM can review the information provided. For terminating FDR agreements, the OhioRISE Plan must notify their contract administrator. ODM, in its sole discretion, may require the OhioRISE Plan to submit the complete and exact text of the proposed new or amendment of a FDR agreement for ODM review. Unless otherwise specified by ODM, FDR agreements may not be executed, amended, or terminated until ODM has completed its review of the information contained in the notification, and its review of the FDR agreement as applicable.

3. For new, amended, or terminated FDR agreements that directly impact members' access to care, claims, provider payments, require system testing, member communication or clinical policy review, or otherwise would require an implementation or transition timeline longer than 45 days, the OhioRISE Plan must ensure there is minimal disruption to members and providers throughout the implementation or transition. The OhioRISE Plan must notify the contract administrator at the earliest opportunity and include:

    a. A description of whether the activity will be transitioned to the OhioRISE Plan, delegated to a new or different FDR, or terminated entirely. If the activity will be new or transitioned to a different FDR, the OhioRISE Plan must indicate the entity that will be responsible for the activity after termination of the FDR arrangement and submit an FDR agreement notification to ODM as described in this Agreement for the new entity.

    b. A transition plan describing how the MCP will ensure minimal disruption to members as a result of the new, amended, or terminated agreement.

4. The OhioRISE Plan must completely and accurately respond to ODM's questions and requests for information about the FDR and any provisions in the proposed FDR agreement within the timeframes established by ODM.

5. ODM has the right and authority to designate the FDR agreement, or any portion thereof, incompatible with this Agreement, incompatible with ODM Medicaid state plan amendment (SPA) or other federal authorities, incompatible with federal, state, or local regulations and laws, or unacceptable to ODM for any other reason, without limitation.

6. If ODM determines that the FDR agreement as a whole or any part of the proposed FDR agreement is unacceptable or incompatible as stated above, the OhioRISE Plan must amend the FDR agreement to ODM's satisfaction or seek a new FDR agreement.

7. ODM reserves the ability to review and approve all FDR agreements. Standard form contracts that apply to numerous provider entities, however, are generally excluded from this initial review and prior approval process. If any uncertainty exists regarding whether a potential agreement needs to be disclosed to ODM, the OhioRISE Plan should seek guidance from ODM.

8. The FDR disclosure, review, and approval processes are subject to change at ODM's discretion.

c. Transparency Requirements

i. The OhioRISE Plan must include a term in all FDR agreements that requires the FDR to grant ODM access to documents and other records ODM deems relevant to evaluate the FDR's performance thereunder.

ii. Upon ODM's request, the OhioRISE Plan must disclose to ODM all financial terms and arrangements for payment of any kind that apply between the OhioRISE Plan, or the OhioRISE Plan's FDR, and any provider of a Medicaid service, except where federal and state law restricts disclosing the terms and arrangements.

1. If applicable, the OhioRISE Plan and FDR must narrowly designate as proprietary portions of any FDR agreement that it deems to contain as proprietary information. Portions of any FDR agreement designated as proprietary information must be limited to the following:

a. Portions of the FDR agreement that meet the definition of proprietary information in Article VII.C of the Baseline Provider Agreement; and

b. Portions of the FDR agreement that consist of unique business or pricing structures that a competitor may use to gain an unfair market advantage over the FDR.

2. Proprietary designations in every FDR agreement must be limited consistent with the foregoing.

3. Every portion of an FDR agreement that is not designated as proprietary may be deemed by ODM to be a public record as defined in ORC 149.43.

d. Additional Requirements for FDR Agreements with Related Parties

i. "Related party" means any person or entity related to, or otherwise affiliated with, the OhioRISE Plan by common ownership or control, or aligned financial interests. A related party includes but is not limited to agents, managing employees, individuals with an ownership or controlling interest in the OhioRISE Plan and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons, or otherwise part of the same corporate family, who has the ability or perceived ability to influence the OhioRISE Plan in making financial or operating decisions.

ii. Prior to entering into a new or amended FDR with a related party after July 1, 2025, the OhioRISE Plan must submit to ODM a conflict mitigation plan outlining the protections which will be in place to mitigate any actual, potential, or perceived conflict of interest. The mitigation plan will contain at a minimum a detailed description of the proposed FDR agreement, describe the protections ensuring that the agreement will be negotiated at arms-length and not exploit the relationship for financial gain for either the OhioRISE Plan or the related party, and describe how the OhioRISE will ensure the FDR arrangement does not impede members' access to care or free choice of provider. The OhioRISE Plan may not execute the FDR agreement prior to ODM approving the mitigation plan.

iii. If either prior to its approval of the mitigation plan, or at any point thereafter, ODM determines that the mitigation plan as a whole or any part of the mitigation plan is unacceptable, insufficient, or incompatible as stated above, the OhioRISE Plan must amend the mitigation plan to ODM's satisfaction or else not contract with the related party, or else terminate the agreement with the related party if the agreement has already been executed

e. FDR Agreement Provisions

i. The OhioRISE Plan must ensure all FDR agreements include the following enforceable provisions:

1. A description of the administrative services to be provided by the FDR and any requirements for the FDR to report information to the OhioRISE Plan;

2. The beginning date and expiration date or automatic renewal clause for the arrangement, as well as applicable methods of extension, renegotiation, and termination;

3. Identification of the service area and Medicaid population, either "non-dual" or "non-dual and dual" the FDR will serve;

4. A provision stating that the FDR must release to the OhioRISE Plan and ODM any information necessary for the OhioRISE Plan to perform any of its obligations under the OhioRISE Plan's provider agreement with ODM, including compliance with reporting and quality assurance requirements;

5. A provision that the FDR's applicable facilities and records will be open to inspection by the OhioRISE Plan, ODM, ODM's designee, or other entities as specified under the OhioRISE Plan's provider agreement with ODM;

6. A provision that the agreement is governed by and construed in accordance with all applicable state or federal laws, regulations, and contractual obligations of the OhioRISE Plan; and that the agreement is automatically amended to conform to any changes in laws, regulations, and OhioRISE Plan contractual obligations to ODM without the necessity for written amendment;

7. A provision that Medicaid-eligible members and ODM are not liable for any cost, payment, co-payment, cost-sharing, down payment, or similar charge,

refundable or otherwise for services performed, including in the event the FDR or the OhioRISE Plan cannot or will not pay for the administrative services. This provision does not prohibit waiver entities from collecting patient liability payments from OhioRISE Plan members as specified in OAC rule 5160:1-6-07.1;

8. The procedures to be employed upon the ending, non-renewal, or termination of the arrangement, including, at a minimum, to promptly supply any documentation necessary for the settlement of any outstanding claims or services;

9. A provision that the FDR must abide by the OhioRISE Plan's written policies regarding the False Claims Act and the detection and prevention of fraud, waste, and abuse;

10. A provision that requires the FDR to adhere to all screening and disclosure requirements as described in Appendix G, Program Integrity;

11. A provision that the FDR, and all employees of the FDR, are subject to the applicable provider qualifications in OAC rule 5160-26-05;

12. For an FDR providing administrative services that result in direct contact with a Medicaid-eligible member, a provision that the FDR must meet the member information requirements as stated in this appendix and identify, and where indicated, arrange pursuant to the mutually agreed upon policies and procedures between the OhioRISE Plan and FDR, for the following at no cost to the member or ODM:

    a. Sign language services;

    b. Oral interpretation; and

    c. Auxiliary aids and services.

13. For an FDR providing administrative services that result in the selection of providers, a provision that the OhioRISE Plan retains the right to approve, suspend, or terminate any such selection;

14. A provision that permits ODM or the OhioRISE Plan to seek revocation of the OhioRISE Plan's contractor with the FDR or other remedies, as applicable, if ODM or the OhioRISE Plan determines that the FDR has not performed satisfactorily, or the arrangement is not in the best interest of the OhioRISE Plan's members;

15. A provision stating that all provisions in an FDR agreement must conform to and be consistent with all of the provisions of the OhioRISE Plan's provider agreement with ODM;

16. A provision that all of the provisions applicable to the FDR of under the OhioRISE Plan's provider agreement with ODM supersede all applicable provisions in an FDR agreement. If a provision in an FDR agreement contradicts or is incompatible with any applicable provision in the OhioRISE Plan's provider

agreement with ODM, the applicable provision in the FDR agreement is rendered null and void, unenforceable, and without effect;

17. A provision stating that all FDRs must fully assist and cooperate with the OhioRISE Plan in fulfilling the OhioRISE Plan's obligations under the OhioRISE Plan's provider agreement with ODM;

18. A provision that allows the OhioRISE Plan, ODM, and ODM's designee to obtain and gather data, documents, and information from FDRs for purposes of an audit, evaluation, or inspection of its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members; and, that the right to audit will exist through ten years from the final date of the contract period or from the date of completion of any audit, whichever is later, for the purpose of any audit conducted by Ohio Auditor of State, pursuant to ORC Chapter 117;

19. A provision that requires FDRs to provide all data and information to the OhioRISE Plan needed for the OhioRISE Plan to provide complete reporting to ODM for the requirements and standards set forth in Appendix N, Compliance Actions; and

20. A provision stating that FDRs must provide any information that ODM requests for purposes of compliance assessments as described in Appendix N, Compliance Actions.

f. OhioRISE Plan's Accountability

i. The OhioRISE Plan is ultimately responsible for meeting all contractual obligations under the OhioRISE Plan's provider agreement with ODM, regardless of delegation.

ii. For all OhioRISE Plan delegated responsibilities under this Agreement, the OhioRISE Plan must:

1. Monitor FDR performance on an ongoing basis and conduct a formal review at least annually to identify any deficiencies or areas for improvement;

2. Communicate the results of the performance review to the FDR and impose corrective action on the FDR as necessary;

3. Notify ODM and submit a corrective action plan to ODM if at any time the FDR is found to be in non-compliance with OhioRISE Plan delegated contractual obligations;

4. Report the results of the annual performance review and any corrective action plan (FDR Oversight Report) to ODM as specified in Appendix P, Chart of Deliverables; and

5. Ensure there is no disruption in meeting the OhioRISE Plan's contractual obligations to ODM, if the FDR or the OhioRISE Plan terminates the arrangement between the FDR and the OhioRISE Plan.

iii. Unless otherwise specified by ODM, all information must be submitted to ODM directly by the OhioRISE Plan.

iv. In accordance with 42 CFR 438.602, the OhioRISE Plan must post on its website the name and title of individuals included in 42 CFR 438.604(a)(6). For the purposes of this requirement, "subcontractor" is defined as any individual or entity that has a contract with the OhioRISE Plan that relates directly or indirectly to the performance of the OhioRISE Plan's obligations under this Agreement, not including a network provider.

10. Comprehensive Disaster/Emergency Response Planning

a. Comprehensive Disaster/Emergency Response Plan

i. As directed by ODM, the OhioRISE Plan must develop and implement a Comprehensive Disaster/Emergency Response Plan for natural, man-made, health care, or technological disasters, and other public emergencies (e.g., floods, extreme heat or cold, and public health emergencies).

ii. The OhioRISE Plan, as directed by ODM, must collaborate and share information with ODM-contracted managed care entities to address the disaster and implement the emergency response plan.

iii. The OhioRISE Plan must make the ODM-approved Comprehensive Disaster/Emergency Response Plan available to all staff.

b. Primary Point of Contact

i. As identified in the OhioRISE Plan staffing requirements in this appendix, the OhioRISE Plan must designate both a primary and alternate point of contact who will perform the following functions with respect to the OhioRISE Plan's Comprehensive Disaster/Emergency Response:

1. Be available 24/7 during the time of an emergency;

2. Be responsible for monitoring news, alerts, and warnings about disaster/emergency events;

3. Have decision-making authority on behalf of the OhioRISE Plan;

4. Respond to directives and emergent requests for information issued by ODM; and

5. Cooperate with the local- and state-level Emergency Management Agencies.

c. The OhioRISE Plan must participate in workgroups and processes as required by ODM to establish a state-level emergency response plan that will include a provision for Medicaid recipients, and must comply with the resulting procedures.

d. During the time of an emergency or a natural, technological, or man-made disaster, the OhioRISE Plan must:

i. Generate a current list of members for whom an individual disaster plan, according to the specifications below, has been developed, including the risk and the individual-level plan; and

ii. Distribute the list to local and state emergency management authorities according to the protocol established by ODM.

e. The OhioRISE Plan must identify members who are at risk for harm, loss, or injury during any emergency or potential natural, technological, or man-made disaster. OhioRISE Plan identification of vulnerable members must include populations as identified by ODM.

i. For these members, the OhioRISE Plan must develop an individual-level plan with the member when appropriate.

ii. The OhioRISE Plan must ensure staff, including care coordination staff, are prepared to respond to and implement the plans in the event of an emergency or disaster.

iii. The member-level plan must:

1. Include a provision for the continuation of critical services appropriate for the member's needs in the event of a disaster, including but not limited to access to medication/prescriptions;

2. Identify how and when the plan will be activated;

3. Be documented in the member record maintained by the OhioRISE Plan; and

4. Be provided to the member.

11. General Administrative and Operational Requirements for the OhioRISE 1915(c) Waiver

a. The OhioRISE Plan must adhere to the administrative and operational requirements described in the OhioRISE 1915(c) waiver.

b. Unless otherwise specified in this Agreement, all aspects of this Agreement are applicable to OhioRISE 1915(c) waiver enrolled members.

c. The OhioRISE Plan's process for reviewing and approving CFCPs that include OhioRISE 1915(c) waiver services serves as prior authorization of those waiver services. The OhioRISE Plan must ensure providers identified on the CFCP are certified as Medicaid 1915(c) waiver service providers prior to delivering 1915(c) waiver services.

d. If the OhioRISE Plan approves a CFCP that includes OhioRISE 1915(c) waiver services, the OhioRISE Plan's claims payment system must recognize the approval of the waiver services on the CFCP as prior authorization for claims payment purposes. Similarly, the OhioRISE Plan's claims payment system must not authorize payment for an OhioRISE 1915(c) waiver service when it was not prior authorized on the CFCP nor for members not enrolled on the OhioRISE 1915(c) waiver.

e. The OhioRISE Plan must ensure access to OhioRISE 1915(c) waiver level of care assessments conducted by the CMEs and must comply with all other waiver level of care assessments and eligibility requests from ODM.

f. The OhioRISE Plan must assist ODM with ongoing assessment and evaluation of the OhioRISE 1915(c) waiver enrollment processes and reconciling enrollment against the CMS-approved waiver enrollment capacity for each waiver year (note: the waiver will be phased in during the first waiver year).

g. The OhioRISE Plan must assist ODM with OhioRISE 1915(c) waiver service provider recruitment , waiver service provider network development, and contracting with waiver service providers that meet the provider qualifications for each waiver service as set forth in Chapter 59 of the Administrative Code.

h. Participant Direction

   i. The OhioRISE Plan must provide information and assistance to members to support participant direction of services. ODM views these activities as elements of case management provided by the OhioRISE Plan and the OhioRISE Plan's contracted CMEs, under treatment planning requirements per 42 CFR 438.208(c). The OhioRISE Plan and/or the CME must support the member in developing the CFCP and assist the member in exercising budget authority.

   ii. The OhioRISE Plan must contract with a Financial Management Services (FMS) entity to assist members as needed when a member has a documented need for Primary or Secondary Flex Funds as offered under the OhioRISE program. The contract must also include the OhioRISE Plan's responsibility for compensation to the FMS. The OhioRISE Plan shall have a contract with an FMS entity for the entire period of this Agreement.

   iii. The OhioRISE Plan must oversee and ensure that the FMS entity is reporting, at least monthly, all expenditures and information associated with exercising budget authority related to the provision of the Primary and Secondary Flex Funds services to the OhioRISE Plan. On a monthly basis, using the data sent by the FMS, the OhioRISE Plan must send a report to ODM that identifies inconsistencies based on that information. The OhioRISE Plan must develop this report by analyzing service utilization (including determining whether the service provided was within the scope of the service definition); member budgets; expenditures; dates of service; and when applicable, OhioRISE 1915(c) waiver enrollment date.

i. The OhioRISE Plan must monitor a member's waiver services under the OhioRISE 1915(c) waiver budget to ensure that it does not exceed the annual waiver cost cap of $15,000 in a 12-month period, excluding emergency funds. This includes oversight of the member's budget determined by their assigned CME. The OhioRISE Plan must submit quarterly cost cap reports as specified in Appendix P, Chart of Deliverables.

j. OhioRISE 1915(c) Waiver Operational Reporting Requirements

   i. The OhioRISE Plan must report the following to ODM as described in Appendix P, Chart of Deliverables:

      1. Member requests for Waiver Services and Access to Care;

      2. Waiver Restrictive Intervention, Restraint and/or Seclusions Report;

      3. Waiver Monthly Enrollment Report;

4. Waiver Enrollment and Disenrollment Statistics;
5. Waiver Cost Cap Report;
6. Waiver Service Claims Audit Report;
7. OhioRISE 1915(c) initial and redetermination level of care evaluations (Number of LOC Evaluations report) and;
8. Waiver Service Providers with an Active Medicaid Provider Agreement Report.

k. Ensuring Access Rule and HCBS Quality Measure Set. In accordance with the Deficit Reduction Act of 2005 (Pub. Law 109-171), the OhioRISE Plan will work with ODM to develop and implement the processes required per the Centers for Medicare and Medicaid Services Final Rule entitled Ensuring Access to Medicaid Services Final Rule (CMS-2442-F), including, but not limited to, the Home and Community Based Services Quality Measure Set.

APPENDIX B – COVERAGE AND SERVICES

1. OhioRISE Basic Benefit Package

a. Service Coverage Requirements

i. Pursuant to OAC rule 5160-59-03, the OhioRISE Plan must cover and ensure members have timely access to all medically necessary services listed below, in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to members under fee-for-service (FFS) Medicaid:

1. Care coordination as described in OAC rule 5160-59-03.2.

2. Mobile response and stabilization services (MRSS) as described in OAC rule 5160-27-13.

3. Intensive Home-based treatment (IHBT) as described in OAC rule 5160-59-03.3.

4. Behavioral health respite services in accordance with OAC rule 5160-59-03.4

5. Inpatient hospital services provided in accordance with OAC Chapter 5160-2 in a free-standing psychiatric hospital or a general acute care hospital that are:

   a. Inpatient psychiatric services; or

   b. Inpatient substance use disorder (SUD) services (including withdrawal management) provided in accordance with American Society of Addiction Medicine (ASAM) level of care four.

6. Psychiatric residential treatment facility (PRTF) services as described in 42 C.F.R. 441.151(October 1, 2023) through 42 C.F.R 441.184 (October 1, 2023), OAC Chapter 5122-41 and OAC rule 5160-59-03.6.

7. Opioid treatment program (OTP) services delivered by community SUD programs licensed by Ohio department of mental health and addiction services as a methadone administration program and/or certified by the substance abuse and mental health services administration (SAMHSA) as an OTP.

8. Behavioral health services provided in accordance with Chapter 5160-27 of the Administrative Code.

9. Behavioral health services provided in accordance with OAC rule 5160-8-05 .

10. Behavioral health services rendered by psychiatrists and physician assistants under the supervision of psychiatrists in accordance with Chapter 5160-4 of the Administrative Code and psychiatric advanced practice registered nurses in accordance with OAC rule 5160-4-04 .

11. Behavioral health services rendered by outpatient hospital providers in accordance with Chapter 5160-02 of the Administrative Code except for emergency department services.

12. Behavioral health services rendered in federally qualified health centers (FQHCs) and rural health clinics (RHCs) in accordance with Chapter 5160-28 of the Administrative Code.

13. Physician administered drugs for the treatment of mental health and SUD conditions, in accordance with OAC rule 5160-9-03; and services provided by pharmacist providers for the treatment of mental health and SUD conditions, in accordance with OAC rule 5160-8-52.

    a. Payment may be made for a pharmacist service rendered within a pharmacist's scope of practice when medically necessary. The service must be rendered for the purpose of managing medication therapy or administering medications in accordance with OAC rule 5160-8-52.

    a. All Medicaid-covered pharmacy services are provided by ODM's contracted single pharmacy benefit manager (SPBM). The OhioRISE Plan must coordinate and collaborate with the SPBM as necessary to ensure that members receive medically necessary pharmacy services.

    b. Annual Drug Utilization Review (DUR) Survey. The OhioRISE Plan shall submit the Annual CMS DUR survey, for all periods of time when the OhioRISE Plan was under contract with ODM, in compliance with CMS survey requirements. This survey shall be completed for all covered outpatient drugs (COD), including physician administered drugs (PAD).

14. Primary flex funds in accordance with OAC rule 5160-59-03.5.

15. Other services identified by ODM during the period of this Agreement.

ii. In accordance with 42 CFR 438.210, the OhioRISE Plan may place appropriate limits on service coverage, as specified in this appendix, with the exception of emergency and post-stabilization services, including mobile response services. The OhioRISE Plan must provide coverage and payment for these services, in accordance with 42 CFR 438.114 and OAC 5160-59-03.

iii. The OhioRISE Plan is not required to pay for services not covered by Ohio Medicaid, except as specified in this Agreement. Coverage exceptions can be found in OAC rules 5160-1-61.

2. OhioRISE 1915(c) Waiver Benefit Package

a. Pursuant to OAC rule 5160-59-05, the OhioRISE Plan must cover and ensure members have timely access to all medically necessary services listed below:

   i. Out-of-home respite in accordance with OAC rule 5160-59-05.1

   ii. Transitional services and supports (TSS) in accordance with OAC rule 5160-59-05.2

   iii. Secondary flex funds in accordance with OAC rule 5160-59-05.3.

3. Non-Risk Payments

a. State plan OhioRISE covered PRTF services must be paid for by the OhioRISE Plan and are paid on a non-risk basis outside the capitation rate for children and youth ineligible for enrollment in the OhioRISE program due to their incarceration status and eligibility for the limited Inpatient Hospital Services Plan (IHSP).

4. Ohio Medicaid Services Not Covered by the OhioRISE Program

a. The OhioRISE Plan is not required to cover pharmacy services for members other than the limited pharmacy services described in this appendix. All other pharmacy benefits are covered by the SPBM. The OhioRISE Plan must coordinate and collaborate with the MCOs and SPBM as necessary to ensure that members receive medically necessary pharmacy services.

b. The OhioRISE Plan is not required to cover behavioral health services for members enrolled in ODM's contracted MCOs when the member is not also enrolled in the OhioRISE Plan.

c. The OhioRISE Plan is not required to cover any medical services for members that are not listed in Section 1.a. of this appendix as covered OhioRISE Program's services.

5. Provider-Preventable Conditions

a. The OhioRISE Plan must not use Medicaid funding to pay for a service resulting from a provider-preventable condition (PPC) as defined in 42 CFR 447.26.

i. In accordance with 42 CFR 438.3(g), the OhioRISE Plan must identify and report all PPCs, regardless of the provider's intention to bill for that event, to ODM in the manner specified by ODM.

ii. The OhioRISE Plan must ensure that the prohibition on payment for PPCs does not result in a loss of access to care or services for members.

6. Service Specific Clarifications

a. Medication Therapy Management Program

i. As requested by ODM, the OhioRISE Plan shall work with other MCOs, the SPBM, ODM, and other stakeholders to develop medication therapy management (MTM) services, including the trigger events and MTM activities. These include but are not limited to initiatives focused on polypharmacy and the use of antipsychotic medications in pediatric populations served by the OhioRISE Plan and MCOs.

ii. Clinical and utilization outcomes must be tracked for successfully completed Targeted Medication Reviews (TMRs) and submitted to ODM four quarters after TMR completion as specified in Appendix P, Chart of Deliverables.

iii. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must submit an MTM Program Description for its MTM program. The description must include but not be limited to the MTM triggering events, activity that occurs after a triggering event, how each MTM interaction is documented and reimbursed, and how an action plan will be initiated and monitored.

b. Moral or Religious Objections

i. If the OhioRISE Plan determines that it will no longer provide, reimburse, or cover a counseling service or referral service due to an objection to the service on moral or religious grounds, the OhioRISE Plan must immediately notify ODM to coordinate the implementation of this change.

1. ODM will provide coverage and reimbursement for these services in accordance with ODM policy.

2. The OhioRISE Plan must notify its members of this change at least 30 calendar days prior to the effective date. The OhioRISE Plan must include in its member handbook and provider directory any such services that the OhioRISE Plan will not cover.

c. Behavioral Health Crisis Services

i. The OhioRISE Plan must ensure thatOhioRISE Plan's staff who have direct member contact know the continuum of community resources for behavioral health crisis services, including the 988 Suicide & Crisis Lifeline and the designated Regional MRSS Provider (RMP) within each region.

ii. The OhioRISE Plan must train OhioRISE Plan's staff who interface with the public or have direct member contact how to connect (through warm handoffs) members in need of behavioral health crisis services to 988 and the designated RMP.

iii. The OhioRISE Plan must track and document behavioral health crisis contacts from members and ensure that this information is shared as soon as possible and no later than the next business day with the member's OhioRISE Plan or CME for appropriate follow-up.

iv. The OhioRISE Plan must work with ODM, the OMHAS, and other entities as identified by ODM to develop a robust continuum of behavioral health crisis services.

d. Substance Use Disorder Treatment

i. The OhioRISE Plan must utilize the American Society of Addiction Medicine (ASAM) level of care criteria, and the OhioRISE Plan must not add additional criteria when reviewing level of care for substance use disorder (SUD) treatment provided in a community behavioral health center. When making medical necessity determinations for inpatient or outpatient hospital services for co-occurring behavioral health and physical health conditions or for co-occurring substance use and mental health disorders, the OhioRISE Plan must use clinically-accepted, evidence-informed medical necessity criteria for determining hospital level of care (i.e. MCG or InterQual) that takes into consideration all symptoms and clinical issues (SUD, psychiatric, and other medical conditions). For individuals with SUD conditions, the OhioRISE Plan must consider ASAM criteria prior to denying inpatient or outpatient hospital services. Inpatient or outpatient hospital services for individuals with SUD must be authorized if either of the following apply:

1. The request meets level of care criteria using the clinical guidelines for hospital services (i.e. MCG or InterQual); or

2. The request meets ASAM criera.

ii. The OhioRISE must use the adolescent ASAM level of care criteria for members under the age of 21.

iii. The OhioRISE Plan must continue to work with ODM to implement Ohio's 1115 SUD demonstration waiver to provide services to members under the age of 21 who have an SUD diagnosis. Additional work will include developing utilization management strategies, increasing care coordination efforts, and monitoring network adequacy. The OhioRISE Plan shall assist with the development and integration of these activities in alignment with System of Care Principles and child and family-centered practice. Upon implementation of a standardized SUD treatment form, when properly submitted by a provider, the OhioRISE Plan must accept the identified form to prior authorize SUD services and determine level of care.

e. Emergency Hospitalizations

i. In accordance with ORC section 5122.10 regarding emergency hospitalizations, also referred to as "pink slips," the OhioRISE Plan must cover inpatient psychiatric hospital services, including initial evaluation for up to 24 hours and stabilization services for up to three court days thereafter.

f. Inpatient Hospital Services

i. The OhioRISE Plan must not implement utilization management or claim payment denial for inpatient hospital readmissions unless otherwise approved by ODM.

g. Coordinated Services Program

i. The OhioRISE Plan must coordinate with ODM and the MCOs for lock-in member monitoring, as described in OAC rule 5160-20-1, as well as Coordinated Services Program (CSP) performance measurement and program evaluation.

h. The OhioRISE Plan must ensure the provision of care coordination to any member who is enrolled in the CSP, including coordination with any care management activities at the applicable MCO.

i. Telehealth

i. Services set forth in 1.a.i of this Appendix that are provided through telehealth must be consistent with the requirements set forth in Appendix F.9 of this Agreement.

j. Non-Emergency Medical Transportation Services

i. The member, their family, or their caregiver may contact the MCO using processes in the OhioRISE Plan's member handbook to arrange for transportation to receive a medically necessary Medicaid-covered service. If the member, their family, or their caregiver requests or requires assistance, the member's care coordinator (whether

provided by a CME or the OhioRISE Plan) must work with the identified MCO representative (e.g., MCO care coordination staff) or the county to arrange for transportation.

ii. Should a member, their family, or their caregiver experience problems related to non-emergency transportation services, the OhioRISE Plan shall develop a procedure for contacting and working with an MCO at an organizational level and the county to address and resolve these problems.

iii. The OhioRISE Plan must collaborate with ODM, ODM contracted MCOs, and the counties within the regions served to improve member experience and access to transportation services.

iv. The OhioRISE Plan will assist ODM and MCOs in the development of criteria to identify when it is necessary and appropriate for family members to be transported with the member for OhioRISE Plan-related services.

k. Consolidated Appropriations Act Section (2023) Section 5121 Requirements

i. The OhioRISE Plan will work with ODM and partners (e.g., state agencies, carceral facilities, etc.) to develop required processes needed to implement Section 5121 of the Consolidated Appropriations Act (2023). The OhioRISE Plan's responsibilities related to Section 5121 will be specified in ODM's Expectations for the OhioRISE Plan to Support Justice-Involved Individuals.

7. Additional Benefits

a. Value-Added Services

i. In accordance with 42 CFR 438.3(e)(1)(i), the OhioRISE Plan may elect to provide services in addition to those covered under the Ohio Medicaid FFS program. Before the OhioRISE Plan notifies potential or current members of the availability of those services, the OhioRISE Plan must first notify ODM of its plans to make such services available through the process determined by ODM.

ii. The OhioRISE Plan must demonstrate to the satisfaction of ODM that the value-added services are readily available and accessible to members who are eligible to receive them for at least six calendar months, unless otherwise approved by ODM.

iii. When determining the types of value-added services the OhioRISE Plan elects to provide, the OhioRISE Plan should consider the population health needs of the members.

iv. The OhioRISE Plan must give advance notice of at least 90 calendar days to ODM and members when decreasing or ceasing any additional benefits. When the OhioRISE Plan finds that it is impossible to provide 90 calendar days prior notice for reasons beyond its control, as demonstrated to ODM's satisfaction, the OhioRISE Plan must notify ODM within at least one business day of discovery.

v. The OhioRISE Plan may include, at its option, activities or other benefits to members, or their families, to facilitate accessing care according to CFCPs. These activities should be tailored to the needs of the individual family, but could include:

1. Offering childcare for any other children in the same family during in-home appointments for the member;

2. Reimbursing for lodging or extended lodging for caregivers visiting children in inpatient/residential treatment facilities including out-of-state facilities; or

3. Providing access to a phone or phone application to the enrolled members or caregivers to help facilitate virtual visits with their providers or care coordinators.

b. Pilot and Trial Incentive Programs

i. The OhioRISE Plan may elect to operate pilot and/or trial incentive programs. A pilot incentive program is a short-term program in a specified area or region(s) of the state, or with a defined member population that is measured to determine if it meets the specified program goal. A health care quality improvement activity is a structured quality improvement activity meeting the requirements specified in 45 CFR 158.150. A trial incentive program is a time limited monetary or non-monetary reward offered to a member who complies with the intended goals of the program as outlined by the OhioRISE Plan in the submission.

ii. If the OhioRISE Plan elects to operate pilot and/or trial incentive programs, the OhioRISE Plam must submit a description of a proposed pilot, health care quality improvement activity, or trial incentive program to ODM for review and approval prior to implementation. The OhioRISE Plan's proposed pilot or incentive program:

1. Must aim to improve health outcomes by engaging members in their own care;

2. May consist of short-term, time-limited, or long-term projects;

3. Must demonstrate that the OhioRISE Plan used data to select incentive program goals and priorities; and

4. Must not discriminate against members based on race, national origin, limited English proficiency, gender, disability, chronic disease, whether a person resides or receives services in an institutional setting, frailty, health status, or other prohibited basis. The OhioRISE Plan must implement incentive programs to ensure equal access for members eligible for the OhioRISE Plan’s proposed incentive program.

iii. If the OhioRISE Plan elects to operate a pilot and/or trial incentive program, the OhioRISE Plan must not use a medically necessary Medicaid-covered service or an additional benefit as offered in the OhioRISE Plan’s member handbook as an incentive.

iv. Pilot and trial incentive program requirements described in this section do not apply to performance-based programs specified in Appendix J, Quality Withhold or Incentives, of this Agreement or any federally required quality improvement projects.

v. The OhioRISE Plan must refer to and submit the ODM form 10267 Managed Care and MyCare Ohio Organization Pilot Program Request Template for additional clarification including information on the cadence for process and outcome measure reporting.

vi. The OhioRISE Plan must ensure that any incentive program or combination of incentive programs complies with state and federal requirements. ODM's approval of a pilot or trial incentive program should not be construed as an assurance that the program meets such requirements.

c. In Lieu of Services

i. In accordance with 42 CFR 438.3(e)(2) the OhioRISE Plan may propose to ODM coverage for services that are in lieu of those covered under the Ohio Medicaid state plan (in lieu of services).

1. The OhioRISE Plan's proposal must demonstrate that any in lieu of service is a medically appropriate and cost-effective substitute for a service covered under the Ohio Medicaid state plan.

2. The OhioRISE Plan's proposal must include a cost-benefit analysis for any in lieu of service it proposes to provide, including how the proposed service would be a medically appropriate and cost-effective substitute for a service covered under the Ohio Medicaid state plan.

ii. In lieu of services must be approved by ODM in writing prior to being delivered.

iii. The OhioRISE Plan must not require a member to use an in lieu of service as an alternative to a service covered under the Ohio Medicaid state plan.

8. Member Cost-Sharing

a. Pursuant to OAC rules 5160-26-05 and 5160-26-12 and 42 CFR 438.108, the OhioRISE Plan may not impose any member co-payment on any services covered under this Agreement.

b. The OhioRISE Plan's payment for any covered services constitutes payment in full and the OhioRISE Plan must ensure its subcontractors do not charge members, their custodians, or ODM any additional co-payment, cost sharing, down payment, or similar charge, refundable or otherwise.

c. In accordance with 42 CFR 438.106(b), the OhioRISE Plan is prohibited from holding a member liable for the cost of services provided to the member in the event that ODM fails to make payment to the OhioRISE Plan.

d. Pursuant to OAC rule 5160-26-05, the OhioRISE Plan must ensure that OhioRISE Plan's subcontractors and providers do not bill members or their custodians any amount greater than would be owed if the entity provided the services directly (i.e., no balance billing by providers).

9. Utilization Management Program

a. General Requirements

i. The OhioRISE Plan must establish a Utilization Management (UM) program to ensure access to care and utilization of services for children and youth who are its members. The UM program must be developed and implemented consistent with Systems of Care Principles and include the review of the OhioRISE Plan member's CFCP. All UM staff and peer advisors must be specially trained in Ohio's child and youth family System of Care guiding principles in order to facilitate the child and family-centered model. The UM program must be responsible for determining adequacy and appropriateness of the child and family-centered plan, consistent with Fidelity Wraparound and Systems of Care Principles, clinical need for included services, authorizing specific services appropriate to the child or youth's needs where indicated, and reviewing member utilization to ensure services are adequate given their level of need.

ii. The OhioRISE Plan must develop, implement, and maintain a UM program that is National Committee for Quality Assurance (NCQA) accredited and that facilitates the delivery of high-quality, cost-efficient, and effective care. The OhioRISE Plan's UM program must be used to inform the OhioRISE Plan's population health and quality improvement strategies as outlined in Appendix C, Population Health and Quality.

iii. The OhioRISE Plan must monitor its UM program on an ongoing basis, and evaluate and update UM program requirements at least annually as a component of the OhioRISE Plan's quality improvement plan and assessment. This monitoring, evaluation, and update requirement shall include and consider the CFCP Review process as described in this agreement. Based upon the evaluation and assessment, the OhioRISE Plan must update the UM program policies, structures, and processes as necessary. The OhioRISE Plan's monitoring and evaluation of its UM program shall include:

    1. Monitoring the timeliness of service authorization as stipulated in this Agreement;

    2. Monitoring the consistency and inter-rater reliability of the OhioRISE Plan's application of service authorization criteria;

    3. Assessing to determine whether the OhioRISE Plan's prior authorization procedures unreasonably limit member access to Medicaid-covered services;

    4. Assessing the UM program's adherence and support of a child and family-centered care planning process consistent with High-Fidelity Wraparound practice and System of Care Principles, including:

        a. Monitoring the comprehensiveness of the CFCP needs and goals to ensure that all necessary CME and other provider services and supports are incorporated into the CFCP, Individual Crisis and Safety Plan, and the back-up plan for waiver services for OhioRISE 1915(c) waiver enrollees;

        b. Monitoring alignment between CFCP needs and goals, and OhioRISE Plan's service authorizations;

        c. Training needs for OhioRISE Plan's staff involved with the UM process; and

d. Training needs for other parties (e.g., CMEs, families and caregivers, other providers, etc.) related to medical necessity, child and family-centered plans, and appropriate levels of services.

5. Reviewing the OhioRISE Plan's list of services that are subject to prior authorization to determine whether there is an ongoing need for prior authorization to ensure appropriate utilization of services;

6. Using provider advisory feedback to identify opportunities to standardize and streamline service authorization processes to reduce administrative burden for providers; and

7. Monitoring for updates to ODM clinical coverage criteria, evidence-based nationally recognized medical necessity guidelines, and other professional literature to inform and update the OhioRISE Plan's clinical coverage policies and criteria. This shall also include ensuring alignment between OhioRISE Plan and MCO criteria for the same services.

8. Monitoring utilization of OhioRISE 1915(c) waiver services to ensure waiver members are using the waiver services in accordance with their approved CFCP. If the OhioRISE Plan becomes aware that 1915(c) waiver services are no longer needed by a member prior to the member's 1915(c) level of care redetermination date, the OhioRISE Plan must submit a recommendation for evaluation of disenrollment from the OhioRISE 1915(c) waiver to ODM.

iv. While the OhioRISE Plan must have mechanisms in place to ensure that its UM program interfaces with and informs the OhioRISE Plan's program integrity responsibilities under Appendix G, Program Integrity, the OhioRISE Plan must demonstrate that the primary function of its UM program is to:

1. Meet the clinical needs of the member consistent with the child and family-centered care planning process and Systems of Care principles;

2. Meet all state and federal requirements, including early and periodic screening, diagnostic and treatment (EPSDT);

3. Ensure continuity for members when transitioning between the OhioRISE Plan, the MCOs, or between CMEs; and

4. Deliver efficient and appropriate services.

v. In accordance with 42 CFR 438.210(e), the OhioRISE Plan must ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member.

vi. In accordance with 42 CFR 438.210, the OhioRISE Plan must ensure that required services are not arbitrarily denied or reduced in amount, duration, or scope solely because of diagnosis, type of illness, or condition of the member.

vii. The OhioRISE Plan must use UM data (including data from the SPBM, MCO's, or ODM) and other quality information to identify and appropriately address providers who appear to be operating outside peer norms with respect to service utilization, prescribing patterns, and quality of care concerns. The OhioRISE Plan must report providers who are operating outside of such peer norms, including practices that impact member safety, to ODM consistent with the requirements of Appendix G, Program Integrity.

viii. The OhioRISE Plan must have the capabilities to receive service authorization requests by EDI or a flat file.

b. Policies and Procedures

i. The OhioRISE Plan must develop and implement clearly defined UM policies, structures, and processes pursuant to OAC rule 5160-59-03.1 to maximize the effectiveness of care provided to members.

ii. The OhioRISE Plan must implement UM requirements for SUD services as necessary to support Ohio's SUD 1115 demonstration waiver implementation plan.

iii. The OhioRISE Plan must submit clinical coverage policies and any subsequent proposed changes to ODM for review and approval prior to implementation. The OhioRISE Plan's submission must include a proposed list of the services and items subject to UM clinical coverage reviews. The OhioRISE Plan must submit the proposed list and changes.

1. As part of the OhioRISE Plan's submission of clinical coverage policies or changes thereto, the OhioRISE Plan must include a summary of the OhioRISE Plan's analysis, in the format specified by ODM, that demonstrates that the policy or changes comport with the parity requirements in 42 CFR 438.910(d).

2. The OhioRISE Plan's parity analysis must demonstrate that the non-quantitative treatment limits resulting from the OhioRISE Plan's clinical coverage policies for mental health/SUD benefits in all classifications are comparable to, and are applied no more stringently than, the non-quantitative treatment limits for medical/surgical benefits in the classification. More information can be found in Section 8, Mental Health Parity and Addiction Equity Act (MHPAEA) requirements.

iv. The OhioRISE Plan must notify network and out-of-network providers of clinical coverage policies. The communication must include an outline or summary specifying the changes and their impact on specific providers receiving these policy changes. Changes to policies require 30 calendar days' advance notice. Provider notifications must meet the requirements in Appendix A, General Requirements.

c. Utilization Management Program Structure

i. The OhioRISE Plan must structure the OhioRISE Plan's Utilization Management (UM) program to meet requirements in OAC rule 5160-59-03.1.

ii. The OhioRISE Plan must ensure that the administrative and organizational staff of the OhioRISE Plan's UM program reports to the Chief Medical Officer (CMO).

iii. The OhioRISE Plan must employ at least one child-trained Medical Director (i.e., either pediatrician or child board certified psychiatrist) who participates in the UM program.

iv. The OhioRISE Plan's UM structure must include a UM Committee, chaired or co-chaired by the OhioRISE Plan's CMO, to review and approve the OhioRISE Plan's UM program, plan, and annual evaluations, as well as UM policies and procedures. The OhioRISE Plan must include the Behavioral Health Clinical Director as a member of the UM Committee.

v. The OhioRISE Plan's clinical leadership must ensure the UM program is implemented in a manner reflective of System of Care Principles and a High-Fidelity Wraparound practice.

vi. The OhioRISE Plan must have appropriately qualified UM review staff who are available by telephone from 8 am to 5 pm Eastern Time Monday through Friday (except for the major holidays and two optional closure days as described in Appendix A, General Requirements) to render UM decisions for providers. UM review staff must be based in and operate from Ohio. They must be available by telephone 24/7 to respond to authorization requests for inpatient admissions and other urgent services requiring prior authorization as specified by ODM. With ODM's prior approval, the OhioRISE Plan may have policies and procedures that allow for admissions to inpatient or other urgent services with authorization the next business day.

d. Authorization Data and Reporting

i. Pursuant to OAC rule 5160-26-03.1, the OhioRISE Plan must submit information on prior authorization requests as directed by ODM.

ii. The OhioRISE Plan must conduct root cause analysis of authorization denials and appeals and develop a targeted plan to decrease inappropriate denials and ensure ease of appeal of medical necessity denials on a quarterly basis. This must include analysis of discrepancies between authorizations and recommendations on the CFCP. The results of this analysis shall be reviewed in the quality and UM committee structure.

10. Coverage Requirements

a. Medical Necessity Criteria

i. Pursuant to OAC rule 5160-59-03, the OhioRISE Plan's coverage requirements and decisions must be based on the coverage and medical necessity criteria published in OAC Chapter 5160 and practice guidelines as specified in OAC rule 5160-26-05.1.

ii. The OhioRISE Plan must have objective, written criteria based on sound clinical evidence to make medical necessity and utilization decisions. The OhioRISE Plan must involve appropriate providers as well as the Member and Family Advisory Council input in the development, adoption, and review of medical necessity criteria. The OhioRISE Plan's written criteria must meet NCQA standards and must specify procedures for appropriately applying the criteria.

iii. The OhioRISE Plan must use ODM-developed medical necessity criteria where it exists. In the absence of ODM-developed medical necessity criteria or ODM-approved, clinically accepted, evidence-informed medical necessity criteria, the OhioRISE Plan's adaptation

or development of medical necessity criteria must be based upon evaluated, peer reviewed medical literature published in the United States.

1. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources.

2. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy, and a rationale that is based upon well-designed research and endorsements by national medical bodies or panels regarding scientific efficacy and rationale.

iv. When applying coverage policies and medical necessity criteria, the OhioRISE Plan must consider individual member needs as demonstrated through the child and family-centered care planning process, an assessment of the local delivery system, and continuity of care for the same or similar services available and accessed through the MCOs.

b. Child and Family-Centered Care Plan Review Criteria

i. The OhioRISE Plan must have and use objective written criteria to evaluate and provide feedback on CFCPs to the CMEs.

ii. The OhioRISE Plan must ensure all members have an established Individual Crisis and Safety Plan to ensure continuous safety of the member.

iii. For members enrolled in the OhioRISE 1915(c) waiver, the OhioRISE Plan must:

1. Ensure an established back-up plan for OhioRISE 1915(c) waiver services is part of the CFCP to meet the members' needs.

2. Ensure the CFCP is signed by the member, their care coordinator, and their providers of OhioRISE 1915(c) waiver services.

3. Monitor the use of out-of-home respite and ensure that it does not exceed the limit of 90 cumulative days in a 365-day period.

iv. The OhioRISE Plan must ensure CFCPs meet ODM CFCP specifications in the OhioRISE Plan and/or CME program guidance manuals.

v. As part of their review and approval process, the OhioRISE Plan is responsible for ensuring the CFCP is signed by the individual, their care coordinator and their providers included on the CFCP. The OhioRISE plan is also responsible for distributing the approved signed copy to the individual, their care coordinator, and their providers included on the CFCP.

c. Inter-Rater Reliability

i. The OhioRISE Plan must perform inter-rater reliability testing to ensure consistent application of the OhioRISE Plan's medical necessity criteria when making coverage decisions and comprehensive understanding and consistent application of the child and family-centered care planning process.

ii. At least annually, the OhioRISE Plan must ensure that all staff performing initial and continuing stay authorizations, denial reviews, and child and family-centered plan reviews participate in inter-rater reliability testing to assess consistency in the application of practice guidelines and access to care criteria.

iii. The OhioRISE Plan must establish specific inter-rater reliability thresholds by service or category of service.

iv. The OhioRISE Plan must not permit staff performing below acceptable thresholds for inter-rater reliability to make independent review or authorization decisions until such time that staff member has been retrained and monitored and demonstrates performance that exceeds the acceptable threshold.

v. The OhioRISE Plan must continually monitor performance and implement corrective measures if the OhioRISE Plan does not meet internal inter-rate reliability benchmarks.

11. Service Authorization

a. General Requirements

i. The OhioRISE Plan must cooperate with ODM to develop processes and systems necessary to allow providers to submit requests for service authorization, and for the OhioRISE Plan to accept and respond to authorization requests from providers through secure electronic transmission and exchanges with ODM's OMES. Authorization requests include prior authorizations, concurrent reviews, and retrospective reviews. The OhioRISE Plan must require its providers to comply with service authorization submission requirements through ODM's OMES as determined by ODM..

ii. When required or permitted by ODM, the OhioRISE Plan must use the OhioRISE Plan-developed PRTF Request portal to accept and process requests for PRTF services. The OhioRISE plan must issue an approval or denial related to the medical necessity of the PRTF request, with appeal rights, within three business days of receiving a complete request in the PRTF Request portal.

iii. The OhioRISE Plan must comply with requirements in OAC rule 5160-59-03.1 for responding to provider requests for initial and continuing authorization of services.

iv. For any designated service or prior authorization request or decision, ODM may require an additional clinical review or a different clinical review process. The OhioRISE Plan must cooperate with and assist, as needed, with this additional or different review. ODM retains authority to ultimately decide whether a service should be approved.

v. Upon medical necessity review and in accordance with approved medical necessity criteria, if a needed level of care for treatment is not available, the OhioRISE Plan must authorize at the next highest available level of care for treatment.

vi. The OhioRISE Plan must comply with service authorization requirements to meet the member transition of care requirements in Appendix D, Care Coordination, and within this Agreement.

vii. The OhioRISE Plan must permit and facilitate ODM real time, read-only access to the OhioRISE Plan's CFCP review and service authorization systems, including all approval and denial documentation.

viii. The OhioRISE Plan must ensure coordination between the service authorization process and the CFCP review process.

ix. When required or permitted by ODM, the OhioRISE Plan must use the CFCP submission process to request prior authorization of specific covered services and use the CFCP review and concurrence/non-concurrence process to provide OhioRISE Plan approval or denial of such prior authorization requests. The OhioRISE Plan must implement ODM expectations to standardize and streamline requirements to reduce administrative burden for providers that deliver services to MCO and OhioRISE members, including:

1. Standardizing some aspects of approved lengths of stay for certain services requiring prior authorization (e.g., 30 days for SUD Level 3 residential services);

2. Standardizing prior authorization requirements for SUD residential services;

3. Standardizing expectations for OhioRISE Plan's notification of providers for submission of authorization requests to continue services that require prior authorization; and

4. Standardizing and specifying the type of clinical documentation required for CFCP review and prior authorization decision-making.

b. Behavioral Health Service Authorization

i. Prohibition of Prior Authorization and Concurrent Review

1. The OhioRISE Plan is prohibited from requiring prior authorization for the following behavioral health services:

a. An Ohio Children’s Initiative Child and Adolescent Needs and Strengths (CANS) assessment;

b. Mobile response activities (crisis mobile response and crisis response follow-up); and

c. The first six weeks of stabilization services, in accordance with OAC rule 5160-27-13.

ii. Use of the CFCP for Prior Approval

1. When required or approved by ODM, the OhioRISE Plan must use the CFCP submission and review process to request authorization of certain services. Such services will be described as requiring “prior approval” through the CFCP process.

2. The OhioRISE Plan must require prior approval through the CFCP process for the following covered services:

a. OhioRISE 1915(c) waiver services, as described in OAC rule 5160-59-05.

b. Primary Flex Funds, as described in OAC rule 5160-59-03.5.

3. All prior approvals resulting from the CFCP process must be maintained for 365 days, unless a significant change in the member's condition occurs.

4. The OhioRISE Plan may not require separate provider-initiatedprior authorization of services that require prior approval using the CFCP process.

iii. Utilization Management Decisions

1. All UM decisions shall be made in the context of the member's CFCP (when one exists and is current). When a member is receiving care coordination services through a CME, the OhioRISE Plan's UM clinical staff shall coordinate and collaborate with the CME care coordinator or their supervisor.

iv. Substance Use Disorder Services

1. The OhioRISE Plan must make medical necessity determinations for inpatient and outpatient SUD treatment authorizations in accordance with the ASAM Criteria for Adolescents and Adults. When making medical necessity determinations for inpatient services for individuals with co-occurring SUD and physical health diagnoses, the OhioRISE Plan must also use other clinical criteria (i.e., MCG® or InterQual®) in addition to ASAM criteria, and must authorize services when either ASAM or MCG®/InterQual® indicates the need for inpatient services.

2. The OhioRISE Plan must ensure that all OhioRISE Plan's reviewers, medical directors, peer advisors, clinical directors, and clinicians involved in conducting reconsiderations of SUD treatment service authorization denials are trained annually in use of ASAM adolescent and adult criteria and complete competency and inter-rater reliability testing to ensure consistent application of criteria.

3. All OhioRISE Plan's medical directors, peer advisors, clinical directors, and clinicians that have a role in the denial or reconsideration of SUD treatment must have documented SUD and ASAM experience. At least one OhioRISE Plan-employed or contracted Board-Certified addiction medicine physician must be available for consultation with OhioRISE Plan's staff.

4. Upon medical necessity review and in accordance with ASAM adolescent and adult criteria, if a needed level of care for SUD treatment is not available, the OhioRISE Plan must authorize at the next highest available level of care for SUD treatment. For example, if an authorization request for ASAM 4.0 does not meet clinical criteria for inpatient hospitalization, but the member needs medically monitored withdrawal management at ASAM level 3.7, the OhioRISE Plan must authorize level 4.0 until access to level 3.7 withdrawal management.

5. OhioRISE Plans must have processes in place, including the use of quality improvement methods, provider development assistance, and corrective action plans, to address providers not complying with ASAM adolescent and adult

criteria or otherwise evidencing patterns of high denial or other authorization process issues for SUD treatment services.

v. Psychiatric Residential Treatment Facility Services

1. The OhioRISE Plan must make medical necessity determinations for PRTF requests using Ohio's PRTF Clinical Criteria or the Clinical Criteria for the PRTF-MI/ID.

2. The OhioRISE Plan must ensure that all OhioRISE Plan reviewers, medical directors, peer advisors, clinical directors, and clinicians involved in conducting reconsiderations of PRTF service authorization denials are trained annually in use of PRTF Clinical Criteria and Clinical Criteria for the PRTF-MI/ID and complete competency and inter-rater reliability testing to ensure consistent application of criteria.

3. The OhioRISE Plan must provide ODM staff access to all systems used to receive, process, track, and monitor PRTF requests, referrals, capacity, and provider activities in alignment with the requirements in Appendix K of this agreement.

4. The OhioRISE Plan must make a medical necessity determination within three business days of receiving a PRTF Request Form in the OhioRISE Plan's PRTF Request Portal.

5. Within one business day of a determination that PRTF treatment is medically necessary, the OhioRISE Plan must refer to and initiate the admission process to the PRTF provider closest to the member's home that has an available bed and whose admission criteria best matches the needs of the member for whom PRTF treatment is medically necessary.

    a. If a PRTF bed is not available at any Ohio-based PRTF, the OhioRISE Plan must:

        i. Ensure safety of the member in the current setting and work with the member's child and family team to determine whether hospitalization is necessary and/or which immediate additional supports can be put in place.

        ii. Determine, using the PRTF census and other data collected from contracted PRTFs, when an Ohio-based PRTF will be likely to have a bed available to meet the member's treatment needs.

        iii. Refer to out-of-state, non-contracted PRTFs that may meet the member's needs if an Ohio-based contracted PRTF bed will not be available within 14 calendar days of the medical necessity determination.

    b. Ensure admission to a PRTF within 30 calendar days of approval of the PRTF Request Form.
        i. If admission to PRTF is not expected within the next 30 calendar days:

1. Within seven calendar days of the OhioRISEPlan's determination that no PRTF will be available to meet the member's treatment needs, the OhioRISE Plan must:
    a. Proactively authorize and secure the next highest level of care until access to PRTF services can be established; or
    b. Develop, implement, and submit to ODM an alternative treatment plan for the member that:
        i. Ensures a safe environment where the member can receive intensive clinically appropriate care until access to PRTF services can be established;
        ii. Outlines the actions that were taken to determine no PRTF beds were available; and
        iii. Identifies what actions will be completed on an ongoing basis, as specified by ODM, until access to PRTF services are secured.

6. The OhioRISE Plan will cover medically necessary PRTF services for incarcerated children and youth in the same manner it does for an OhioRISE member.

    a. The OhioRISE Plan will work with ODM and system partners to develop processes for submission of PRTF Request Forms, claims, and encounters.

7. The OhioRISE plan must provide ODM with a PRTF Annual Report that identifies PRTF metrics including length of stay, admissions, improved functioning, re-referrals, educational services, and transitions as specified in Appendix P, Chart of Deliverables.

8. The OhioRISE plan must provide ODM with a PRTF Quarterly Report that identifies PRTF metrics including length of referral, length of stay, admissions, meeting participation, treatment plan goals, and transitions as specified in Appendix P, Chart of Deliverables.

c. Pharmacy Service Authorization

    i. The OhioRISE Plan shall not impose a prior authorization requirement in the case of a drug that meets the requirements in ORC section 5167.12. The OhioRISE Plan may include strategies for the management of drug utilization, but any such strategies are subject to the limitations and requirements of this section and the approval of the department of Medicaid.

    ii. Drug Utilization Management. OhioRISE shall operate a drug utilization review (DUR) program and participate in ODM's DUR committee and Board designed to promote the

appropriate clinical prescribing of covered drugs including physician administered drugs (PAD) that complies with the requirements described in Section 1927(g) of the Social Security Act and 42 CFR Part 456 subpart K. As specified by ODM, OhioRISE shall submit information to fulfill the requirements of the annual report detailed in 42 CFR 456.712 of subpart K, including a detailed description of the program and program requirements per 42 CFR 438.3(s)(4) and 42 CFR 438.3(s)(5). Pursuant to ORC section 5167.12, OhioRISE may implement strategies for the management of drug utilization. ODM may request details of drug utilization management programs and require changes to such programs, if they cause barriers to care. OhioRISE may, subject to ODM prior-approval, place limitations on the type of provider and locations where certain drugs may be administered; however, OhioRISE cannot require PA for drugs used to prevent preterm birth nor can they require PA for the location of administration (e.g., home or office). OhioRISE shall establish their PA system so that it does not unnecessarily impede member access to medically necessary Medicaid-covered services as follows:

1. OhioRISE shall adhere to specific PA limitations to assist with the transition of new members from FFS Medicaid.

2. As outlined in ORC section 5167.12, OhioRISE is prohibited from requiring prior authorization (PA) in the case of a drug to which all of the following apply:

    a. The drug is an antidepressant or antipsychotic;

    b. The drug is administered or dispensed in a standard tablet or capsule form, except that in the case of an antipsychotic, the drug also may be administered or dispensed in a long-acting injectable form;

    c. The drug is prescribed by any of the following:

        i. An MCE panel provider psychiatrist; or

        ii. A psychiatrist practicing at a location on behalf of a CBHC; or

        iii. A certified nurse practitioner or clinical nurse specialist who is certified in psychiatric mental health by a national certifying organization;

    d. The drug is prescribed for a use indicated on the drug's labeling, as approved by the federal food and drug administration.

3. OhioRISE may require PA for antidepressant or antipsychotic drugs that do not meet the criteria outlined above. OhioRISE shall take into consideration the prescribing provider’s verification that the member is stable on the specific medication when making the PA decision.

4. OhioRISE shall comply with provisions of 1927(d)(5) of the Social Security Act, 42 USC 1396r-8(d)(5), 42 CFR 438.3(s)(6), and OAC rule 5160-26-03.1 regarding the timeframes for prior authorization of Covered Outpatient Drugs, including physician administered drugs. This includes the requirement to provide a response within 24 hours of receipt for a prior authorization request. A

response is defined as a decision if sufficient information is provided to make a decision. Alternatively, a notification of request for additional information should be sent within 24 hours.

5. OhioRISE must use information available through the Ohio Board of Pharmacy's prescription drug monitoring program, in addition to other available resources (e.g., claims data), to monitor member utilization and provider prescribing patterns of controlled substances and other drugs.

6. OhioRISE must continue to work with ODM to create a consistent utilization management and prior authorization approach for all opioids and Medication Assisted Treatment (MAT). OhioRISE must, at a minimum, ensure same day coverage of the first dose of a long-acting injectable opioid antagonist for substance use disorders.

7. The OhioRISE Plan must comply with ODM guidance concerning coverage of medications that are available via both the OhioRISE benefit and the pharmacy benefit. All applicable medications must align in prior authorization status and clinical criteria between OhioRISE coverage and the ODM (Unified Preferred Drug List (UPDL). The OhioRISE Plan must also not implement utilization management or site-of-care strategies that intend to shift medication coverage to the pharmacy benefit without prior approval of ODM.

iii. Pharmaceutical Drug Reporting and Pricing Requirements.

1. Drug Rebates. Section 1927 of the Social Security Act, 42 U.S.C. 1396r-8, mandates that drug companies or labelers shall sign a Medicaid Drug Rebate Agreement with the federal government to provide federal drug rebates to the State in order to have their products covered by the Medicaid Program. Additionally, the Affordable Care Act (ACA) requires ODM to obtain federal drug rebates for drugs paid for by the MCPs. In order to ensure compliance with federal law, the MCP shall:

   a. Report the necessary encounter data to ODM for the invoicing of manufacturer rebates for all Covered Outpatient Drugs. This includes physician-administered drugs, drugs personally furnished by a physician, drugs provided in clinics and non-institutional settings, drugs dispensed by 340B covered entities, and drugs dispensed to MCP members with private or public pharmacy coverage and the MCP provided secondary coverage.

   b. Work cooperatively with ODM and its designees, providing ODM with sufficient data and information to enable ODM to secure federal drug rebates for all utilization and administration of Covered Outpatient Drugs as described above. The MCP shall also fully cooperate and assist ODM and its rebate vendor and/or designees with the resolution of drug manufacturer disputes or questions regarding claims for federal drug rebates for drugs dispensed or administered to OhioRISE members as specified by ODM.

c. Report Covered Outpatient Drug utilization information that is necessary for ODM to bill manufacturers for rebates in accordance with section 1927(b)(1)(A) of the Act no later than 45 calendar days after the end of each quarterly rebate period. Such utilization information must include, at a minimum, information on the total number of units of each dosage form, strength, and package size by National Drug Code of each Covered Outpatient Drug dispensed or covered by the MCP.

d. Report all Covered Outpatient Drug information, including National Drug Codes (NDCs) and accurate NDC units for all drug claim types, NCPDP, 837 Professional, 837 Institutional, etc. as designated by ODM. OhioRISE is prohibited from negotiating their own supplemental rebates for pharmaceutical products listed on the UPDL with drug manufacturers.

e. Report all drugs billed to OhioRISE that were acquired through the 340B drug pricing program using standard modifiers so they can be properly excluded from federal drug rebates. OhioRISE shall accommodate for the reporting of an SE modifier with drugs acquired through the 340B Drug Pricing Program.

f. OhioRISE shall report the following information to ODM upon request:

i. The top 25 drugs by total net cost after any discount and rebates are applied; and

ii. The top 25 drugs by highest percent increase in price paid per unit to the MCP's pharmacies based upon average price in the quarter being reported compared to the previous quarter.

iv. Carve-Out. ODM may specify carve-out of selected covered outpatient drugs (COD), including physician administered drugs (PAD) from MCEs. Carved-out medications will be covered under the Medicaid fee-for-service benefit. A current listing of these medications is located at https://medicaid.ohio.gov/stakeholders-and-partners/phm/carved-out-drugs . Notification of ODM's intent to carve-out a medication will be made to plans at least 30 calendar days prior to implementation. Regardless of the setting and the payer (FFS or Managed Care), these medications must be prior authorized through FFS. The approved prior authorization will be shared with OhioRISE for care management purposes. Carved out medications will not be included in capitation rates and the OhioRISE will continue to be responsible for any and all medically necessary costs associated with the administration and/or monitoring of any of these medications.

d. Retroactive Coverage Requirements

i. Pursuant to the criteria in ORC section 5160.34(C), the OhioRISE Plan is prohibited from retroactively denying a prior authorization request as a utilization management strategy. When performing a pre-payment review of a claim, the OhioRISE Plan may not deny the claim due to medical necessity when the service was prior authorized. In addition, the OhioRISE Plan must conduct the retrospective review of a claim submitted

for a service where prior authorization was required, but not obtained, in accordance with the criteria in ORC section 5160.34(B)(9).

e. Notification of Authorization Decisions

i. The OhioRISE Plan must meet Notice of Action requirements pursuant to OAC rule 5160-26-08.4.

1. The OhioRISE Plan must submit all new and revised Notice of Action template to ODM for approval prior to distribution, and all information included by the OhioRISE Plan must meet the member information requirements as described in Appendix A, General Requirements.

f. Peer-to-Peer Consultation and Provider Appeals

i. When the OhioRISE Plan denies a service authorization request from a provider, the OhioRISE Plan must include and offer the following information to providers in the initial denial notice , via a separate notice, the option to request a peer-to-peer consultation, provider appeal, and external medical review. The provider appeal process must satisfy the requirements and timeframes in ORC 5160.34(B)(12).

ii. When the denial of authorization is for a service on a member's established CFCP, the peer-to-peer consultation must be offered to the appropriate clinical representative at the assigned CME who shall serve as the liaison to the member's Child and Family Team if one has been established. If the requesting provider for the service is not the CME, peer-to-peer consultation shall be offered to the provider and to the CME who is responsible for the CFCP developed by the care plan team in addition to the CME.

iii. The OhioRISE Plan must use accepted clinical guidelines under this Agreement when conducting peer-to-peer consultations and provider appeals.

iv. The OhioRISE Plan must ensure that the peer-to-peer review process does not interfere with the provider's right to request an external medical review, or a member's right to request an appeal or state hearing, or the timeliness of appeal and/or state hearing resolutions

v. The OhioRISE Plan must ensure that OhioRISE Plan's staff conducting peer-to-peer consultations and provider appeals are behavioral health care professionals who have clinical expertise in treating the member's condition, with the equivalent or higher credentials as the requesting/ordering provider. All OhioRISE Plan's staff conducting peer-to-peer consultations must be trained in the Ohio Child and Family Team approach using High-Fidelity Wraparound and Systems of Care Principles to serving multi-system children and youth and must be based in Ohio.

vi. The OhioRISE Plan's staff conducting the peer-to-peer consultation must clearly identify what documentation the provider must provide in order to obtain approval of the specific item, procedure, or service; or of a more appropriate course of action based upon accepted clinical guidelines.

vii. The OhioRISE Plan must offer a peer-to-peer consultation within a mutually agreed-upon time within 24 hours of a provider and/or CME's request for a peer-to-peer consultation.

12. Mental Health Parity and Addiction Equity Act Requirements

a. The OhioRISE Plan must comply with Mental Health Parity and Addiction Equity Act (MHPAEA) requirements outlined in 42 CFR Part 438 Subpart K, with regard to services provided to OhioRISE members. The requirements apply to the provision of all covered benefits and additional services (i.e., value-added and in lieu of services) to all populations included under the terms of this Agreement.

i. The OhioRISE Plan must participate in ODM-requested meetings, respond to ODM information requests, work with ODM to resolve compliance risks, and notify ODM of any changes to benefits or limitations that may impact compliance with MHPAEA.

ii. The OhioRISE Plan must conduct ongoing monitoring to determine compliance with MHPAEA and report compliance analysis and determinations using the MHPAEA Compliance Assessment Tool (MHPAEA Tool) provided and required by ODM.

iii. The OhioRISE Plan must submit an updated MHPAEA Tool and written attestation of MHPAEA compliance to ODM:

1. At least 30 calendar days prior to the proposed effective date for implementing any new clinical coverage policy or changes to previously approved clinical coverage policies;

2. At least 30 calendar days prior to the proposed effective date to apply a financial requirement (co-payment);

3. At least 30 calendar days prior to the effective date of a change to benefits or limitations that may impact MHPAEA compliance;

4. Annually, as specified in Appendix P, Chart of Deliverables; and

5. Upon ODM's request.

iv. The OhioRISE Plan's annual updated MHPAEA Tool must include an annual summary of self-monitoring activities that describes:

1. The OhioRISE Plan's processes for reviewing and analyzing changes to benefit packages, service delivery structures, operational requirements, and policies to ensure ongoing parity compliance; and

2. The OhioRISE Plan's processes for monitoring parity compliance in operation on a regular basis, including:

a. The data/information monitored by the OhioRISE Plan to identify potential parity compliance concerns, the frequency of the OhioRISE Plan's review of the data/information;

b. How the OhioRISE Plan determines when further analysis is necessary; and

c. The process used by the OhioRISE Plan to conduct further analysis when the data/information suggests the possibility of a parity compliance concern.

v. The OhioRISE Plan will work with ODM to ensure all members are provided access to a set of benefits that meets the MHPAEA requirements regardless of which behavioral health services are provided by the OhioRISE Plan.

APPENDIX C – POPULATION HEALTH AND QUALITY

1. Population Health Management

a. General

i. ODM defines "population health management" as an approach to maintain and improve physical and psychosocial well-being and address health disparities through cost-effective, child- and family-centered health solutions that address members' health needs in multiple settings at all points along the continuum of care.

ii. ODM will lead Ohio's Medicaid population health management approach and will identify the respective roles and responsibilities of ODM, the MCOs, OhioRISE Program, and SPBM for population health. The OhioRISE Plan must participate in ODM-led meetings and activities, and fulfill ODM-established population health roles and responsibilities as directed by ODM.

iii. Consistent with the construct of ODM's population health management approach, the OhioRISE Plan must support the population health management strategies developed by each of the MCOs, recognizing each MCO must lead population health efforts across the MCO, OhioRISE Program, and SPBM for the members of that MCO.

1. The requirements and components of the MCO Population Health Management Strategy are detailed in the MCO Provider Agreement, Appendix C.

iv. The OhioRISE Plan must continuously coordinate with the ODM and the MCOs to ensure that the OhioRISE Plan is appropriately participating in and supporting the population health management strategies across the MCOs.

b. The OhioRISE Plan's Role in Support of MCO Population Health Management Strategies

i. The OhioRISE Plan will support its members, by:

1. Coordinating with ODM, the MCOs, and other ODM-contracted managed care entities to support the ODM population health approach;

2. Coordinating with each MCO on population health efforts at the leadership/organizational level;

3. Sharing available individual and aggregate data with MCOs in support of their population health management strategies and strategic initiatives;

4. Providing consultation related to the behavioral health care needs of children and youth and the Children with Behavioral Health Conditions Population Stream;

5. Supporting alignment across MCO care coordination efforts, care coordination provided by the OhioRISE Plan, and care coordination managed by the care management entities (CMEs) in support of population health management strategies and strategic initiatives.

ii. The specific role and activities of the OhioRISE Plan within each MCO's Population Health Management Strategy shall be described in the MCO/OhioRISE Plan's Model Agreement (described in Appendix A, General Requirements) executed between the OhioRISE Plan and each MCO.

2. Support for the Children with Behavioral Health Conditions Population Stream

a. Population Streams

i. To organize its population health work, ODM has identified six population streams for Stage 3 of Ohio's Next Generation Medicaid Managed Care Program: healthy children and adults, women and infants, behavioral health children and adults, children and adults with chronic physical and developmental conditions, and older adults. Each MCO must stratify populations within its membership to drive the MCO population health management approach, prioritization of initiatives, and resource allocation and to optimize health outcomes.

ii. The OhioRISE Plan must, at the direction of ODM, play a primary role in driving population health efforts for high-risk children and youth in the population stream focused on children with behavioral health conditions, including:

1. Work with ODM and the MCOs to develop cross-cutting population health and quality improvement initiatives for high-risk children and youth within this population stream;

2. Providing consultation, upon ODM request, to ODM, the MCOs, the SPBM, and other ODM-contracted managed care entities in the following areas related to this population stream:

a. The development and implementation of population health strategies;

b. The collection, analysis, and reporting of quality measures;

c. Service system and clinical issues;

d. population-specific differences; and

e. Strategic initiatives and other quality improvement activities.

3. Monitoring and evaluating population health and quality improvement activities under this population stream.

3. Population Health Infrastructure

a. General

i. The OhioRISE Plan must provide the infrastructure necessary to support ODM's population health management approach and each MCO's population health management strategy, including but not limited to:

1. The support of senior leadership;

2. A robust information system and the related analytics; and

3. Adequate staffing and resources to support each MCO's strategic initiatives to improve population health and to evaluate and integrate the results of population health improvement strategies into MCO and OhioRISE Plan practices.

b. Senior Leadership Support

i. The OhioRISE Plan's senior leadership must foster and create an ongoing dynamic culture of innovation and health care excellence in support of Ohio's Medicaid population health management approach. The lead member of the senior quality improvement (QI) leadership team must report directly to the OhioRISE Plan's Chief Executive Officer (CEO).

ii. The OhioRISE Plan must ensure that the Chief Medical Officer (CMO) is involved with and provides oversight for all clinically related population health and quality improvement initiatives.

iii. The OhioRISE Plan, through its senior leadership, must:

1. Provide direction and oversight of OhioRISE Plan's activities related to population health improvement efforts under the ODM Population Health Approach, including OhioRISE Plan's activities related to MCO population health management strategies;

2. Promote an OhioRISE Plan culture that is focused on supporting an optimal health care delivery system through collaborative, cross-system population health management strategies;

3. Ensure a focus on both individual and systemic levels of improving quality of care and reducing health disparities;

4. Ensure that gaps in behavioral health care are remedied at both the individual and systemic levels and ensure that any physical health gaps identified at either level are reported to the MCOs of the impacted members;

5. Consistently and frequently use data and analytics strategically to identify improvement opportunities, evaluate the effectiveness of improvement initiatives, and incorporate results and lessons learned into OhioRISE Plan's business processes;

6. Ensure that the OhioRISE Plan works collaboratively with the MCOs, other ODM-contracted managed care entities, SPBM, CMEs and OhioRISE' Plan network providers, care coordination entities (CCEs), and ODM to work collaboratively to share results of improvement activities, and to develop and implement strategies to have a collective impact in improving population health outcomes for all, including optimizing population-specific outcomes and social determinants of health (SDOH);

7. Ensure relevant staff (e.g., member services, provider relations, care management, Utilization Management [UM] staff) are engaged in population health improvement efforts (e.g., care coordination and quality improvement efforts) to inform and address barriers to optimal care and behavioral health outcomes;

8. Ensure transparent communication and coordination among the leadership team, CEO, and relevant functional areas of the organization;

9. Promote ongoing, rapid-cycle improvement of the quality of care and services provided by the OhioRISE Plan, CMEs, OhioRISE Plan's network providers, and other OhioRISE Plan's subcontractors; and

10. Engage in high-impact leadership activities as described in High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs.[1]

c. Staffing Resource Allocation

i. General

1. The OhioRISE Plan must allocate sufficient staffing to support MCO population health activities and strategic initiatives, and to respond to the needs of internal and external stakeholders.

ii. Analytical Support

1. The OhioRISE Plan must have dedicated staff who conduct data analytic activities that include but are not limited to:

a. Data cleaning and quality assurance;

b. Data integration and data aggregation;

c. Population identification and risk stratification;

d. Descriptive and predictive analyses necessary to support population health strategies (e.g., care coordination and quality improvement efforts, alternative payment models, school-based health services);

e. Collaboration with child-serving state agencies, including: Department of Developmental Disabilities (DODD), Ohio Department of Education (ODE), Ohio Department of Health (ODH), Ohio Department of Job and Family Services (ODJFS), Ohio Department of Mental Health and Addiction Services (OMHAS), Ohio Department of Rehabilitation and

[1] Swensen S, Pugh M, McMullan C, Kabcenell A. High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2013. (Available at ihi.org)

Correction (ODRC), Ohio Department of Youth Services (DYS), and Ohio Family and Children First (OFCF) for the purpose of analyzing information to improve the population health of enrolled OhioRISE Plan members; and

f. Collaboration with MCOs, other ODM-contracted managed care entities, CMEs and OhioRISE Plan's network providers, and health care system and community stakeholders, including school districts and school-based health partners to ensure that data integration and analysis is optimized for population health improvement.

iii. Community Initiative Staffing

1. The OhioRISE Plan must have sufficient community initiative staffing resources, which may be organized under the Population Health Director, to:

a. Actively contribute to quality improvement projects within each of the ODM identified children's population health streams;

b. Attend ODM-led meetings and make connections with community initiative staff from ODM, MCOs, and other ODM-contracted managed care entities;

c. Coordinate community initiative work with other ODM-contracted managed care entities;

d. Provide support to CMEs and OhioRISE Plan's network providers related to OhioRISE Plan's population-specific and quality improvement efforts; and

e. Establish relationships with communities and community-based entities, including school districts and school-based health partner sto inform and address local health and population-based opportunity issues.

iv. Quality Improvement Staffing

1. The OhioRISE Plan must use quality improvement (QI) activities and initiatives to improve population health outcomes, including the creation of new processes and procedures through iterative testing and evaluation that incorporate insights from, at a minimum, data, research, members, and providers.

2. The OhioRISE Plan must dedicate sufficient staff to fulfill the OhioRISE Plan's set of clearly defined QI functions and responsibilities, including coordinating with the MCOs, SPBM, and other involved entities, so that staffing is proportionate to, and adequate for, support for the number and types of OhioRISE Plan-managed aspects of QI initiatives, including QI initiatives that are part of MCOs' population health management strategies.

3. The OhioRISE Plan must have staff fully dedicated to the OhioRISE Program who represent the following areas of expertise:

a. Continuous QI;

b. Analytics;

c. Subject matter expertise in clinical or non-clinical improvement topics being addressed through improvement efforts;

d. Population health which includes optimization of healthcare access and outcomes for special populations;

e. Other child-serving systems;

f. OhioRISE Plan policies and processes related to child and youth behavioral health, care coordination, coordination with MCOs, and general operations of the OhioRISE Plan and CMEs; and

g. Member and provider perspectives (may be staff or liaisons with the OhioRISE Plan's member and provider services).

d. Population Health Information System

i. General

1. The OhioRISE Plan must have information systems necessary to integrate and analyze data from multiple data sources to support MCO population health management strategies for its members, OhioRISE Plan's quality improvement efforts as described in this appendix, and calculate quality performance metrics, including but not limited to HEDIS.

ii. System Capabilities

1. The OhioRISE Plan's information system must fully support all components of its role in the ODM's and MCOs' population health strategies, and comply with the requirements in Appendix K, Information Systems, Claims, and Data. At a minimum the OhioRISE Plan's data information system must have the capabilities necessary to support the OhioRISE Plan in performing the following essential activities:

a. Integration of multiple data and information sources (e.g., enrollment data, care coordination data, claims, member services, data from MCOs, data from CMEs, and prior authorization data) to facilitate internal OhioRISE Plan's communication and coordination related to a specific member (e.g., the Utilization Management reviewer is able to see the OhioRISE Plan (including CME) care coordinator assigned to a particular member) or population;

b. Inform population identification, risk assignment, stratification, and assignment of care coordination tier and status;

c. Identification of members participating in Medicaid School Program and the services provided to each member through the MSP;

d. Identification of behavioral health providers and community-based organization involvement; and

e. House data to support each MCO's population health management strategies specific to OhioRISE Plan members, including:

i. OhioRISE Plan care coordination tier (Tier 3 - Intensive Care Coordination using a High-Fidelity Wraparound, Tier – 2 Care Coordination using a Wraparound informed model, Tier – 1 OhioRISE Plan Care Coordination);

ii. Identification of the primary entity providing care coordination (e.g., CME or OhioRISE Plan Care Coordination);

iii. CFCP content, including goals, interventions, outcomes, and completion dates; and

iv. Data needed to monitor the effectiveness and impact of the each MCO's population health strategies as specified in the MCO/OhioRISE Plan's Model Agreement (referenced in Appendix A, General Requirements).

2. The OhioRISE Plan must coordinate with the MCOs and ODM to search for and proactively incorporate useful data sources that would assist in supporting each MCO's population health management strategies and improve the OhioRISE Plan's ability to serve its members, network providers, families, and communities.

3. The OhioRISE Plan's information system must support the OhioRISE Plan to perform timely information system improvements, testing, and execution necessary to operationalize MCO- and ODM-coordinated population health efforts.

4. The OhioRISE Plan's information system must support the use of health information exchanges (HIEs) and electronic health records (EHRs) necessary for near real time understanding of member needs and reporting metrics, such as electronic clinical quality measures (eCQMs).

5. The OhioRISE Plan's data systems must integrate key member information to facilitate internal OhioRISE Plan communication and care coordination related to a specific member, as well as to inform the MCO population stream initiatives. Key information includes, but is not limited to:

a. Clinical data (including EHR and HIE data);

b. Data provided by CCEs;

c. Health risk assessments and other assessments (e.g., MCO Health Risk Assessment, Child and Adolescent Needs and Strengths [CANS] whether conducted by the OhioRISE Plan, MCO, Network Providers, or CMEs);

d. Enrollment data;

e. Financial data;

f. Utilization data (e.g., professional, hospital, pharmacy, services provided by CMEs and network providers);

g. Data from the OhioRISE Plan and MCO provider portal;

h. Lab results;

i. Programmatic data (e.g., level of care coordination);

j. Improvement project outcome, process, and balancing measures;

k. Survey data;

l. Registry data (e.g., immunization data);

m. Complaints, grievances, and appeals;

n. Identification of members receiving services through the Medicaid School Program and the services provided to each member through the MSP.

o. Resource information from community-based behavioral health organizations serving Medicaid members;

p. Data from state child-serving agencies (e.g., DODD, ODE, ODH, ODJFS, OMHAS, ODRC, DYS, and OFCF) for the purpose of analyzing information to improve the population health of enrolled OhioRISE Plan members;

q. Local governmental data (e.g., data from County Alcohol, Drug and Mental Health Boards [ADAMH], County Boards of Developmental Disabilities [BDD], County Departments of Job and Family Services [CDFJS], County Juvenile Courts, Educational Service Centers [ESCs], Family and Children First Councils [FCFCs], Public Children Services Agencies [PCSAs], and School Districts);

r. Data from CMEs;

s. Data from MCOs;

t. Data from the SPBM; and

u. Administrative data from ODM.

6. The OhioRISE Plan's data system must support population-specific efforts by:

   a. Allowing for the identification of differences in areas such as service access, utilization, health outcomes, intervention effectiveness, social risk factors, and OhioRISE Plan-specific member survey results by member characteristics; and

b. Supporting the monitoring and comparison of process and outcome measures over time to inform efforts to reduce differences in outcomes.

7. The OhioRISE Plan's data system must efficiently and securely share data with ODM, the Centers of Excellence (COEs), CCEs, MCOs, the SPBM, CMEs, and other community-based behavioral health organizations, subject to state and federal privacy requirements, including:

    a. Data to identify gaps in services for members;

    b. Attribution file;

    c. Risk factors related to SDOH and other relevant information; and

    d. Data to support care coordination efforts by CMEs and OhioRISE Plan's Care Coordinators.

8. The OhioRISE Plan's data system must be accessible to the COE(s) for providing support to the CMEs for data aggregation and analytics.

9. The OhioRISE Plan's data system must efficiently and securely exchange care coordination data with CMEs, MCOs, and behavioral health providers to facilitate integrated care planning, subject to state and federal privacy requirements. Data sharing must use industry standard formats (Consolidated Clinical Document Architecture and Fast Health Interoperability Resources).

10. To prevent any unapproved OhioRISE 1915(c) waiver services from being paid, the OhioRISE Plan’s data system must reconcile claims against the approved CFCP to accurately adjudicate OhioRISE 1915(c) waiver service claims prior to payment.

4. Population Health Improvement Approaches

a. General

i. The OhioRISE Plan will coordinate with each MCO to support its population health management approaches, including support for:

1. Care coordination, consistent with the requirements in Appendix D, Care Coordination;

2. Optimizing the delivery system through quality and performance improvement activities, optimization of health access and outcomes for all populations, and the identification and promotion of clinical and payer best practices; and

3. Supportive payment structures to promote a system-wide population health management approach.

b. Optimal Delivery System

i. The OhioRISE Plan must continuously improve all aspects of the care delivery system to optimize the health of its members through inclusion of input from members, families,

providers, and other partners across the care continuum into the design, execution, evaluation, and refinement of OhioRISE Plan service delivery policy and practice.

ii. The OhioRISE Plan must develop and apply clinical and payer best practice guidelines for service delivery decisions pertaining to utilization management, including medical necessity determinations, care coordination, member grievance and appeals, provider dispute resolution, member education, coverage of services, quality improvement projects, addressing disparities, and other areas to which these guidelines apply.

1. Clinical Best Practice Guidelines

a. The OhioRISE Plan must develop and implement clinical practice guidelines that:

i. Are based on valid and reliable clinical evidence or consensus of behavioral health care professionals;

ii. Consider the needs of members;

iii. Are adopted in consultation with the CMEs and OhioRISE Plan's network providers, which may be done through a provider advisory group;

iv. Include input from children, youth, and families who have received services, and from ODJFS, DYS, FCFC, OMHAS, ODRC, ODE, ODH and DODD;

v. Are reviewed and updated quarterly, or more frequently if needed;

vi. Are provided in an efficient and effective format to all affected providers, members, and potential members;

vii. Incorporate the results of quality improvement projects when applicable; and

viii. Are reported annually within the QAPI evaluation template.

2. Payer Best Practices

a. As a strategy for optimizing the care delivery system, the OhioRISE Plan must identify and demonstrate best payer practices that optimize member and provider experiences. The OhioRISE Plan must provide evidence of best practices (e.g., results of intervention testing, pilot, or program evaluations) to ODM upon request. Activities in support of this approach must include:

i. Incorporating the perspective of members, families, ADAMH, County BDD, CDFJS, County Juvenile Courts, ESCs, FCFCs, PCSAs, School Districts, and providers;

ii. Obtaining input from network providers on burdens generated by OhioRISE Plan's policies and procedures and efforts to minimize these burdens;

iii. Incorporating feedback from OhioRISE Program Member and Family Advisory Council and Provider Advisory Council on their needs and barriers;

iv. Researching industry standards;

v. Reviewing trade journals and other literature;

vi. Conversing with other lines of business within the OhioRISE Plan's parent company; and

vii. Co-designing and testing strategies with members and providers through science-based quality improvement methods and incorporating successful strategies into OhioRISE Plan's operations and policy.

c. Care Coordination

i. The OhioRISE Plan must develop and provide a care coordination program as required in Appendix D, Care Coordination, that honors individual care preferences while supporting and enhancing partnerships with the MCOs, SPBM, CCEs, CMEs, and other community-based behavioral health entities providing care coordination.

ii. The OhioRISE Plan's approach to care coordination must demonstrate the qualities of a high-performing system:

1. Provide timely, proactive, planned communication and action;

2. Be individualized, child-centered, strength-based, and family-focused with the strengths and needs of the child, youth, or young adult and their family/caregivers dictating the services received and the level of service coordination;

3. Be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve;

4. Be collaborative across the continuum of care and child- and youth- serving systems; and

5. Demonstrate comprehensive consideration of physical, behavioral, and social determinants of health.

d. Community Initiatives

i. The OhioRISE Plan must participate in and support ODM's efforts to reduce demographic differences in health outcomes, address social risk factors, and achieve

optimal health for all of its members. The OhioRISE Plan's community initative efforts must include the following:

1. Identifying demographic differences in health care access, service provision, satisfaction, and outcomes. This includes:
    a. Obtaining data on member demographics and social determinants; and
    b. Stratifying OhioRISE Plan data (e.g., claims, CANS, care plan data, member-identified race and ethnicity, geography, language, and SDOH) to determine populations with the highest needs.
2. Ensuring the delivery of services in a culturally appropriate and effective manner to all members by promoting cultural humility at all levels of the OhioRISE Plan and with CMEs and other community-based behavioral health providers, including promoting awareness of implicit biases and how they impact policy and processes;
3. Engaging youth and families when designing services and interventions that integrate care and address childhood adversity and trauma;
4. Obtaining ongoing input from members and families to:
    a. Create strategies for reducing disparities that incorporate the perspective of the member and their family;
    b. Define metrics, timelines, and milestones that indicate success; and
    c. Establish credibility and accountability through active member and family involvement and feedback.
5. Ensuring that each functional area with outward-facing communications tests potential publications with members and families for understanding and conveyance of the intended message, as well as cultural appropriateness;
6. Collaboratively partnering with members, families, MCOs, other ODM-contracted managed care entities, SPBM, network providers, and internal staff to test, refine, and share successful strategies for improving outcomes for all members;
7. Connecting and engaging with individuals, families, and organizations within the communities the OhioRISE Plan serves to understand community needs and resources;
8. Supporting CMEs to partner with community-based organizations and contributing to solutions addressing SDOH-related needs, such as:
    a. Lack of access to nutritious food (food insecurity, food deserts, and food swamps);
    b. Employment;

c. Homelessness and housing instability;

d. Education;

e. Transportation;

f. Recreational and social supports;

g. Interpersonal safety; and

h. Toxic stress.

9. Ensuring the active referral to and follow-up on identified needs related to SDOH such as those outlined above by:

    a. Supporting CMEs to maintain validated and up-to-date community resource lists for member and provider use;

    b. Sharing Health Risk Assessments, CANS, and other sources identifying SDOH needs, subject to state and federal privacy requirements, with CMEs, network providers, HUBS and community health workers;

    c. Ensuring SDOH needs and strategies are included in the CFCPs developed by the child and family teams;

    d. Reimbursing providers for notificiation of SDOH needs (e.g., use of ICD z codes); and

    e. Reimbursing network providers for follow-up after referral to confirm that the member received the service (e.g., HIEs).

10. Staying informed of innovations and research findings that impact the health of populations experiencing disparities; and

11. Tracking data over time and increasing performance targets when milestones are met.

12. Coordination with MCOs to ensure submission of the ROP for all OhioRISE-identified pregnant woman without a ROP or PRAF already in NurtureOhio.

ii. The OhioRISE Plan must describe how the OhioRISE Plan meets the requirements for optimizing health outcomes for all subpopulations as part of its Quality Assurance Performance Improvement (QAPI) evaluation submission as described below in this appendix.

e. Coordination for Specialized Services and Resources

i. The OhioRISE Plan must ensure that care coordination efforts through the OhioRISE Plan and CMEs work in concert with specialized services and resources (e.g., home visiting, community workers) identified by the MCO in MCO population health management strategies and MCO care plans.

ii. Specialized Services for High Risk Populations

1. The OhioRISE Plan must support and implement ODM's programs and initiatives for justice-involved individuals as specified in ODM's Expectations for the OhioRISE Plan to Support Justice-Involved Individuals.

f. Utilization Management

i. The OhioRISE Plan must monitor health care service under- and overutilization as outlined in Appendix B, Coverage and Services, and OAC rule 5160-59-03.1 to support the MCO population health management strategies for the children's behavioral health population stream. This includes:

1. Analyzing utilization by subpopulation demographics to ensure optimal care for all populations;

2. Analyzing utilization by service type and geographic area;

3. Establishing a process for setting thresholds for selected types of utilization (e.g., clinical criteria);

4. Establishing standards for timeliness of utilization management decisions and OhioRISE Plan's performance;

5. Immediately investigating any identified under- or overutilization of services in order to determine root cause, corrective action to identified problem areas, and monitoring of data over time to ensure sustained correction of the problem that led to the service under- or overutilization;

6. Establishing methods to ensure that the OhioRISE Plan's UM decision-making process is as efficient and uncomplicated as possible for the member, the provider, and the provider's staff;

7. Evaluating the consistency of the application of UM criteria through inter-rater reliability testing, as specified in Appendix B, Coverage and Services; and

8. Communicating identified trends to OhioRISE Plan's staff, ODM, MCOs, SPBM, and providers, as appropriate.

ii. In accordance with 42 CFR 438.330, the OhioRISE Plan must describe its mechanisms to detect both under- and over-utilization of services as part of its annual QAPI evaluation submission. The OhioRISE Plan must link the utilization analysis documented in the QAPI to population health outcomes, and incorporate the information obtained through this analysis into the OhioRISE Plan's QI strategy.

g. Community Reinvestment

1. Beginning July 2023, the OhioRISE Plan must demonstrate a commitment to improving health outcomes for its OhioRISE Plan-enrolled population in local communities in which it operates through community reinvestment activities. The OhioRISE Plan's community reinvestment must be used to support population health strategies statewide. The OhioRISE Plan must not use

community reinvestment funding to pay for Medicaid covered services or OhioRISE Plan administrative expenses.

2. The OhioRISE Plan must contribute a specified percentage of its estimated annual after-tax underwriting margin to community reinvestment. The original calculation for the 2023 community reinvestment amounts was an estimate provided by ODM based on the projected member months for each calendar year. For 2023, ODM calculated 3% of the OhioRISE Plan's assumed 1.5% risk margin with the expectation that the OhioRISE Plan will begin implementation of community reinvestment during CY 2023, following approval of its Community Reinvestment Plan. Actual underwriting margin will be calculated for 2023 based on the OhioRISE Plan's annual cost report with adjustments applied in recognition of taxes, as applicable. If the OhioRISE Plan's underwriting margin results are negative or otherwise less than actual community reinvestment spending in 2023, ODM will apply a credit to the OhioRISE Plan for the next community reinvestment year. If the OhioRISE Plan's underwriting margin results are positive or otherwise more than actual community reinvestment spending in 2023, the OhioRISE Plan must add the balance to the next year's community reinvestment required amount.

3. Beginning in 2024, the actual underwriting margin will be calculated annually based on the same year's annual cost report with adjustments applied in recognition of taxes, as applicable. For 2024, the OhioRISE Plan must contribute 4% of the annually calculated after-tax underwriting margin amount to the community reinvestment by December 31, 2025. For 2025 and beyond, the OhioRISE Plan must contribute 5% of the annually calculated after-tax underwriting margin amount to community reinvestment by the end of the following year, e.g., the 2025 amount must be awarded by December 31, 2026. Any unspent community reinvestment dollars required in CY 2023 or thereafter must be carried over and added to the required amount for the next year.

   All funds must be kept in an interest-bearing account and the interest must be returned to the fund. Also, for 2024-2026, a set amount of $7 million annually will be allocated to community reinvestment activities. ODM will review this amount annually to set the amount for the following years.

4. ODM encourages the OhioRISE Plan to maximize the collective impact of community reinvestment funding by working collaboratively with child-serving state agencies and local community entities, including but not limited to: DODD, ODE, ODH, ODJFS, OMHAS, ODRC, DYS, OFCF, ADAMH Boards, County BDD, CDFJS, County Juvenile Courts, ESCs, FCFCs, PCSAs, School Districts, and family- and youth-run organizations.

5. ODM encourages the OhioRISE Plan to solicit Community Reinvestment opportunities from the Member and Family Advisory Committee, child-serving state agencies, local community entities, and others as directed by ODM in order to ensure alignment of OhioRISE Plan's Community Reinvestment with other OhioRISE Plan population-specific initiatives.

6. The OhioRISE Plan must work collaboratively with the other MCEs in a region to maximize the collective impact of community reinvestment funding. submit a proposed list of Community Reinvestment opportunities to ODM for review and approval to ensure consistency with ODM Quality Strategy.

7. The OhioRISE Plan must submit a Community Reinvestment Plan and Evaluation to ODM for ODM approval as specified in Appendix P, Chart of Deliverables. The OhioRISE Plan's Community Reinvestment Plan must detail the OhioRISE Plan's anticipated collaborative community reinvestment activities and describe how those activities support the OhioRISE Plan's enrolled population.

8. After the first submission, the OhioRISE Plan must include an evaluation of the Community Reinvestment Plan in its annual Community Reinvestment Plan submission to ODM. The evaluation must describe and quantify the impact of community reinvestment funding on population health improvement. The evaluation should include evaluation data gathered from state and local community entities, members, and their families.

h. Quality Improvement

i. General Requirements

1. The OhioRISE Plan must establish and implement an ongoing, comprehensive Quality Assessment and Performance Improvement (QAPI) program in accordance with the requirements in 42 CFR 438.330.

2. The OhioRISE Plan's QI program must employ a deliberate, defined, and science-informed approach that is responsive to member and provider needs and incorporates systematic methods for discovering reliable approaches to improving the health outcomes for all segments of the OhioRISE Plan-enrolled population.

3. The OhioRISE Plan's QI program must encompass all levels of the organization, clearly linking the OhioRISE Plan's QI strategy to the OhioRISE Plan's and ODM's mission and vision.

4. The OhioRISE Plan's QI program must include the voice, experience, and participation of enrolled members and their families, including but not limited to the Member and Family Advisory Council, member complaints/appeals, surveys, and other methods.

5. The OhioRISE Plan must provide the OhioRISE Plan's QI strategy, structure, execution, and evaluation of its QI program to ODM as part of its QAPI evaluation submission described below in this appendix.

ii. Quality Improvement Strategy

1. As described in this appendix, on an annual basis, the OhioRISE Plan must submit a clearly delineated, outcomes-driven QI strategy within the QAPI evaluation submission.

iii. Quality Improvement Program Structure and Accountability

1. Organizational and Cross-Organizational Quality Improvement Efforts

    a. The OhioRISE Plan must integrate QI efforts throughout the organization.

    b. The OhioRISE Plan must ensure that staff at all levels of the organization are fully equipped and committed to improving health outcomes for all populations.

    c. The OhioRISE Plan must openly communicate the results of successful and unsuccessful QI efforts, internally and externally, to foster a culture of innovation, including to child-serving state and local agencies, Member and Family Advisory Council, and others as determined by ODM.

    d. The OhioRISE Plan must engage and empower staff across all levels of the organization to seek out the root cause of problems, collaboratively test improvement strategies, and rapidly learn what works to maintain and spread successes.

    e. The OhioRISE Plan must collaborate with ODM, MCOs, SPBM, and other contracted entities, on QI activities as required by ODM.

2. System of Care Quality Improvement Committee

    a. The OhioRISE Plan's QI program will include the establishment of a System of Care QI committee that provides input into the quality improvement activities related to serving and supporting OhioRISE Plan members. This committee will include a broad representation of System of Care stakeholders, including representatives from providers, members and their families, child-serving state and local entities, and others as directed by ODM.

    b. The OhioRISE Plan will maintain records of meetings, documenting representatives and attendance, as well as Committee's findings and recommendations.

    c. The OhioRISE Plan will solicit input and recommendations from the Committee on all of its System of Care QI related activities.

    d. The OhioRISE Plan is encouraged to establish other processes, in addition to the System of Care QI Committee to seek input on priorities and improvement opportunities, share findings and lessons learned from members and their families, child-serving state and local agencies, Medicaid contracted entities, and others as directed by ODM consistent with expectations for cross-system collaboration.

3. Collaboration to Support Quality Improvement

a. The OhioRISE Plan must collaborate with the State's designated COE(s), child-serving state agencies and local agencies on QI activities as required by ODM.

4. Administrative Oversight by Senior Leadership

    a. The OhioRISE Plan must establish administrative oversight and accountability for its QI program.

    b. The OhioRISE Plan's oversight must include the assignment of an ODM-approved, senior QI leadership team responsible for the QI program (e.g., Quality Improvement Director, CMO).

    c. The OhioRISE Plan must ensure that the CMO is involved and provides oversight for all clinically-related improvement projects.

5. Quality Improvement Tools, Methods, and Principles

    a. General

        i. The OhioRISE Plan must provide opportunities for staff training and hands-on application of ODM-approved, QI science-based tools, methods, and principles in daily work and strategic initiatives in order to build internal OhioRISE Plan's staff QI skills and capacity throughout the organization.

    b. Quality Improvement Training Requirements

        i. To create an organizational foundation with the necessary QI skills and proficiencies, the OhioRISE Plan must:

            1. Ensure the OhioRISE Plan's CMO, Behavioral Health Clinical Director, Population Health Director, QI Director, analytic support staff, and at least one OhioRISE Plan staff person assigned to each improvement team have completed training that covers the QI training content described below from an ODM-approved entity The OhioRISE Plans's QI training is not a substitute for the certification required in Appendix A, General Requirements; and

            2. Document the OhioRISE Plan's ongoing efforts to build QI expertise and capacity in the annual QAPI evaluation submission to ODM.

    c. Quality Improvement Training Content

        i. The OhioRISE Plan's QI training content must include but is not limited to:

1. The Deming System of Profound Knowledge® (SoPK);

2. Using data to understand opportunities for improvement, including understanding how improvement opportunities differ by subpopulation, geography, and provider type, as well as where differences exist in optimal service utilization, healthcare experience, and health outcomes;

3. The Model for Improvement developed by the Associates in Process Improvement and popularized by the Institute for Healthcare Improvement (IHI);[2]

4. Defining a Quality Improvement Project goal as a Specific, Measureable, Achievable, Relevant, and Time-bound (SMART) Aim;

5. Continuously obtaining, listening to, and incorporating information and feedback from enrolled members and their families, providers, and other stakeholders, including child-serving state agencies and local entities to inform understanding of the member/patient journey, barriers to achieving the SMART Aim, identification of root cause(s) of failures, development of the theory for improvement, and codesigning of interventions through iterative testing using PDSAs;

6. Use of ongoing input and feedback from members, families, providers, child-serving entities and other stakeholders (e.g., voice of the customer; Gemba walks) to develop and refine process maps and simplified failure mode and effects analysis (sFMEA) tools that reflect the member/patient journey and their barriers to achieving the SMART Aim, including barriers related to current OhioRISE plan or system processes;

7. Use of root cause analysis based on input and feedback from members, providers, child-serviing entities, and other stakeholders to drill down to the root cause of the most prevalent or important barriers to achieving the SMART Aim;

[2] Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance (2nd edition). San Francisco: Jossey-Bass Publishers; 2009.

8. Use of dynamic key driver diagrams for demonstrating the theory for improving the SMART Aim and building testable hypotheses;[3]

9. Selection and use of process, outcome, and balancing measures to allow assessment of whether interventions are impacting the theorized key drivers of the SMART Aim;

10. Codesigning and active intervention testing through the use of rapid (i.e., less than monthly cycles) Plan-Do-Study-Act (PDSA) cycles with clearly defined predictions of success, data used to determine whether results match prediction, metrics and data to determine whether results match predictions, documentation of resulting learning and consequent planned actions, as well as updates to the theory for improvement (i.e., KDD) based on learning;

11. Active application of iterative rapid cycle, quality improvement tools and methods;

12. The use of time series and trend charts to understand and act upon special cause variation, including the use of annotated run charts and Shewhart control chart;

13. Considerations and techniques for successful implmenetation, spread, and sustainability of interventions with data-based evidence of success under multiple circumstances; and

14. The sequence and interaction of the above components to achieve sustainable improvements to member and provider experience, access to services and supports, and health outcomes.

d. Quality Improvement Training Completion

   i. The OhioRISE Plan must submit training curricula to ODM for approval prior to start of OhioRISE Plan operations under this Agreement, and prior to substantive changes to an existing training curricula.

[3] http://www.ihi.org/resources/Pages/Tools/Driver-Diagram.aspx

ii. The OhioRISE Plan must submit evidence of QI training completion as specified in Appendix P, Chart of Deliverables.

iii. The CMO and Medical Directors with a substantial role in improvement projects or who are accountable for the QAPI program, as well as QI Directors, must complete the course work within twelve months of the contract date. The CMO and Medical and Quality Directors are exempt from this requirement if they have evidence of course completion covering the content above within the two years prior to their effective OhioRISE Plan's start date.

e. Applying Quality Improvement Training Concepts

i. The OhioRISE Plan must ensure that during and subsequent to quality improvement training, all OhioRISE Plan staff are actively involved as QI team members in at least one improvement project in order to continue to build the QI capacity of the OhioRISE Plan.

ii. For purposes of this Agreement, "active involvement" means applying QI tools, methods, and concepts to a clinical or non-clinical problem, including the analysis of data to determine opportunities for improvement, root cause determinations, barrier assessment, intervention design, and testing using PDSA cycles, longitudinal measurement, and assessment of intervention impact on outcome measures using statistical process control methods.

iv. OhioRISE Plan's Clinical and Non-Clinical Improvement Projects

1. The OhioRISE Plan must design and conduct improvement projects in clinical and non-clinical topic areas that use the tools, methods, and principles defined above to improve population health outcomes (focused on areas with greater improvement needs) of enrolled members and their families.

2. The OhioRISE Plan must initiate improvement projects, as well as conduct improvement projects that ODM requires. ODM-required improvement projects may be coordinated with:

a. Other ODM-contracted managed care entities and providers;

b. The SPBM, MCO, and/or ODM to consult, coordinate, and train on prescriber patterns and other medication issues relevant to children for CMEs and prescribers in the OhioRISE Plan or MCO provider networks; and

c. Other child-serving state agencies or local agencies (e.g., reducing length of stay in inpatient behavioral health facilities for children in child welfare and juvenile justice, or improving timely access to mobile

response services to support a child's tenure in a school/community setting).

3. The OhioRISE Plan's improvement projects must aim to achieve significant and sustained improvement over time in health outcomes for all populations; quality of life; child, youth, young adult, and family satisfaction; and provider satisfaction (e.g., increase utilization/penetration for evidence-based services, increased engagement in care, or increased tenure in the home/community and school). This includes reducing differences in outcomes among populations.

4. In conducting improvement projects, the OhioRISE Plan must:

    a. Designate a member of the Senior QI Leadership team as project sponsor to ensure that resource needs are met, issues are identified and elevated on a timely basis, and learning is effectively shared throughout the organization;

    b. Appropriately staff projects as described in this appendix;

    c. Use ODM-specified QI methods and tools such as PDSA cycles, along with frequent and ongoing analysis to quickly determine the effectiveness of interventions;

    d. Use ODM-developed templates (e.g., QI template; Key Driver Diagram [KDD] template; PDSA template) to document the OhioRISE Plan's manual, rapid-cycle, iterative work, as well as the lessons learned from this process;

    e. Use data to identify improvement opportunities and longitudinally monitor project progress. This includes using data analysis methods such as statistical process control to differentiate common and special cause variation in order to identify improvement, sustained successes, and additional opportunities for improvement;

    f. Analyze data to identify population differences in services or care, and tailor interventions to specific child, youth, and young adult populations when needed in order to optimize health of all populations; and

    g. Actively incorporate children, youth, and family, provider, child-serving state and local agency perspectives into improvement activities.

5. The OhioRISE Plan must use ongoing analysis, data feedback, and the associated learning to determine improvement subjects and interventions.

6. As required by ODM, the OhioRISE Plan must share knowledge gained from successful and unsuccessful intervention testing of improvement projects, as well as project outcomes, with ODM, other managed care contracted entities, child-serving state and local agencies, Member and Family Advisory Council, and other relevant stakeholders as directed by ODM to improve population health planning statewide.

7. Performance Improvement Projects

    a. Performance improvement projects (PIPs) are a subset of all OhioRISE Plan's improvement projects that must comply with 42 CFR 438.330. Each year, ODM designates at least one improvement project to serve as the OhioRISE Plan's PIPs. Based on the review of the OhioRISE Plan's quality improvement efforts, ODM may require other PIPs in subsequent years of the contract. As with all other improvement projects, ODM requires that PIPs are conducted using rapid cycle quality improvement science techniques.

        i. The OhioRISE Plan must initiate and complete PIPs in topics selected by ODM. For CY 2023, the PIP is focused on improving metabolic monitoring amount individuals prescribed antipsychotics.The OhioRISE Plan must work with ODM and ODM's External Quality Review Organization (EQRO), and others as directed by ODM (e.g., managed care entities, child-serving state and local agencies), to develop and implement the PIP designated by ODM.

        ii. As part of this process, the OhioRISE Plan must participate in PIP planning, including assisting in the recruitment of participating members, entities, or providers, determining initial key drivers and interventions.

        iii. The OhioRISE Plan must ensure that all PIPs designed or implemented demonstrate improvement and the OhioRISE Plan must clearly articulate lessons learned during the course of the initiative.

        iv. The OhioRISE Plan must adhere to ODM-specified reporting, submission, and frequency guidelines during the life of the PIP; establish and implement mechanisms for rapid testing of interventions; and, establish mechanisms for spreading and sustaining successful interventions in order to optimize improvement gains.

        v. Upon request, the OhioRISE Plan must provide longitudinal data demonstrating sustained improvement over the course of the project and during the sustainability phase following final validation of the PIP by ODM's EQRO.

        vi. The OhioRISE Plan must fully cooperate with ODM's EQRO in its PIP validation activities, performed in accordance with 42 CFR 438.338.

    b. The OhioRISE Plan is required to work collaboratively on the following PIP topic: Antipsychotic Metabolic Monitoring (APMM)

c. Collaborative PIPs require that the participating managed care entities (MCEs) select a lead analyst who is charged with ensuring the use of common data definitions across MCEs and compiling individual MCE data to meet the needs of the PIP.

v. Collection and submission of performance measurement data as specified in Appendix I, Quality Measures

vi. Quality Improvement Communication Strategy

1. The OhioRISE Plan must develop and use a clearly defined communication strategy for QI activities. The OhioRISE Plan's communication strategy must include:

a. Mechanisms for data receipt and exchange, analyzing and interpreting data, and transparently and proactively involving the input from the enrolled members and their families, child-serving state and local agencies, public school districts, Member and Family Advisory Council, System of Care Quality Improvement Committee, and other stakeholders and partners identified by the OhioRISE Plan or as directed by ODM, in applying data to inform improvement efforts;

b. A description of the internal mechanisms used to frequently, transparently, and proactively communicate improvement status updates across the organization, to executive leadership, to ODM, and to others as directed by ODM. Status updates must include lessons learned from intervention testing, advances to the theory of knowledge, and progress on process and outcome measures;

c. Mechanisms for proactive, regular communication with ODM and EQRO, state and local child-serving agencies, behavioral health stakeholders, and others as directed by ODM regarding improvement opportunities and priorities, intervention successes, lessons learned, and future activities; and

d. Mechanisms and standards for responding promptly and transparently to data and information requests by ODM or the EQRO.

i. Child and Family-Centered Care Plan Review

i. Purpose of the Care Plan Review Process

1. The OhioRISE Plan shall ensure that CFCPs for members in all Tiers, are completed, submitted for review, and accepted by the OhioRISE Plan according to standards approved by ODM. The OhioRISE Plan will use the current sampling methodology that is approved by ODM for CFCP reviews. If the CFCP includes OhioRISE 1915(c) waiver services, the waiver services on the CFCP must be reviewed and approved prior to services starting. The QI/UM program is responsible for reviewing and monitoring:

a. The timeliness of care plan completion;

b. Comprehensiveness of the CFCPs and back-up plans (only for OhioRISE 1915(c) waiver enrollees) to ensure that all necessary CME and other provider services and supports are incorporated into the CFCP at the needed intensity of service; and

c. Ensure the plans adhere and support a child and family-centered care planning process consistent with System of Care Principles, and High-Fidelity Wraparound practice when that method is used.

ii. Care Plan Review Staffing and Qualifications

1. The care plan review process must be independent from the staff and organizational structure responsible for developing care plans.

2. The care plan review process must be closely coordinated with utilization management and the service authorization process to avoid duplication of review effort, ensure single voice in feedback to providers on care planning needs, and to ensure timeliness.

3. Staff conducting care plan reviews, if other than UM staff, shall have credentials, training and experience consistent with requirements for UM staff as defined in this agreement.

iv. Notice of Concurrence or Non-Concurrence For CFCP With OhioRISE 1915c Waiver Services And / Or OHR Services Requiring Prior Approval

4. When the care plan is found to meet requirements, the QI/UM program shall provide notice of concurrence to the OhioRISE Plan or CME care coordinator through an ODM agreed-upon method.

a. A notice of concurrence issued for a CFCP containing services that require prior approval using the CFCP process shall serve as prior authorization of such services.

5. When the Care Plan Feedback process does not result the QI/UM program determining that the care plan meets requirements, the QI/UM program shall provide notice of non-concurrence to the OhioRISE Plan or CME care coordinator through an ODM agreed-upon method.

a. When a notice of non-concurrence is issued for a CFCP that contains services requiring prior approval using the CFCP process, this constitutes an adverse benefit determination that can be appealed in accordance with rule 5160-26-08.4 of the Administrative Code

iii. Care Plan Feedback

1. If the QI/UM program cannot determine that a care plan meets requirements, feedback must be provided to the OhioRISE Plan or CME care coordinator through an ODM agreed upon method. The feedback must occur within the timeframe specified by ODM and must specify:

a. The specific standard or requirement in question;

b. The additional information requested;

c. Additional information requested shall be limited to the minimum, essential information directly related to the question.

i. The OhioRISE Plan shall collaboratively develop with the CMEs an Additional Information Request Questions set that details the typical questions and additional documentation that can be requested during the Care Plan Feedback process.

d. The offer of verbal feedback and discussion between the OhioRISE Plan and the CME or OhioRISE Plan's Care Coordinator.

iv. Care Plan Structure and Requirements

1. The structure of the CFCPs and the minimum requirements and standards associated with them shall be established by ODM. The OhioRISE Plan shall adhere to the structure, minimum requirements, and standards as approved by ODM when evaluating care plans. Any proposed additional standards, criteria, or changes must be approved in writing by ODM prior to implementation.

2. The OhioRISE Plan must retain copies of CFCPs and Individual Crisis and Safety Plans developed for members, including those developed by CMEs. The OhioRISE Plan must ensure CMEs retain CFCPs and Individual Crisis and Safety Plans in accordance with record retention requirements in 45 CFR 92.42.

v. Care Plan Submission Timeliness

1. The OhioRISE Plan shall have processes to track and report timeliness of care plan submission for review by the OhioRISE Plan and have processes to notify and prompt the CME or OhioRISE Plan's care coordinator when care plan submissions are due and past due.

2. The OhioRISE Plan shall have policies and procedures to ensure that access to needed services and supports are not delayed as a result of the care plan review process.

vi. Care Plan Review Timeliness

1. The OhioRISE Plan must complete its initial CFCP review and provide notice of concurrence, or engage the submitting care coordinator in a collaborative process that ensures the care plan is approved within five business days of initial submission. The OhioRISE Plan must track and report care plan review status, including timing and outcomes of all steps in the feedback cycle, through its determination of concurrence.

vii. Care Plan Review Conflict Resolution

1. The OhioRISE Plan shall collaboratively work with the CMEs to develop a phased conflict resolution process that shall be followed when the OhioRISE Plan and the CME cannot reach concurrence on the adequacy and appropriateness of the care plan. This conflict resolution process shall be subject to ODM review and concurrence.

viii. The Care Plan Review Conflict Resolution process applicability is limited to care plan review. It does not replace or impact the formal authorization of services or related denial and appeal rights, responsibilities, or procedures. Care Plan Review of the OhioRISE 1915(c) Waiver Services

1. The CME and the OhioRISE Plan must monitor the cost of OhioRISE 1915(c) waiver services on an ongoing basis, but at a minimum every 365 days, to ensure OhioRISE 1915(c) waiver services expenditures do not exceed the annual $15,000 limit per member.

2. Once an OhioRISE 1915(c) waiver service has been reviewed and approved on the CFCP, the approval must be maintained for 365 days unless a significant change occurs.

3. The OhioRISE Plan must ensure CFCPs for all members who are OhioRISE 1915(c) waiver enrollees are developed with the member and their CFT within 30 calendar days of the member being enrolled on the OhioRISE 1915(c) waiver. The care coordinator must submit the completed CFCP to the OhioRISE Plan within one business day of completion. The OhioRISE Plan must review and approve OhioRISE 1915(c) waiver enrollees' CFCPs in an expedient manner to facilitate access to 1915(c) waiver services, as follows:

4. The OhioRISE Plan must provide approval of the CFCP as expeditiously as the member's situation warrants but no later than five business days after receipt of the CFCP.

ix. If the OhioRISE Plan does not approve the original CFCP submitted by the care coordinator, and instead provides feedback and requests additional planning or information prior to approval, the OhioRISE Plan must directly contact the care coordinator via electronic communication or telephone and ensure prompt resubmission of the CFCP. Care Plan Distribution

1. The OhioRISE Plan must ensure the approved signed copy of the CFCP is provided to the member, members of the CFT, and providers of services included on the CFCP.

5. Cross System Collaboration

a. The OhioRISE Plan must facilitate cross-system collaboration and coordination with other child-serving state and local agencies that impact the health of the enrolled population of children, youth, and their families. This includes developing knowledge of, aligning policy, and working toward shared outcomes with other state and local child-serving agencies on the policy areas they direct. All collaboration and coordination are subject to state and federal privacy requirements. Such agencies include but are not limited to:

i. Child-serving state agencies and local entities, including but not limited to: DODD, ODE, ODH, OMHAS, ODRC, DYS, OFCF; ADAMH Boards, County BDD, CDFJS, County Juvenile Courts, ESCs, FCFCs, PCSAs, and School Districts;

ii. ODJFS efforts with implementing the Family First Prevention Services Act (FFPSA);

iii. ODM-contracted entities, including but not limited to the MCOs, CCEs, ODM-funded entities associated with alternative payment approaches, and the SPBM;

iv. COE(s);

v. CMEs, CCEs, including ODM-funded entities associated with alternative payment models (Comprehensive Primary Care) and conflict-free case management agencies (PASSPORT Administrative Agencies, County Boards of Developmental Disabilities, Ohio Home Care Case Management Agencies); and

vi. Others as directed by ODM or identified by the OhioRISE Plan.

b. Cross-system collaboration and coordination includes:

i. Developing a communication strategy with state and local child-serving agencies that includes:

1. Disseminating relevant information on a regular basis regarding the policies and programs offered through the OhioRISE Plan;

2. Attending meetings at the request of the child-serving agencies. Meetings may include but are not limited to technical assistance sessions, performance and compliance, provider network decisions, and policy and program development;

3. Responding to questions and concerns on a timely basis from state and local child-serving systems; and

4. Incorporating feedback from the state and local child-serving systems into policy and program decisions (e.g., provider network development, quality improvement strategies).

ii. Identification of service gaps and assistance in closing gaps in care (e.g., timely access to services, facilitating referrals and linkages to care, coordinating transitions and services across child-serving systems) in order to optimize health outcomes;

iii. Data sharing, subject to state and federal privacy requirements;

iv. Coordination between involved entities, including but not limited to care coordinators and primary care providers, child-serving systems, schools, and community organizations;

v. Ensuring seamless care transitions and follow-up as outlined in Appendix D, Care Coordination, including coordinating services and transitions across child-serving systems and community providers;

vi. Early identification of care needs (e.g., behavioral health screening and assessment, identification of SDOH needs, connection to natural supports, and community-based services);

vii. Promotion of services that facilitate care delivery (e.g., telehealth, home-based services, community-based services; engagement of families in a member's treatment);

viii. Integrating behavioral and physical health;

ix. Addressing SDOH, such as trauma and adverse experiences, food scarcity and insecurity, housing instability and unsafe conditions, school engagement and tenure, family and community violence, and transportation needs; and

x. Provider and workforce development activities, including coordination with the COE(s) and others as directed by ODM.

6. Evaluation

a. Support of MCOs' Population Health Management Strategy (PHMS) and QAPI Evaluations

i. The OhioRISE Plan must actively participate in each MCO's Population Health Management Strategy and QAPI evaluations. This must include but not be limited to monitoring data from multiple areas of the system (e.g., claims, assessments, member grievances and appeals, care coordination) in order to identify patterns (e.g., service utilization patterns), anticipate problem areas (e.g., unmet SDOH needs), and adapt as needed.

ii. The OhioRISE Plan must utilize its monitoring of process and outcome measures to inform its own and each MCO's risk stratification algorithms, as well as to inform input and recommendations to the MCOs regarding their ongoing design or adaptation of strategies and initiatives to better serve the needs of the population.

iii. The specific role and activities of the OhioRISE Plan in each MCO's Population Health Management Strategy Evaluation must be described in the MCO/OhioRISE Plan's Model Agreement (described in Appendix A, General Requirements) executed between the OhioRISE Plan and each MCO.

b. Quality Assessment and Performance Improvement Program and Evaluation

i. The OhioRISE Plan's Quality Assessment and Performance Improvement (QAPI) Program, required by 42 CFR 438.330, must include:

1. A description of ODM- and OhioRISE Plan-initiated improvement projects, including the annual Performance Improvement Project;

2. A summary of the OhioRISE Plan's assessment of the effectiveness of improvement projects based on statistical process control charts annotated with payer and clinical based interventions;

3. A description of how the OhioRISE Plan meets the requirements for the development and dissemination of clinical practice guidelines described in this appendix;

4. Collection and submission of performance measurement data;

5. A description of mechanisms the OhioRISE Plan uses to detect both underutilization and overutilization;

6. A description of mechanisms the OhioRISE Plan uses to assess the quality and appropriateness of care furnished to members;

7. A description of the OhioRISE Plan's efforts to prevent, detect, and remediate critical incidents that are based, at a minimum, on state requirements for home and community-based waiver programs.

ii. In addition to these federal requirements, the OhioRISE Plan must provide information regarding its QI strategy and the OhioRISE Plan's evaluation of the effectiveness of its QI strategy within its annual QAPI evaluation submission.

1. The OhioRISE Plan's QI strategy must include and describe, at a minimum, the following:

a. The OhioRISE Plan's leadership team, including leadership positions and how each role supports and champions the OhioRISE Plan's QI strategy and related initiatives and projects;

b. The OhioRISE Plan's senior QI leadership team structure, reported in the Accountability Component of the QAPI evaluation template, that reflects:

i. Senior QI leadership team roles and responsibilities for QI activities; and

ii. Senior QI leadership team QI training and experience related to both quality and knowledge of the needs of children and youth with complex behavioral health needs, and child-serving systems.

c. The role and impact of the Member and Family Advisory Council;

d. The role and impact of the System of Care Quality Improvement Committee;

e. The OhioRISE Plan's mechanisms for frequently and transparently sharing information and data throughout the organization to inform improvement activities (e.g., dashboards, newsletters, staff meetings);

f. Methods for identifying and ensuring the assignment of needed quality improvement resources, including the assurance of dedicated analytical and project management support and oversight;

g. Methods for building and sustaining QI culture and capacity throughout the organization;

h. How the OhioRISE Plan's QI strategy aligns with ODM's Quality Strategy, including how the OhioRISE Plan will collaborate with other ODM-contracted MCOs, the SPBM state and local child-serving systems, and others as directed by ODM, on ODM-directed population health efforts;

i. The OhioRISE Plan's improvement projects, including:

    i. How the improvement project relates to the OhioRISE Plan's other population health initiatives, as well as to MCO and ODM quality improvement strategies; and

    ii. The theory of change for each improvement initiative (e.g., cause and effect diagrams, key driver diagrams).

j. Criteria considered when choosing and prioritizing the OhioRISE Plan's improvement projects such as input and recommendations from the Member and Family Advisory Council and the System of Care Quality Improvement Committee, data from multiple areas (e.g., claims, grievance/appeals, assessments, care coordination, service utilization patterns, penetration rates), and other input from child-serving state and local agencies, Medicaid contracted entities; and

k. The OhioRISE Plan's evaluation strategy, including:

    i. Process, outcome, and balancing measures for each initiative, including:

    ii. Baseline, milestones, and target goals;

    iii. Timeframes for baseline, milestones, and target goals;

    iv. Data sources;

    v. Numerator and denominators for each measure; and

    vi. Frequency of measurement (e.g., daily, weekly, monthly).

2. The OhioRISE Plan's evaluation of its QAPI program must demonstrate how it meets all requirements above, as well as how the OhioRISE Plan evaluated the impact and effectiveness of each improvement activity within the QAPI program;

    a. The OhioRISE Plan's evaluation must, at a minimum, include:

        i. The outcomes and trended results of each improvement project, including documentation of successful and unsuccessful interventions;

ii. The results of any efforts to support improved health outcomes for members, with specific attention to reduction in outcomes differences between populations;

iii. How the OhioRISE Plan will incorporate the results into those efforts; and

iv. How the OhioRISE Plan plans to update its QI Strategy based on the findings of the self-evaluation.

c. Quality Improvement Meeting Requirements

i. The OhioRISE Plan must document project learning using the ODM QI template and submit the template at least two business days prior to each meeting, as specified in Appendix P, Chart of Deliverables.

1. During the planning phase of an improvement project, the OhioRISE Plan must support ODM in their efforts to coordinate and lead the QI meetings. The OhioRISE Plan should use the QI template to provide:

a. Detailed and high-level process maps of the OhioRISE Plan's processes related to the outcome of interest;

b. Results of obtaining member/family, provider, and relevant child-serving systems perspectives on the OhioRISE Plan's processes (e.g., identified barriers and ideas for improvement); and

c. Strategies, timelines, and milestones for next steps (including what must be accomplished before the next meeting).

2. During the active testing stage of an improvement project, the OhioRISE Plan must ensure its QI template and accompanying meeting reflects the results of the OhioRISE Plan's weekly or more frequent PDSA cycles as demonstrated by documentation of testing and annotated run or control charts.

3. Once changes have resulted in improvement, the OhioRISE Plan must begin actively testing in new circumstances for purposes of effectively spreading the improvement.

d. External Quality Review

i. ODM will select an EQRO to provide for an annual external and independent review of the quality, outcomes, timeliness of, and access to services provided by the OhioRISE Plan.

ii. The OhioRISE Plan must submit data and information, including member medical records, at no cost to, and as directed by, ODM or its designee for the annual external quality review activities.

iii. The OhioRISE Plan must participate in an annual external quality review that must include but is not limited to the following activities:

1. A comprehensive administrative compliance review as directed by ODM in accordance with 42 CFR 438.358;

    a. In accordance with 42 CFR 438.360 and 438.362, the OhioRISE Plan, if it is accredited by a national organization approved by the Centers for Medicare and Medicaid Services may request to be exempted (deemed) from certain portions of the administrative compliance review. ODM will inform the OhioRISE Plan if the OhioRISE Plan may request a non-duplication exemption.

    b. The EQRO may conduct focused reviews of OhioRISE Plan's performance as directed by ODM in the following domains that include but are not limited to the following:

        i. Availability of services;

        ii. Assurances of adequate capacity and services;

        iii. Coordination and continuity of care;

        iv. Coverage and authorization of services;

        v. Provider selection;

        vi. Confidentiality;

        vii. Grievance and appeal systems;

        viii. Sub contractual relationships and delegation;

        ix. Practice guidelines; and

        x. Health information systems.

2. Encounter data studies;
3. Validation of performance measurement data;
4. Review of information systems;
5. Validation of performance improvement projects; and
6. Provider surveys and member and family satisfaction and quality of life surveys.

APPENDIX D – CARE COORDINATION

1. OhioRISE Program Care Coordination

a. General Requirements

i. The OhioRISE Plan must develop and implement a high performing care coordination program that meets the care coordination requirements in this appendix, and reflects guiding principles to optimize the health of the individual members and populations it serves.

ii. The OhioRISE Plan's care coordination program must serve as the foundation to ensure that all members have access to quality care coordination for services identified in the members' CFCP developed by the Child and Family Team (CFT), the OhioRISE Plan-contracted CME, the OhioRISE Plan, or a combination thereof.

iii. The OhioRISE Plan may delegate any requirement specified in this appendix to a CME in accordance with the requirements in the subcontractual relationships and delegation section in Appendix A, General Requirements.

iv. The OhioRISE Plan must use a tiered care coordination model as described below, varying the intensity of care coordination in a manner that aligns with the needs of enrolled children, youth, and their families.

v. The OhioRISE Plan's care coordination program must include processes and protocols for ensuring that its efforts support, but do not supplant, MCOs' care coordination and the care coordination entities (CCEs) for their shared members.

vi. The OhioRISE Plan's care coordination program must include processes and protocols for ensuring that its efforts support, but do not duplicate, care coordination activities performed for members by state and local agencies and their designees.

vii. The OhioRISE Plan's care coordination program must safeguard confidential information in accordance with the privacy compliance requirements specified in Appendix A, General Requirements.

viii. The OhioRISE Plan must have a process to communicate member assignment and enrollment data to the CME within the timeframe specified Appendix D of this agreement. The OhioRISE plan must report this data as specified in the Chart of Deliverables.

ix. The OhioRISE Plan must ensure members receive Tier 2 and Tier 3 care coordination services from the CME assigned to the catchment area in which they reside or in the catchment area of the member / guardian’s preference as appropriate, unless the member is in the custody of a Title IV-E agency. Members in the custody of a Title IV-E agency will be assigned to the CME in the child's county of eligibility.

1. When there are multiple CMEs within a county, members will be assigned to the CME in the zipcode for their placement address within that county.

2. When a placement address is not in the child's county of eligibility, the child's PCSA will be contacted to determine where they want the child assigned, either to the CME in the county of eligibility or the child's placement address.

x. The OhioRISE Plan must review and approve CME change requests in accordance with the requirements of Appendix D.1.a.viii.

b. OhioRISE 1915(c) Waiver Care Coordination Requirements

i. The OhioRISE Plan's care coordination program must incorporate all requirements of 1915(c) waiver case management, including person-centered care planning and the development of a person-centered care plan. For the purposes of the OhioRISE 1915(c) waiver:

1. Delivery of OhioRISE care coordination by the OhioRISE Plan or CME will serve as the mechanism for 1915(c) waiver case management. The planning processes used by the OhioRISE Plan and CMEs, including convening the Child and Family Team, will serve as the mechanism to facilitate 1915(c) waiver person-centered care planning.

2. The CFCP will serve as the 1915(c) waiver person-centered care plan.

ii. The OhioRISE Plan must provide day-to-day oversight of care coordination performed by the OhioRISE Plan and CME care coordinators. OhioRISE Plan oversight must include but is not limited to:

1. Ensuring the prompt development and implementation of the CFCP, including the identification and provision of OhioRISE 1915(c) waiver services, in accordance with the process and criteria set forth in OAC rule 5160-44. In doing so, the OhioRISE Plan must ensure:

a. The CFCP, including incorporating the OhioRISE 1915(c) waiver services, is developed and submitted to the OhioRISE Plan for review within 30 days of a member's OhioRISE 1915(c) waiver enrollment. The OhioRISE Plan must ensure:

i. The development of the CFCP includes the member and their Child and Family Team and that the details of the CFCP are shared with the CFT for review/approval.

ii. The CFCP is signed and dated by the member by the 30th calendar day of the member's OhioRISE 1915(c) waiver enrollment, reflecting consent to the CFCP.

iii. A signature is obtained from the OhioRISE 1915(c) waiver service provider(s) acknowledging and affirming theiragreement to provide the service as identified on the CFCP.

b. The member does not receive OhioRISE 1915(c) waiver services prior to the OhioRISE Plan's approval of the CFCP.

c. The member has continued access to coordination of the OhioRISE 1915(c) waiver services approved within the CFCP.

d. The member's health and welfare and adequacy of service delivery.

2. Ensuring the member resides in and that services are provided in a setting that possesses the home and community-based setting characteristics set forth in OAC rule 5160-44-01.

3. As detailed in rule 5160-59-03.2, for members enrolled on the OhioRISE 1915(c) waiver, at initial enrollment and at the member's annual redetermination, ensuring care coordinators conduct an assessment of waiver settings where OhioRISE 1915(c) waiver enrolled member reside and waiver services are provided to verify those settings meet the CMS criteria to provide home and community-based services in accordance with OAC rule 5160-44-01. The OhioRISE Plan must notify ODM of settings that do not meet the outlined criteria.

4. Conducting quality reviews to ensure that HCBS child and family-centered care planning and waiver care coordination is occurring locally;

5. Implementing corrective action for any OhioRISE 1915(c) waiver program violation whether identified by the OhioRISE Plan or by ODM.

c. Guiding Principles

i. The OhioRISE Program's approach to care coordination is built on a Systems of Care approach and is based on the guiding principles of a Wraparound Philosophy. These principles include:

1. Family and child or youth perspectives are intentionally elicited and prioritized during all phases of the care coordination process.

2. Planning is done by CFTs consisting of individuals agreed upon by the family and committed to the family through informal, formal, and community support and service relationships.

3. Planning is grounded in family members' perspectives, and the CFT strives to provide options and choices such that the plan reflects family values and preferences.

4. The process actively seeks out and encourages the full participation of CFT members drawn from family members' networks of interpersonal and community relationships.

5. Care coordinators work cooperatively with the CFT and share responsibility for developing, implementing, monitoring, and evaluating a single CFCP.

6. The CFT implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings

possible and that safely promote child or youth and family integration into home and community life.

7. The care coordination process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child or youth, their family, and their community.

8. The care coordination efforts develop and implement an individualized and customized set of strategies, supports, and services.

9. The care coordination process and the plan identify, build on, and enhance the strengths, capabilities, knowledge, skills, and assets of the child or youth and their family, their community, and other team members.

10. The care coordinator continues working towards meeting the needs of the child or youth and family and towards achieving the goals in the CFCP until the CFT reaches agreement that a formal Wraparound process is no longer necessary.

11. The OhioRISE Plan implements systems capable of efficiently receiving, providing, and exchanging the data and information necessary to effectively coordinate the care of members who are served by multiple entities.

d. Care Coordination Tiers

i. The OhioRISE Plan must use a tiered care coordination model, varying the intensity of care coordination in a purposeful way that aligns with the strengths and needs of the members enrolled in the OhioRISE Plan.

ii. The OhioRISE Plan's care coordination approach must include three tiers:

1. Tier 3 – Intensive Care Coordination using a High-Fidelity Wraparound approach for members that have high behavioral health needs;

2. Tier 2 – Moderate Care Coordination using a Wraparound informed model for members with more moderate behavioral health needs; and

3. Tier 1 – Limited Care Coordination for members who may refuse care coordination or may need lower intensity care coordination than in the Wraparound models.

iii. The care coordination continuum must be managed by the OhioRISE Plan and must include provider organizations referred to as care management entities (CMEs). The CMEs will be responsible for providing and/or coordinating the provision of intensive and moderate care coordination, community-based services, and other services and supports to improve health outcomes. Tier 2 and Tier 3 care coordination may only be provided by CMEs.

iv. OhioRISE Plan-employed care coordinators will provide Tier 1 Limited Care Coordination, the lowest intensity of the three tiers of care coordination.

v. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must submit a monthly Care Coordination Activity Report to ODM of the care coordination activities performed for members enrolled in Tier 1 care coordination. Tier's 2 and 3 care coordination activities will be submitted through encounter data from the CME claims.

e. OhioRISE Program Care Coordination Description

i. The OhioRISE Plan must submit a written Care Coordination Program Description as specified in Appendix P, Chart of Deliverables, which includes the care coordination approach in this appendix, for ODM approval prior to implementation. Following initial approval, the OhioRISE Plan must submit all changes to its care coordination program to ODM for approval prior to implementing the change.

ii. The OhioRISE Plan's care coordination program submission must describe the following components, described in more detail within this appendix:

1. The process that the OhioRISE Plan will use to select and contract with local CMEs to provide Tier 3 – Intensive Care Coordination using High-Fidelity Wraparound as established by the National Wraparound Initiative, and Tier 2 – Moderate Care Coordination using a Wraparound-informed model, including but not limited to provider minimum qualifications, geographic distribution, leadership, clinical supervision, caseload assignment methodology, and a process for addressing member or family complaints;

2. Processes and protocols that the OhioRISE Plan will develop to ensure that all CMEs provide care coordination consistent with the principles and requirements in this appendix and requirements established by ODM, including coordination with MCOs, other child-serving systems case managers, and providers;

3. The respective roles and responsibilities of the OhioRISE Plan and State's designated COE(s) for developing CMEs and providing training for Tier 3 – Intensive Care Coordination using High-Fidelity Wraparound and Tier 2 – Moderate Care Coordination using a Wraparound-informed model;

4. Transition of care processes for members who enrolled in the OhioRISE Plan prior to completing the CANS assessment, including activities performed by OhioRISE employed care coordinators, linkages to CMEs and timelines for each task to support appropriate care coordination engagement and activities for these transitioning members;

5. The process to be used to transition a member from one CME to another;

6. The process to be used to transition a member from one tier of care coordination provided by the OhioRISE Plan or CME to another;

7. The process for coordinating with other child-serving systems case managers and providers, including County Boards of Developmental Disability (BDD), Regional Department of Youth Services (DYS), public school districts, Public Child Serving Agencies, Family and Children First Councils and providers certified by the Ohio Department of Mental Health and Addiction Services (OMHAS);

8. The OhioRISE Plan's roles and responsibilities for performing care coordination activities for Tier 1 – Limited Care Coordination. This includes:
    a. Establishing a care coordination structure and staffing, including but not limited to:
        i. Care coordinator activities and responsibilities as the single point of contact for care coordination;
        ii. Care coordinator assignment with appropriate clinical expertise to coordinate care needs;
        iii. Conducting assessments;
        iv. Developing and updating the CFCP;
        v. Requirements for contacting members and their families;
        vi. Monitoring the CFCP;
        vii. Coordinating across the care team; and
        viii. Incident reporting.
    b. Processes and protocols for ensuring the OhioRISE Plan care coordination efforts are consistent with the principles in this appendix;
    c. The OhioRISE Plan's proposed care coordination caseloads and staffing (including care coordinators supervisors), as well as the number of staff by role, qualifications, and physical location; and
    d. The training topics and frequency of training provided to OhioRISE Plan care coordination staff.
9. The methodology of assignment of members to the OhioRISE Plan's care coordination tiers;
10. The OhioRISE Plan's roles and responsibilities to support CMEs;
11. The OhioRISE Plan’s process for transitioning members from the OhioRISE Plan to their MCO or FFS Medicaid due to disenrollment, including requirements for a transition plan and information to be provided to the MCO and new providers.
12. The OhioRISE Plan's data and information systems and how they will be used to support and exchange data with the CME (including an assessment of the CMEs Electronic Health Records capacities) and OhioRISE Plan's responsibilities for care coordination regardless of which entities are providing care coordination;
13. Methods used by the OhioRISE Plan to monitor the care coordination program for individual and systemic improvements;

14. The OhioRISE Plan's roles and responsibilities to support an integrated care approach with the MCOs' care coordination efforts (for OhioRISE Plan-enrolled members) and the MCOs' CCEs in providing care coordination to the OhioRISE Plan's members;

15. The OhioRISE Plan's strategy for communicating with the member's MCO and CCE (when appropriate) assignment of CME and CME care coordinator; and

16. Methods used by the OhioRISE Plan to provide oversight of the care coordination provided by the OhioRISE Plan's care coordinators and CMEs to ensure the needs of the OhioRISE Plan's membership are met.

2. Care Coordination Requirements

a. OhioRISE Plan Care Coordination Staffing and Training

i. The OhioRISE Plan's care coordination staffing must include a range of behavioral health disciplines with complementary skills and knowledge to deliver a comprehensive, integrated care coordination program fully capable of addressing members' behavioral and psychosocial needs.

ii. The OhioRISE Plan must ensure staff who are performing care coordination functions are operating within their professional scope of practice, are appropriate for the member's behavioral health care needs, and comply with the state's licensure and credentialing requirements.

iii. The OhioRISE Plan must provide onboarding and ongoing training for OhioRISE Plan's care coordination staff that includes: health equity, cultural competency, , racial equity, social determinants of health (SDOH) and health disparities, Child and Adolescents Needs and Strengths (CANS) process, child and family-centered care planning, needs for multi-system children and youth, early childhood development, member engagement, shared decision-making, trauma-informed care (including secondary trauma to caregivers and family members), motivational interviewing, grievance and appeal processes and procedures, community resources within the OhioRISE Plan's service areas, incident reporting requirements, and Health Insurance Portability and Accountability Act (HIPAA) requirements.

b. Assigning Care Coordination Tiers

i. The OhioRISE Plan must develop and implement a framework and process for assigning members to care coordination tiers provided by the CMEs or the OhioRISE Plan's care coordination staff.

1. The OhioRISE Plan must report the timeframe to assign care coordination tiers, as specified in the Chart of Deliverables.

ii. The OhioRISE Plan must assign a care coordination Tier 1 – 3 to each member (i.e., from lowest to highest: low need [Tier 1], moderate need [Tier 2], and intensive need [Tier 3]).

iii. The OhioRISE Plan's tiering framework must include the criteria and thresholds to determine member assignments for each tier.

iv. The OhioRISE Plan's tiering criteria and thresholds must identify the factors the OhioRISE Plan considers when determining a member's level of care coordination. At a minimum, the tiering criteria and thresholds must include the following current and historical factors:

1. Acuity of substance use and mental health disorders as identified through the CANS;

2. Encounter information on previous utilization of behavioral health services, including inpatient, emergency department (ED), or Mobile Response and Stabilization Services (MRSS) utilization;

3. Information on SDOH and safety risk factors; and

4. Information from the member's Health Risk Assessment, the MCO person-centered care plan or other MCO data sources and information.

v. The OhioRISE Plan must assign an initial care coordination tier and make a referral to a CME (Tier 2 or Tier 3) or OhioRISE Plan's care coordination department within two business days of OhioRISE Plan enrollment, except for crisis referrals (“crisis” in this context is defined by an MRSS interaction or inpatient psychiatric hospitalization).

1. For crisis referrals, the initial care coordination tier must be assigned and referred to a CME or the OhioRISE Plan's care coordination department within 24 hours of enrollment notification.

vi. Members and caregivers will be notified of the care coordination tier assignment using the following methods:

1. Notification From Care Coordinator

a. The assigned care coordinator must communicate the care coordination tier to the member and caregiver as a part of the initial outreach contact. The initial care coordination contact must occur within two business days of the referral (except for crisis referrals) ("crisis" in this context is defined by an MRSS interaction or inpatient psychiatric hospitalization).

b. For crisis referrals, the assigned care coordinator must outreach to the member and caregiver as soon as possible, but not later than one business day following the referral.

2. Written Notification

a. The OhioRISE Plan must mail a letter to the member and caregiver with the tier assignment level, a description of the outreach from the assigned care coordinator, and contact information if the outreach does

not occur or if the member or caregiver has any questions. The content of the letter must be reviewed and approved by ODM.

vii. The OhioRISE Plan must review and update the member's care coordination tier following the completion of an updated CANS or other information available to the OhioRISE Plan that informs appropriate assignment of care coordination tiers.

viii. The OhioRISE Plan must evaluate a member's care coordination tier whenever there is a request from the CME or a significant change in the member's needs or circumstances. If the OhioRISE Plan changes the member's care coordination tier as a result of this evaluation, the OhioRISE Plan must document the tier change as well as the circumstances that led to this change..

1. The OhioRISE Plan must inform the member of these changes. Notification will be provided verbally by the assigned care coordinator from the CME or the OhioRISE Plan, and in writing in a letter from the OhioRISE Plan.

2. The OhioRISE Plan must send a report documenting these changes to ODM in accordance with Appendix P, Chart of Deliverables.

ix. The OhioRISE Plan must communicate care coordination tiering information to ODM, CMEs, the member's MCO, and the single pharmacy benefit manager (SPBM) as specified by ODM.

c. Care Coordination Assignment

i. General

1. The OhioRISE Plan must ensure that members receive necessary and timely care coordination, whether the care coordination is performed by the OhioRISE Plan or its contracted CMEs (for OhioRISE Plan-enrolled members).

2. The OhioRISE Plan must ensure that, to the extent possible, care coordination is provided by CMEs within the member's community. The OhioRISE Plan must only provide care coordination for members who may refuse Tier 2 or Tier 3 care coordination or when the OhioRISE Plan determines the member may not need the intensity of care coordination offered by the CMEs.

3. The OhioRISE Plan must ensure that members and their families have a choice of assigned care coordinator, whether provided directly by the OhioRISE Plan (Tier 1) or by the CME (Tiers 2 and 3).

4. The OhioRISE Plan must ensure that care coordination staff (CME and OhioRISE Plan's staff) are not related by blood or marriage to the member or any paid caregiver, financially responsible for the member, or empowered to make financial or health related decisions on behalf of a member.

5. The OhioRISE Plan must provide the member and their family or caregiver with up-to-date contact information for the care coordination staff (CME and OhioRISE Plan) assigned to the member.

6. The OhioRISE Plan must provide the MCO and SPBM with up-to-date contact information for the care coordination staff (CME and OhioRISE Plan) assigned to the member within five business days of the assignment becoming effective or of contact information change.

ii. Care Coordination Provided by the Members' MCO

1. If a member is enrolled in the OhioRISE Plan and has an assigned MCO care coordinator or CCE, the OhioRISE Plan must preserve and support the care coordination relationship between the MCO/CCE and the member.

2. For those members enrolled in the OhioRISE Plan but not assigned to a care coordinator in the MCO or a CCE and for whom the OhioRISE Plan or CME identifies the need for care coordination from the MCO or CCE, the OhioRISE Plan must recommend evaluation for MCO or CCE care coordination according to requirements specified by ODM.

iii. Care Coordination Caseloads

1. Caseload for care coordination provided by the CME and OhioRISE Plan will vary based on intensity:

a. Tier 3 – Intensive Care Coordination must require care coordinator to child and family ratio consistent with a High-Fidelity Wraparound Approach;

b. Tier 2 – Moderate Care Coordination must require a care coordinator to child and family ratio as directed by ODM; and

c. Tier 1 – Limited Care Coordination provided by the OhioRISE Plan must have caseload standards consistent with the staffing ratios proposed in the program description required in this appendix. The maximum ratio of Tier 1 care coordinators to members (i.e., caseload) must be 1:62.

2. Maximum caseloads specified for Tier 3 – Intensive Care Coordination in this appendix or in the care coordination program description approved by ODM must not be exceeded.

3. Maximum caseloads specified for Tier 2 – Moderate Care Coordination in this appendix or in the care coordination program description approved by ODM must not be exceeded without prior approval from ODM.

4. Maximum caseload sizes apply to care coordination provided by the OhioRISE Plan or the CMEs.

iv. Care Coordination Status

1. The OhioRISE Plan must assign and report a care coordination status for each member who is assigned to a CME or an OhioRISE Plan care coordinator. Care coordination status consists of the following indicators:

a. Status:

i. Assigned, not yet active;

ii. Active (care coordinator has made contact with member or family and the member or family consents to care coordination); or

iii. Declined;

b. Tier:

i. Tier 1 – Limited Care Coordination;

ii. Tier 2 – Moderate Care Coordination using a Wraparound-informed model; or

iii. Tier 3 – Intensive Care Coordination using a High-Fidelity Wraparound.

c. CME (for those in Tier 2 or Tier 3);

d. Name of assigned care coordinator (CME and OhioRISE Plan).

2. The OhioRISE Plan must report care coordination status, CME member assignments, and care coordination tier assignment in the Monthly Member Assignment report as specified in Appendix P, Chart of Deliverables.

d. Care Coordination Activities

i. OhioRISE Plan Care Coordination Activities in support of Care Management Entity-Led Care Coordination

1. For members who are assigned to a CME care coordinator, the OhioRISE Plan must support care coordination performed by the CME.

2. The OhioRISE Plan is responsible for ensuring the care coordination of the member has an established Individual Crisis and Safety Plan to ensure continuous safety of the enrolled member.

3. For members who are OhioRISE 1915(c) waiver enrollees, the OhioRISE Plan must ensure the CFCP has an established back-up plan that meets the member's needs.

4. The OhioRISE Plan's care coordination department is responsible for assisting the CME in a timely manner with the following care coordination activities upon CME request:

a. Supporting member outreach efforts;

b. Identifying, referring, and linking members to behavioral health network providers and social supports as needed (e.g., scheduling appointments, arranging transportation);

c. Assisting in the coordination of member access to OhioRISE Plan-covered services as needed (e.g., scheduling appointments, arranging transportation through the MCO, and making referrals);

d. Assisting in the coordination of member access to Multi-System Youth Custody Relinquishment Prevention Program (MSY Program) technical assistance and funding;

e. Participating in the CME-led CFT to support the development and ongoing updates to the CFCP, including while a youth is receiving treatment in a PRTF;

f. Facilitating a timely CANS assessment, performed by an independent organization or practitioner external to the OhioRISE Plan, when needed based on a change in member's condition and for periodic re-enrollment in the OhioRISE Plan as specified by ODM;

g. Assuring completion of a health risk assessment;

h. Assisting in the coordination of member access to MCO-covered services as needed by linking to MCO or CCE care coordination resources (e.g., linking the member to MCO health education, disease management, and health and wellness programs);

i. Educating the member about available resources and services (e.g., OhioRISE Plan value-added benefits) and assisting the member in accessing those resources and services;

j. Arranging for OhioRISE Plan's staff to provide behavioral health clinical consultation upon MCO or CCE's request;

k. Upon recommendation of the CFT, gathering the appropriate documentation and submitting PRTF Request Forms in the OhioRISE Plan’s PRTF Request portal for OhioRISE Plan members for whom PRTF treatment is being sought.

l. Assisting with bi-directional communication among the CME and other local child serving agencies providing care coordination, including County BDD, Regional DYS, Public Child Serving Agencies, public school districts, and Family and Children First Councils and providers certified by the OMHAS;

m. Assisting with bi-directional communication among the MCO/CME, SPBM, and other providers as needed in order to facilitate timely exchange of information;

n. Communicating and exchanging information across relevant child-serving systems (e.g., child welfare case worker, school) consistent with appropriate releases of information signed by the member/guardian;

o. Sharing care coordination data and information with ODM, the members' MCO/CCE, and the SPBM as applicable to prevent gaps in care and duplication of efforts;

p. Identifying gaps in care and taking action as necessary to close gaps in care;

q. Participating in discharge planning activities with the behavioral health inpatient or residential facility to support a safe discharge placement and to prevent unplanned or unnecessary readmissions, ED visits, and adverse outcomes;

r. Ensuring member access to post discharge services covered by the OhioRISE Plan as specified in the discharge and transition plan;

s. Facilitating clinical hand offs between the discharging facility and other OhioRISE Plan network providers involved in the care and treatment of the member;

t. Actively securing the necessary authorizations for the services in the CFCP that are the responsibility of the OhioRISE Plan:

u. Coordinating with the MCO, CCE, SPBM, and providers to ensure the member's who are the responsibility of the MCO, CCE or SPBM have timely access to the services identified in the CFCP; and

v. Monitoring to ensure that services correspond to the needs and goals as identified and recommended in the child and family–centered care plan.

ii. OhioRISE Plan Activities for OhioRISE Plan-Led Care Coordination

1. For members who are assigned to a OhioRISE Plan care coordinator, the care coordinator is responsible for performing the following care coordination activities for members:

a. Reaching out to members to engage in care coordination within the timeframes established by ODM;

b. Identifying, referring, and linking members to behavioral health network providers and social supports as needed (e.g., scheduling appointments, arranging transportation);

c. Assisting in the coordination of member access to OhioRISE Plan's covered services as needed (e.g., scheduling appointments, arranging transportation through the MCO, and making referrals);

d. Leading the development and ongoing updates to the CFCP, including while a youth is receiving treatment in a PRTF;

e. Leading wraparound-informed team meetings for members for whom the OhioRISE Plan is providing Tier-1 care coordination.

f. Facilitating a timely CANS assessment through an independent evaluator external to the OhioRISE Plan when needed, based on a change in member's condition and for periodic re-enrollment in the in the OhioRISE Plan as specified by ODM;

g. Assuring completion of a health risk assessment;

h. Assisting in the coordination of member access to MCO covered services as needed by linking to MCO or CCE care coordination resources (e.g., linking the member to MCO health education, disease management, and health and wellness programs);

i. Educating the member about available resources and services (e.g., OhioRISE Plan value-added benefits) and assisting the member in accessing those resources and services;

j. Arranging for OhioRISE Plan staff to provide behavioral health clinical consultation upon MCO or CCE request;

k. Upon recommendation of the CFT to seek PRTF care, gathering the appropriate documentation and submitting PRTF Request Forms in the OhioRISE Plan's PRTF Request portal for OhioRISE Plan members for whom PRTF treatment is being sought. For children and youth who are new to the OhioRISE Plan or have recently experienced a change in circumstance (for example, as a result of an inpatient psychiatric hospitalization, crisis, or custody event), this includes the OhioRISE plan assisting with CANS assessments and gathering clinical and historical documentation to ensure the timely and complete submission of PRTF Requests via an expedited ODM-approved process. .

l. Communicating and exchanging information with providers (e.g., primary care provider [PCP], CCEs), ODM, MCOs, and the SPBM to coordinate the care of the member;

m. Communicating and exchanging information across relevant child-serving systems (e.g., child welfare case worker, school) consistent with appropriate releases of information signed by the member/guardian;

n. Sharing care coordination data and information with ODM, the members' MCO/CCE, and the SPBM as applicable to prevent gaps in care and duplication of efforts;

o. Identifying gaps in care and taking action as necessary to close them;

p. Participating in discharge planning activities with the behavioral health inpatient, PRTF, or residential facility to support a safe discharge placement and to prevent unplanned or unnecessary readmissions, ED visits, and adverse outcomes;

q. Ensuring member access to post-discharge services covered by the OhioRISE Plan as specified in the discharge and transition plan;

r. Facilitating clinical hand offs between the discharging facility and other OhioRISE Plan's network providers involved in the care and treatment of the member;

s. Actively securing the necessary authorizations for the services in the CFCP that are the responsibility of the OhioRISE Plan;

t. Coordinating with the MCO, CCE, SPBM, and providers to ensure the member's timely access to the services identified in the CFCP; and

u. Monitoring to ensure that services are delivered as recommended in the CFCP.

v. The OhioRISE Plan must ensure the member has an established Individual Crisis and Safety Plan to ensure continuous safety of the member. For youth with behaviors that pose safety concerns for the youth or others, a licensed clinician working within or for the OhioRISE Plan will consult on the individual crisis and safety plan, recommend de-escalation strategies that can be learned and used by the youth, parents, other caregivers to support the youth and prevent the use of restrictive interventions, and approve of the crisis and safety plan.

w. For members who are OhioRISE 1915(c) waiver enrollees, the OhioRISE Plan must ensure the CFCP has an established back-up plan that meets the member’s needs.

x. Facilitating transition planning and activities for youth exiting the OhioRISE program or the OhioRISE 1915(c) waiver. For youth receiving Tier-1 care coordination who are enrolled in the OhioRISE 1915(c) waiver, transition planning must identify supports the youth will need for the ninety calendar days following disenrollment from the OhioRISE 1915(c) waiver.

iii. CME Catchment Area Map

1. The OhioRISE Plan must assign one CME for each of the following twenty CME catchment areas that will serve the OhioRISE population across the State. The catchment areas are based on the projected population of OhioRISE enrollment and geography.

iv. Assessments

1. The CME or the OhioRISE Plan will be responsible for performing initial assessments as directed by the OhioRISE Plan. Initial assessments consist of a supplemental assessment that occurs in the member's home or another location of the family's choice. The assessment provides additional information that may not be reported in the CANS assessment. Other tools may be determined necessary depending on member needs; and the development of an initial crisis/safety plan should be developed if an existing plan (that includes ODM required elements) from an involved provider doesn't already exist.

2. The CME or OhioRISE Plan will conduct a CANS through an independent evaluator external to the OhioRISE Plan on an annual basis or as specified by ODM and whenever there is a significant change in the member's behavioral health needs or circumstances.

3. The OhioRISE Plan must have a process for identifying and coordinating with the member's MCO/CCE for other assessment data appropriate to the member's unique circumstances and needs (e.g., physical, behavioral, social, and safety) when there is a change in the member's health status or needs or as requested by the member, caregiver, provider, or CME.

4. Health Risk Assessment

    a. The OhioRISE Plan must ensure completion of an ODM-approved health risk assessment (HRA) for all members. The HRA must be completed

within 90 calendar days of a member's effective enrollment date into the OhioRISE Plan, unless an HRA completed within the last 365 days is on file with another MCE. Thereafter, the OhioRISE Plan must complete or ensure an HRA is completed, at a minimum, annually (every 365 days) thereafter.

b. The OhioRISE Plan must report health risk assessment results (Health Risk Assessment Submission File) as specified in Appendix P, Chart of Deliverables.

c. The OhioRISE Plan must include the following components as part of its Care Coordination Program for ODM approval:

i. The methods and timelines utilized to complete the HRA;

ii. How the OhioRISE Plan will use the HRA to inform the care coordination assignment;

iii. The OhioRISE Plan's outreach and engagement approaches for members who cannot be reached or who refuse to complete HRAs;

iv. How the OhioRISE Plan will store HRA data and make it available to members of the Child and Family Team to coordinate care;

v. How the OhioRISE Plan will share HRA data with ODM, the MCOs, the SPBM, and the OhioRISE CMEs as applicable to prevent duplication of efforts.

v. Child and Family-Centered Care Plans

1. For members receiving Tier 2 – Intensive or Tier 3 – Moderate Care Coordination, CMEs must convene and facilitate a CFT, which develops and updates a CFCP that is consistent with ODM guidelines.

2. For members receiving care coordination from the OhioRISE Plan (Tier 1), the OhioRISE Plan care manager must develop the CFCP.

3. At the time of CFCP development and any subsequent updates, the care coordinator must inform members enrolled on the OhioRISE 1915(c) waiver of the process to increase or change an already approved 1915(c) waiver service or to request additional services.

4. For all members, the OhioRISE Plan must have a child and family-centered care planning process that includes the following:

a. Developing the CFCP that is based on the most recent assessment (e.g., CANS);

b. Updating the individual CFCP as set forth in ODM requirements;

c. Tracking and complying with timeframes for developing the initial CFCP and making subsequent updates to the care plan;

d. Developing measurable goals, interventions, and outcomes with the member in collaboration with the CFT and obtaining the member's family or caregiver's agreement;

e. Aligning CFCP goals with the priority issues identified by the CFT so the OhioRISE Plan and CME can support the provider-member relationship;

f. Validating that the member received the services in the CFCP and has a backup plan developed in the event if services cannot be received. If services were not received, taking necessary action to address and close gaps in care; including activating the backup plan and updating services if needed.

g. The OhioRISE Plan must review back up plans for higher risk members. If a backup plan is not feasible, the OhioRISE Plan must assist with the development and adjustment of the backup plan as needed.

h. Verifying that the member received the services in the CFCP, or if services were not received, taking necessary action to address and close gaps in care;

i. Providing the member and the caregiver with the CFCP; and

j. Retaining the CFCP for Tiers 2 and Tier 3 and sharing it with members of the CFT.

vi. Contacts

1. The OhioRISE Plan must follow the ODM-approved member and caregiver contact requirements for members assigned to a CME or OhioRISE Plan to facilitate ongoing communication with the member.

2. The ODM-approved contact schedule must include the number of subsequent attempts to reach the member if the member or caregiver do not respond to the initial attempt, and the OhioRISE Plan's or CME's initial engagement effort.

3. For members and caregivers who do not respond to the OhioRISE Plan's or CME's ongoing care coordination efforts, the OhioRISE Plan or CME must track and report the number of attempts to reach the member or caregiver.

4. The OhioRISE Plan or CME care coordination staff must contact the member as identified in the CFCP, but not less frequently than the ODM-approved minimum contact schedule.

5. If a member, MCO, or SPBM reaches out to the OhioRISE Plan, unless a standard is established elsewhere in this Agreement, the OhioRISE Plan must respond in a timeframe to meet the presenting need of the member, but no later than one business day.

vii. Incident Reporting

1. Upon notification, the OhioRISE Plan, the CME, or their delegated entity must enter incident reports of abuse, neglect, exploitation, misappropriation of greater than $500, self-harm or suicide attempts that result in emergency room treatment, in-patient observation, or hospital admission, and unnatural or accidental death, within one business day, into Ohio's IMS for all members. Additionally, the OhioRISE Plan, the CME, or their delegated entity must enter incident reports of natural deaths within three business days into Ohio's IMS for all members. As set for in Sections 2.d.vii.c and 2.d.vii.d of this appendix, there is an exception for certain members set forth.The OhioRISE Plan, the CME, or their delegated entity must enter the incident report into the IMS and must work with the CCE and CME, if member is so assigned, to support a prevention plan and/or intervention (e.g., re-evaluating risk stratification, doing a home visit, offering services and resources, creating a prevention plan).

    a. The OhioRISE Plan or CME must support ODM in conducting a review of the incident and identifying contributing factors by providing any information and/or documentation related to the case that is requested by ODM and doing so in accordance with the requested timeframe.

    b. For members participating in the OhioRISE 1915(c) waiver or other home and community-based services waivers, the OhioRISE Plan or CME care coordinators must submit incidents in accordance with OAC rule 5160-44-05.

    c. For members with intellectual disabilities and developmental disabilities and receiving care coordination through the Individual Options Waiver (OAC rule 5160-40), Level One Waiver (OAC rule 5160-41) or the Self-Empowerment Life Funding Waiver (OAC rule 5160-41) or Targeted Case Management through a County Board of Developmental Disabilities, the CME's and OhioRISE Plan's care coordinators must submit incidents in accordance with OAC rule 5123-17-02.

    d. The OhioRISE Plan or CME must report incidents in IMS, as specified in OAC 5160-59-03.6, of youth who are receiving treatment in a PRTF facility. The OhioRISE Plan will ensure proper reporting to other relevant entities, to include OhioMHAS, ODJFS, DODD, ODH, CMS, and Disability Rights Ohio, when necessary.

    a. When an incident is substantiated, except in the case of death, the OhioRISE Plan or CME must enter a prevention plan into the IMS and close the case no later than seven business days after the conclusion of the review.The OhioRISE Plan or CME must enter prevention plans in ODM's IMS for all members, regardless of tier assignment.

2. The OhioRISE Plan must comply with member safeguard requirements in Appendix A, General Requirements, when the OhioRISE Plan identifies or becomes aware of risks to a member's health, safety, or welfare.

viii. Multi-System Youth Custody Relinquishment Prevention Program

1. The OhioRISE plan and the CMEs must assist OhioRISE members with accessing and utilizing the State of Ohio's Multi-System Youth Custody Relinquishment Prevention Program (MSY Program). This includes:

    a. OhioRISE Plan and CME care coordinators must assist OhioRISE members and their families with applying for technical assistance and/or funding from the MSY Program, including tracking and timely submission of initial funding requests prior to the date of the youth's admission and updated funding requests for funding at least fourteen days prior when an out of home stay is likely to continue beyond the authorized funding period.

    b. The OhioRISE Plan and the CMEs must continue care coordination activities for OhioRISE members who receive funding through the MSY Program, to include convening the child and family team and, when the member is receiving out of home care, working closely with the out of home provider and CFT to conduct detailed discharge planning, including arranging for services and supports to ensure the member's transition to the family home.

    c. The OhioRISE Plan must provide MSY Program training, tools and supports to OhioRISE Plan and CME care coordinators, including facilitating use of tools and trainings provided by ODM. The OhioRISE plan must ensure access to such materials is readily available in a single location for all OhioRISE Plan and CME care coordinators who assist families with applying for technical assistance and/or funding from the MSY Program.

    d. The OhioRISE plan must:

        i. Receive MSY applications from CMEs;

        ii. Screen to ensure MSY applications are complete and supported documentation is attached;

        iii. Identify and resolve any potential gaps in funding;

        iv. Review MSY applications for adherence with MSY program requirements (including identifying alternative funding sources and associated dates, confirming treatment dates, confirming requested use of MSY funding aligns with MSY program requirements, ensuring MSY funding requested amounts are consistent with the provider's expectations);

        v. Work with CMEs and providers to resolve any discrepancies prior to submitting MSY applications to the State MSY team for review;

        vi. Track authorized dates and amounts of MSY Program funding;

vii. Ensure follow-up recommendations from the State's MSY Program review team are shared with and addressed by CMEs and providers;

viii. Ensure that requested progress updates are submitted to the State MSY Program within requested timeframes;

ix. Identify technical and clinical assistance needs related to youth served by the MSY Program; and

x. Connect with appropriate parties for resolution.

e. The OhioRISE Plan must provide technical and clinical assistance to OhioRISE Plan and CME care coordinators to facilitate appropriate use of the MSY Program and to assist with meeting the clinical needs of OhioRISE members served by the MSY Program. Such assistance may be requested at any time by ODM, a CME, or an individual care coordinator.

f. The OhioRISE Plan must assist ODM with executing payment to providers for services to OhioRISE members funded through the MSY Program.

3. Transitions of Care Requirements

a. General

i. All transitions of care in this section must be documented in the appropriate OhioRISE Plan and CME care coordination records and systems as specified by ODM.

ii. Reporting on transitions of care in this section will be documented to ODM as specified in Appendix P, Chart of Deliverables.

b. New OhioRISE Plan Enrollments

i. General

1. The OhioRISE Plan must follow the transition of care requirements as outlined below for new members transitioning services to the OhioRISE Plan from an MCO or fee-for-service (FFS) for behavioral health services only.

ii. Coordination of Inpatient Hospital Prior Authorizations

1. Upon notification of an inpatient psychiatric or SUD admission from the members MCO or the FFS prior authorization vendor, the OhioRISE Plan will:

a. Follow up with the hospital to provide additional instructions on how to complete the prior authorization for review;

b. Work with the hospital and MCO to support and coordinate transitions of care and ongoing care; and

c. Ensure the psychiatric or SUD inpatient notification has been entered in the CANS IT system

2. The OhioRISE Plan must accept prior authorization approvals from MCOs or FFS in situations where the MCO or FFS first authorized the service, but the final claim's primary diagnosis and reimbursement APR-DRG identify the claim as the OhioRISE Plan's responsibility, in accordance with the OhioRISE Mixed Services Protocol.

iii. Provision of Member Information

1. For members newly enrolled with the OhioRISE Plan and transitioning the receipt of behavioral health services from an MCO or FFS, the OhioRISE Plan will receive member information within three business days for members disenrolling for behavioral health services only from the MCO or transitioning from FFS.

2. Upon notification from ODM that an enrolled member will be disenrolling from receiving behavioral health services only from an MCO and transitioning to the OhioRISE Plan, the MCO must provide access to member information to the OhioRISE Plan within three business days .

iv. OhioRISE Plan Responsibilities

1. For newly enrolled members in the OhioRISE Plan, the OhioRISE Plan must utilize CANS assessment and other data provided by other sources or collected by the OhioRISE Plan (e.g., through assessments, new member/family/caregiver outreach in advance of the member's enrollment effective date) to identify existing sources of care. The data will be used to inform the CFCP to ensure each new member is able to continue existing behavioral health services in accordance with this appendix or access different behavioral health services based on the needs of the member and their family/caregiver.

2. Based on the information available, the OhioRISE Plan must identify and assign an appropriate Tier 3 – Intensive or Tier 2 – Moderate Care Coordinator according to OhioRISE Plan's care coordination policies and procedures approved by ODM. The assignment must be completed within two business days of notification of enrollment, except for crisis referrals ("crisis" in this context is defined by an MRSS interaction or inpatient psychiatric hospitalization) which are within 24 hours.

3. The OhioRISE Plan or its designee must perform outreach to the member and/or member's family/caregiver for the purpose of engagement in the OhioRISE Plan's care coordination program within two business days of referral, except for crisis referrals ("crisis" in this context is defined by an MRSS interaction or inpatient psychiatric hospitalization) which are within one business day. The required outreach is in addition to the OhioRISE Plan's responsibilities for new member materials described in Appendix E, Marketing and Member Materials.

4. For an urgent enrollment, ODM will determine processes and enrollment notification procedures necessary to allow the OhioRISE Plan (and CME if one is assigned) to initiate care coordination planning and engagement as soon as possible to meet member needs.

    a. For urgent enrollments to the OhioRISE Plan, the processes and enrollment notification procedures will include the MCO or FFS provider to facilitate transfer of member information and assignment to the OhioRISE Plan within 24 hours.

5. For members who are enrolled in the OhioRISE Plan prior to completing the CANS assessment, the OhioRISE Plan will be responsible for performing transition of care activities, until a tier assignment and linkage to on-going care coordination can be completed in accordance with Section 2.d of this appendix. Activities include but are not limited to participation in discharge planning, gathering sufficient clinical data to inform care coordination tier assignment, linkage to a CME following tier assignment for Tier 2 or 3 members, and linkage to community services upon discharge.

c. MCO Transitions

    i. When the member makes a transition from one MCO to another MCO, the OhioRISE Plan (and CME if one is assigned) must have a process to complete the following activities:

        1. Ensure the name and contact information for any assigned MCO care management staff is available to the member and caregiver, and recorded in the appropriate OhioRISE Plan's and CME's care coordination documents and systems within three business days;

        2. Reach out to any assigned care management staff at the new MCO within three business days; and

        3. Support the member and caregiver in contacting the new MCO and appropriate care coordination resources as needed as a part of the MCO to MCO transition within three business days.

d. Care Management Entity Transitions

    i. When more than one care management entity (CME) is available and appropriate to meet the needs of the member and their family/caregiver, the OhioRISE Plan must have a process to transition the member from one CME to a different CME.

    ii. The OhioRISE Plan must ensure that relevant Ohio Department of Job and Family Services (ODJFS), Department of Developmental Disabilities (DODD), Department of Youth Services (DYS), and other state or county entities involved in the care of the child or youth must be notified within five business days when there is a transition between CMEs or between care coordinators within a CME.

    iii. The OhioRISE Plan transition process must include:

1. Criteria to be used for CME transitions, including member/family/caregiver choice;

2. Timelines for completing the transition, including assignment of the new care coordinator from the new CME; and

3. Role of OhioRISE Plan care coordination staff to support the transition, assure continuity of care, and engagement with the new CME/care coordinator.

e. Transitions of Care from OhioRISE Plan to MCO, MyCare, or FFS

i. General

1. The OhioRISE Plan must follow the transition of care requirements as outlined below for members transitioning their behavioral health coverage from the OhioRISE Plan to a MCO,MyCare Plan, or to FFS.

2. For the purposes of transitions of care from the OhioRise Plan, the phrase "applicable FFS providers" could include the member's primary care provider, primary behavioral health provider(s), and the member's 1915(c) waiver care coordinator.

ii. Provision of Member Information

1. Within 2 business days upon notification from ODM that an OhioRISE member will be disenrolling from the OhioRISE Plan due to loss of OhioRISE eligibility and transitioning to a MCO, a MyCare Plan, or FFS, the OhioRISE Plan must provide the followingr information to the enrolling MCO, MyCare Plan, or applicable FFS provider(s):

a. OhioRISE disenrollment date

b. Reason for disenrollment from OhioRISE program, if available

c. Current Child and Family-Centered Care Plan; and

d. Most recent CANS assessment.

iii. OhioRISE Plan Responsibilities

1. The OhioRISE Plan must ensure that the OhioRISE Plan, or CME if one is assigned, develops a transition of care plan for applicable FFS providers, an MCO, or MyCare Plan, and its contracted CCEs or other providers, to inform them of member's behavioral health care needs and support for 90 calendar days following disenrollment from the OhioRISE Plan. The transition of care plan should include:

a. Behavioral Health (BH) service needs (types of services and frequency);

b. Current medications;

c. Past utilization of BH services, including providers;

d. BH providers, if any changes from existing provider are required;

e. Recommended engagement with community resources and natural supports;

f. State and local child service agencies involved in the member's care, including contact information;

g. For members transitioning to the MCO or MyCare Plan, recommended care coordination resources and supports; and

h. Current prior authorization information.

2. The OhioRISE Plan must perform outreach to the enrolling MCO, MyCare plan, or applicable FFS providers, and key behavioral health providers in the OhioRISE Plan, MCO, or MyCare plan provider network for input into the transition of care plan within 72 hours of being notified by ODM of the member's disenrollment.

3. The OhioRISE Plan or CME, if one is assigned, must perform outreach to the member's family/caregiver during the development of the transition of care plan to solicit input and to inform regarding the planned OhioRISE Plan disenrollment and the services and supports that will be included in the transition of care plan.

4. The transition of care plan must be provided to the MCO, MyCare Plan, or the applicable FFS providers as follows:

a. For members who will be transitioned to a MCO or MyCare Plan, the transition of care plan must be completed and supplied to the MCO or MyCare Plan at least 15 calendar days prior to the effective date of the disenrollment.

b. For members who will be transitioned to FFS, the transition of care plan must be completed and supplied to the applicable FFS proivders at least ten calendar days prior to the effective date of the disenrollment.

c. For just cause disenrollments, transitioning to a MCO, a MyCare Plan, or to FFS, the transition of care plan must be completed and supplied to the MCO, MyCare Plan, or the applicable FFS providers within seven calendar days of being notified by ODM of the member's disenrollment.

f. Transitions of Care Between Health Care Settings

i. The OhioRISE Plan, in coordination with CMEs as assigned, must effectively and comprehensively manage transitions of care settings in order to prevent unplanned or unnecessary readmissions, ED visits, or adverse outcomes. The OhioRISE Plan must:

1. Identify members who require assistance transitioning between settings and notify the member's CME, if assigned, and the MCO, if assigned;

2. Develop a method for evaluating risk of readmission or deterioration in order to determine the intensity of follow up required for the member after the date of discharge, and share this information with the CME, MCO, and CCE, as assigned;

3. Either directly or through the CME, if one is assigned, designate care coordination staff to communicate with the discharging facility and inform the facility of the designated contacts of the member's care team, including all care coordinators and providers of behavioral health services currently received by the member;

4. Ensure timely notification and receipt of admission dates, discharge dates, and clinical information is communicated between OhioRISE Plan's departments, CME, MCO/CCE, other behavioral health providers, and the member's PCP, as appropriate;

5. Either directly or through the CME, if one is assigned, participate in discharge planning activity with the facility, including making arrangements for safe discharge placement and facilitating clinical hand offs between the discharging facility and the OhioRISE Plan or CME, if one is assigned;

6. Either directly or through the CME, if one is assigned, obtain a copy of the discharge/transition plan and share the plan with the member's care team;

7. Either directly or through the CME, if one is assigned, arrange and confirm services are authorized and delivered in accordance with the discharge/transition plan;

8. Ensure that providers are able to obtain copies of the member's medical records as appropriate and consistent with federal and state law; and

9. Either directly or through the CME, if one is assigned, conduct timely follow up with the member and the member's behavioral health providers to ensure post discharge services have been provided.

g. Psychiatric Residential Treatment Facility Transitions of Care

   i. The OhioRISE Plan must be involved in transitions of care for youth that are receiving treatment at a PRTF including:

      1. Working closely with the PRTF provider to develop a transition plan that ensures successful integration into PRTF treatment;

      2. Meeting a minimum of every 30 days with the PRTF and CFT to discuss transition planning;

      3. When a youth is within 60 days of transition, meeting with the PRTF and CFT at least three times within each 30 day period until the transition to transfer skills and strategies, plan and connect with providers, schools, and/or employers for post-transition resources to support successful transition into the home, community, school, and/or workplace; and

4. While preparing for transition from PRTF services, develop the CFCP with the CFT to delineate roles, services, and supports to be delivered by the PRTF and other providers.

ii. The OhioRISE plan must provide ODM with a PRTF Transition Report that identifies transition of care requirements identified by ODM as specified in Appendix P, Chart of Deliverables.

iii. The OhioRISE Plan is required to maintain active awareness of all youth who have an approved PRTF prior authorization and awaiting PRTF admission. The OhioRISE Plan must proactively partner with the OhioRISE care coordinator who is serving the member awaiting PRTF admission and their organization's leadership team to:

1. Identify and meet any outstanding needs which remain present while the member is awaiting PRTF admission;

2. Utilize care coordinaton data to inform utilization management decisions and referrals to PRTF providers; and

3. Maintain documentation of such efforts.

h. Transition of Care Due to Loss of Medicaid Eligibility

i. If a member loses Medicaid eligibility, the OhioRISE Plan or CME, with the involvement of the CFT and other involved agencies, must develop a transition of care plan for the member to help coordinate the services needed after disenrollment. The transition of care plan must be developed 30 calendar days prior to disenrollment that addresses the member behavioral health care needs for at least 90 calendar days following disenrollment from Medicaid.

i. Transition of Care Due to Loss of OhioRISE 1915(c) Waiver Eligibility

i. If a member loses OhioRISE 1915(c) waiver eligibility, the OhioRISE Plan or CME must develop a transition of care plan for waiver services that will not be available to the member after the loss of waiver eligibility. The CFCP must be updated to reflect the OhioRISE benefits that will replace the loss of waiver services. The OhioRISE Plan or CME must update the CFCP 30 calendar days prior to the member's disenrollment from the 1915(c) waiver that addresses member behavioral health care needs and supports for 90 calendar days following disenrollment from the OhioRISE 1915(c) waiver.

j. Transition of Care from One Ohio Medicaid 1915(c) Waiver to the OhioRISE 1915(c) Waiver

i. The OhioRISE Plan must employ best efforts to honor an enrolled waiver member's preference of provider when transitioning from an Ohio Medicaid 1915(c) waiver to the OhioRISE 1915(c) waiver.

k. HOME Choice

i. The OhioRISE Plan or their designee shall coordinate with HOME Choice staff for enrollment onto HOME Choice when OhioRISE members 18 years of age or older transitioning into the community from a qualified institutional setting are interested in

enrolling on HOME Choice. For those members approved for HOME Choice, the OhioRISE Plan must ensure the member's assigned OhioRISE care coordinator collaborates with HOME Choice staff to create a single comprehensive discharge and community transition plan.

l. Continuity of Care

i. Continuation of Services for Members

1. The OhioRISE Plan must allow a new member to receive services from network and out-of-network providers in the following circumstances:

a. If the member has a prior authorization approved prior to the member's transition:

i. The OhioRISE Plan must honor the prior authorization through the expiration of the authorization, regardless of whether the authorized or treating provider is in- or out-of-network with the OhioRISE Plan.

ii. The OhioRISE Plan may conduct a medical necessity review for previously authorized services if the member's needs change to warrant a change in service. The OhioRISE Plan must render an authorization decision pursuant to OAC rule 5160-59-03.1.

iii. The OhioRISE Plan may assist the member to access services through a network provider when any of the following occur:

1. The member's condition stabilizes and the OhioRISE Plan can ensure no interruption to services;
2. The member chooses to change the member's current provider to a network provider; or
3. There are quality concerns identified with the previously authorized provider.

b. The OhioRISE Plan must allow a member who was receiving behavioral health services from the MCO or FFS to continue to receive those behavioral health services with out-of-network providers if the provider is an ODM-enrolled provider even if the services were prior authorized by the MCO or FFS. The OhioRISE Plan must allow the member to receive behavioral health services from out-of-network providers for at least 45 calendar days from the date of the member's transition to the OhioRISE plan or until the OhioRISE Plan is able to transition services to a network provider. For continuity of care purposes, the OhioRISE Plan will:

i. Work with the service provider to add the provider to their network;

ii. Implement a single case agreement with the provider; or

iii. Assist the member in finding and transitioning service delivery to another provider currently in the OhioRISE Plan's network without a disruption in services.

4. Care Coordination Information Systems and Data

a. OhioRISE Care Coordination Portal

i. The OhioRISE Plan must provide a Care Coordination Portal, specific to the OhioRISE Program (OhioRISE Care Coordination Portal) that collects, stores, shares, and pushes out pertinent member information to the entities involved in coordinating the member's care (ODM, MCOs, CCEs, CMEs, and SPBM as applicable). The OhioRISE Plan's Care Coordination Portal must have the capability of sending electronic notifications of sentinel events to entities involved in the member's care coordination. The OhioRISE Plan must exchange member-level data as required under the Model Agreement. Upon the implementation of the MCOs' Care Coordination Portals, the OhioRISE Plan's Care Coordination Portal must link to each MCO's Care Coordination Portal.

ii. When member is assigned to a CME care coordinator, the OhioRISE Care Coordination Portal must allow CMEs to provide data, through either direct data entry or data exchange. Requirements for CMEs for providing and updating member care coordination data must be specified in the provider contract between the OhioRISE Plan and the CMEs.

iii. The OhioRISE Plan will be required to assess each CME's ability to provide data in an electronic format (e.g., electronic health record [EHR]) to the OhioRISE Care Coordination Portal and provide the necessary technical assistance to CMEs to meet the requirements in Section 4.a.ii of this appendix.

iv. The OhioRISE Plan must provide timely electronic notification of sentinel events to all entities involved in the member's care coordination to support appropriate care coordination. Sentinel events, with expectations of required reporting timeframes, must be entered as follows:

1. Behavioral health inpatient hospitalizations/rehospitalizations must be reported on the same day as admission.

2. ED visits for behavioral health purposes must be entered upon notification to the OhioRISE Plan.

3. Identified gaps in care must be reported within 72 hours of identification, unless immediate action is necessary to ensure health or safety of the member.

4. Admissions to out-of-home placement, including PRTFs, residential treatment centers, American Society of Addiction Medicine (ASAM) Level III residential programs, therapeutic group homes, therapeutic foster care and Qualified Residential Treatment Programs (QRTPs) must be reported within 72 hours.

5. Discharges from all out-of-home placement referenced in Section 4.a.iv of this appendix must be reported at least 72 hours prior to the planned discharge.

6. Members with MRSS contact must be reported within 24 hours.

v. The OhioRISE Care Coordination Portal must be available to members, ODM, the SPBM, MCOs, CCEs, and the CMEs, subject to access controls and requirements necessary to comply with state and federal privacy requirements.

vi. The OhioRISE Plan must provide ODM-specified staff access to the OhioRISE Plan's care coordination system as a health oversight agency with access limited to their appropriate health oversight activities and as required by or permitted by applicable laws.

vii. The OhioRISE Plan must ensure CMEs establish access to the State's IMS and enter critical incidents into the State's IMS for members enrolled in Tier 2 and Tier 3 care coordination.

viii. The OhioRISE Plan must provide ODM full access to the OhioRISE Care Coordination Portal for Medicaid members, subject to the privacy requirements as specified in Appendix A, General Requirements.

ix. The OhioRISE Plan must create a "single sign on" as specified in Appendix K, Information System, Claims, and Data, for the Care Coordination Portal for state staff, as well as the MCO's, CCEs, and/or CMEs providing care coordination services.

b. OhioRISE Plan's Responsibilities for Care Coordination Portal Data

i. The OhioRISE Plan must report the following data in the OhioRISE Care Coordination Portal:

1. Member name and all membership numbers assigned to the member (e.g., OhioRISE Plan's identifier, Medicaid number, and eligibility span);

2. Member demographics and contact information;

3. Care coordination assignment (OhioRISE Plan or CME care coordinator);

4. OhioRISE Plan's or CME care coordinator's name and contact information;

5. Care coordination tier;

6. Member school district, if applicable;

7. Access to care:

a. Referral information (e.g., date, referral source);

b. Initial and ongoing contact information (e.g., date of initial care coordination outreach, initial appointment).

8. OhioRISE Plan's care coordination status (assigned, active, declined, withdrew);

9. OhioRISE Plan/CME conducted assessments;
10. Initial and subsequent CANSassessments;
11. OhioRISE Plan- and CME-developed CFCPs and CFT members, including review status and plan update sentinel events;
12. Utilization data (claims, pharmacy, prior authorizations, ED visits and hospitalizations, value-added benefits if applicable);
13. Medication data;
14. Grievances, appeals, and state hearings;
15. Sentinel events;
16. Incidents; and
17. OhioRISE Plan/CME care team contacts.

ii. The OhioRISE Plan must have the capacity to add data elements to the OhioRISE Plan's Provider Portal in the future based on ODM's direction and specifications.

iii. The OhioRISE Plan must include portal data from the MCO set forth in Section 3.b.ii of this appendix.

c. Member Access to the OhioRISE Care Coordination Portal

i. The OhioRISE Plan must ensure that members have access to the following data and functions in the OhioRISE Care Coordination Portal:

1. Member assignment to the OhioRISE Plan;
2. Member ability to request care coordination from the OhioRISE Plan;
3. Assigned care coordinator and contact information (OhioRISE Plan and CME care coordinator as applicable);
4. OhioRISE Plan- and CME-developed CFCPs and CFT members; and
5. Care team contacts.

d. Public Children's Service Agency and IV-E Court (Title IV-E Agencies) Access to the Portal

i. The OhioRISE Plan's secure Care Coordination Portal (CCP) must be accessible by Public Children's Service Agencies (PCSAs), and Title IV-E Courts (collectively referred to as Title IV-E Agencies) and the child protection oversight agency for children and youth in their custody who are enrolled in the OhioRISE Program.

1. The CCP must allow each Title IV-E Agency to access information about all children and youth in their custody through a single login.

2. The OhioRISE Plan must follow ODM specifications for creating user role designation types and processing daily user transfer files, including MCE processing service level expectations for new users, updated users, and inactive users including provisioning new users within two business days and revoking user access within the next business day.

3. The OhioRISE Plan must provide a daily report via email to the email addresses specified in the PCSA User File Specifications and Architecture Document (latest version) to indicate the status of the daily file.

4. The OhioRISE Plan must create and provide comprehensive CCP user guide for Title IV-E Agency users per ODM specifications.

    a. The comprehensive user guide must contain step by step instructions of how to navigate and utilize the breadth of functions of the CCP that includes screen shots or pictures.

    b. The user guide must be updated to reflect CCP changes and reviewed by ODM.

5. The OhioRISE Plan must create a quick reference guide for Title IV-E Agency users per ODM specifications.

    a. The OhioRISE Plan must provide a 'Title IV-E Agency User CCP Quick Reference Document' specific to the features and functions per ODM specifications.

    b. Screen shots or pictures should be included to help this user group quickly navigate to important content.

    c. The quick reference document must be updated to reflect portal changes and reviewed by ODM.

6. At a minimum, the portal must contain the following features and functions for each child or youth in custody per ODM specifications:

    a. All information listed in this Provider Agreement for what members have~~s~~ access to on a Care Coordination Portal.

    b. All information about requests for prior authorizations or services and request status.

7. The OhioRISE Plan must provide a 'roster' view feature in the portal.

    a. The 'roster' view provides the Title IV-E Agency user with to a complete listing of only youth in their custody.

    b. The 'roster' view provides the child protection oversight agency user with a complete listing of 'child/youth in custody' members in custody.

8. The OhioRISE Plan must provide a Medicaid ID search feature in the portal. This feature allows users the ability to search for a specific 'child/youth in custody' member using solely the member's Medicaid ID.

9. The OhioRISE Plan must provide a name search feature in the portal. The name search feature must allow a Title IV-E user to search 'child/youth in custody' member using the member's first and last name and any additional argument(s) to the first and last name in order to return a more narrowed search result.

10. The OhioRISE Plan's care coordination portal must display all non-prescription claims with the following information:

    a. This feature will return a complete beginning-to-date list of non-prescription claims and claim status associated with a 'child/youth in custody' member.

    b. At minimum the information included for each claim must be the date of service, provider, and diagnosis code.

    c. The claim information and diagnosis code should be displayed so that a non-medical person can understand what procedures or services were received on what date and provided by what provider per claim.

11. The OhioRISE Plan CCP must display claims data received from the Single Pharmacy Benefit Manager (SPBM).This feature will return a complete beginning-to-date list of SPBM claims and claim status associated with a 'child/youth in custody' member. At minimum the information displayed on the care coordination portal for each SPBM claim must be the date of fill, prescriber, pharmacy location, and name of medication. If provided in the claim data, the dosage must also be included.

12. The OhioRISE Plan must work with Title IV-E Agencies to determine additional information about each child and youth that will be made available through their login. At a minimum, information about each child or youth in custody must include:

    a. CME responsible for care coordination, or designation that care coordination is the responsibility of the OhioRISE Plan;

    b. Contact information for the child or youth's assigned care coordinator at the CME or OhioRISE Plan; and

    c. The Child and Family-Centered Care Plan.

e. The OhioRISE Plan must train CMEs and other providers how to enter and review data in the portal appropriate to their role in the member's care and in compliance with state and federal privacy requirements.

f. The OhioRISE Care Coordination Portal must be designed using technology approved by ODM that permits operation of the system to be transferred to ODM or its designee upon termination

of this Agreement. ODM shall own all of the data in the OhioRISE Care Coordination Portal, and the data must be made available in a format specified by ODM upon termination of this Agreement.

g. The OhioRISE Plan is prohibited from using the OhioRISE Care Coordination Portal system in other states or under other contracts without the prior written approval of ODM.

5. OhioRISE Care Coordination Portal Monitoring and Oversight

a. The OhioRISE Plan must monitor and provide oversight to ensure the care coordination needs of members are met.

b. The OhioRISE Plan, on an ongoing basis, must review data indicators (e.g., emergency department, inpatient, and crisis services utilization; prescription drug utilization data provided by the SPBM/MCOs/ODM; utilization patterns stratified by race/ethnicity, gender, and aid category; readmissions; critical incidents; identified gaps in care) to inform the level and type of care coordination needed by the member.

c. The OhioRISE Plan must perform oversight of the quality and effectiveness of OhioRISE Plan- and CME-provided care coordination through case reviews. Case reviews must include whether the OhioRISE Plan and CME have met established quality, clinical best practice, and care coordination standards.

d. Following the identification of unmet member needs or care coordination delivery deficiencies, the OhioRISE Plan, in coordination with ODM, the MCOs, CCEs, CMEs, and the SPBM, must ensure that the member needs are expediently met and that care coordination deficiencies are systemically corrected.

APPENDIX E –MEMBER, PROVIDER, AND MARKETING MATERIALS

1. Member Materials

a. General

i. The OhioRISE Plan must ensure that all member materials meet the member information requirements as stated in Appendix A, General Requirements.

ii. Member materials are those items developed by or on behalf of the OhioRISE Plan, which includes care management entities (CME), to fulfill OhioRISE Plan program requirements or to communicate to all members or a group of members. Member materials include member education, program explanations, and referral and linkage related materials. Member health education materials produced by a source other than the OhioRISE Plan and that do not include any reference to the OhioRISE Plan are not considered to be member materials.

iii. Pursuant to OAC rule 5160-26-05.1, the OhioRISE Plan must adopt practice guidelines and provide a copy of them to eligible individuals and members upon their request.

iv. If the OhioRISE Plan uses and/or distributes member materials that have not been approved by ODM, ODM may issue compliance or the financial sanction listed in Appendix N.

b. ODM Member Material Approval

i. The OhioRISE Plan must submit all member materials to ODM for approval prior to distribution to eligible individuals or members. The OhioRISE Plan must submit the materials in a method identified by ODM.

ii. The OhioRISE Plan and the CMEs must follow and comply with templates and guidelines that are provided by ODM.

iii. CMEs must submit materials to the OhioRISE Plan for review and approval by ODM.

iv. In accordance with 42 CFR 438.104(c), ODM will consult with the Medical Care Advisory Committee or an advisory committee of similar membership in reviewing all OhioRISE Plan-submitted member materials.

c. New Member Materials

i. General

1. The OhioRISE Plan shall not routinely include single pharmacy benefit manager (SPBM) or MCO information in member communications but shall refer and link to the MCO or SPBM.

2. In accordance with 42 CFR 438(c)(6) and 42 CFR 438.10(c)(6), if the OhioRISE Plan provides required member information or the member handbook electronically, it must meet all of the following conditions:

a. The format is readily accessible;

b. The information is located in a prominent and readily accessible place on the member page of the OhioRISE Plan's website;

c. The information is provided in a form that can be electronically retained and printed;

d. The information provided electronically meets the member information requirements as stated in Appendix A, General Requirements;

e. The information is consistent with the content requirements in this appendix; and

f. The member is informed that the information is available in paper form without charge upon request; the information and process (e.g., phone number and/or email address) to request paper forms is included; and the requested information is provided within five business days.

ii. New Member Letter

1. The OhioRISE Plan must use the model language specified by ODM for the new member letter. The OhioRISE Plan's New Member Letter must inform each member of the following:

a. The new member materials issued by the OhioRISE Plan, what action to take if the member did not receive those materials, and how to access the OhioRISE Plan's provider directory;

b. The new member will be assigned to a care management entity (CME) or OhioRISE Plan care coordinator who will be contacting the member and/or their family, and how to reach member services with any needs prior to contact from the care coordinator;

c. How to access MCO-provided transportation services, including how the OhioRISE Plan can assist the member with coordination of transportation services through the MCO; and

d. The issues and circumstances upon which the member should contact their MCO rather than the OhioRISE Plan and an affirmation that the OhioRISE Plan member services line can also provide a warm transfer of the member to the MCO in which the member is enrolled.

iii. Member Handbook

1. The OhioRISE Plan must use the model language specified by ODM for the member handbook. The OhioRISE Plan's member handbook must be clearly labeled as such and include "OhioRISE Program" to clearly distinguish the applicability of the member handbook to members covered under this Agreement from those created for other OhioRISE Plan lines of business. The OhioRISE Plan must ensure the member handbook table of contents precedes all content, with the exception of the tagline to comply with Section 1557 of the Patient Protection and Affordable Care Act. The member handbook must

include ODM definitions of managed care terminology in accordance with 42 CFR 438.10. The OhioRISE Plan must ensure the member handbook includes:

a. The rights of members, including all rights found in OAC rule 5160-26-08.3 and any member responsibilities specified by the OhioRISE Plan:

    i. With the exception of any prior authorization requirements the OhioRISE Plan describes in the member handbook, the OhioRISE Plan cannot establish any member responsibility that would preclude the OhioRISE Plan's coverage of a Medicaid-covered service.

b. Information regarding the services and benefits available through the OhioRISE Program and how to obtain them including, at a minimum:

    i. A summary comparing the services covered by the OhioRISE Plan, MCOs, and SPBM;

    ii. All services and benefits requiring prior authorization or referral by the OhioRISE Plan.

c. Information regarding services excluded from OhioRISE Plan coverage;

d. Information regarding how members can access Mobile Response and Stabilization Services (MRSS) services;

e. Information distinguishing emergency services available from the MCO and from the OhioRISE Plan, including how to obtain more information about those services from the MCO and the OhioRISE Plan. The OhioRISE Plan shall include:

    i. An explanation of the terms "emergency medical condition," "emergency services," and "post-stabilization services," as defined in OAC rule 5160-26-01;

    ii. A statement that prior authorization is not required for emergency services;

    iii. An explanation of the availability of the 911 telephone system or its local equivalent;

    iv. A statement that members have the right to use any hospital or other appropriate setting for emergency services; and

    v. An explanation of the post-stabilization care services requirements specified in OAC rule 5160-59-03.

f. Information required by ODM to promote member awareness and understanding of their rights under the Mental Health Parity and Addiction Equity Act;

g. The procedure for members to express their recommendations for change to the OhioRISE Plan;

h. Identification of the categories of Medicaid recipients eligible for OhioRISE Program membership;

i. Information about the ID card issued by the MCO or ODM, how often the card is issued, how to use it, and how to get a replacement card;

j. A statement that medically necessary health care services must be obtained through the providers in the OhioRISE Plan's provider network with any exceptions that apply, such as emergency care;

k. Information regarding the roles and duties of the OhioRISE Plan compared to the MCO;

l. Information on additional services available to members, including care coordination provided by the CME, OhioRISE Plan and roles of the MCO/care coordination entity (CCE) care coordinator;

m. A description of the OhioRISE Plan's policies regarding access to providers outside the state for non-emergency services and, if applicable, access to providers within or outside the state for non-emergency after hours services;

n. Information on how a member can initiate disenrollment from the OhioRISE Plan in accordance with OAC rule 5160-59-02;

o. Information about OhioRISE Plan-initiated terminations;

p. An explanation of periodic OhioRISE Plan enrollment process as specified by ODM;

q. The procedure for members to file a grievance, an appeal, or state hearing request pursuant to OAC rule 5160-26-08.4, the OhioRISE Plan's mailing address, and copies of the optional forms that members may use to file an appeal or grievance with the OhioRISE Plan;

    i. Copies of the forms to file an appeal or grievance must also be made available through the OhioRISE Plan's member services program.

r. The standard and expedited state hearing resolution timeframes as outlined in 42 CFR 431.244;

s. The member handbook issuance date;

t. A statement that the OhioRISE Plan is prohibited from discriminating on the basis of race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, veteran

status, ancestry, genetic information, health status, or need for health services in the receipt of health services;

u. An explanation of subrogation and coordination of benefits;

v. A clear identification of corporate or parent identity when a trade name or DBA is used for the Medicaid product;

w. Information on the OhioRISE Plan's advance directives policies, including a member's right to formulate advance directives, a description of state law, and a statement of any conscience-based limitation regarding the implementation of advance directives;

x. A statement that the OhioRISE Plan provides covered services to members through a provider agreement with ODM, and how members can contact ODM;

y. The toll-free call-in system phone numbers;

z. A statement that additional information is available from the OhioRISE Plan upon request including, at a minimum, the structure and operation of the OhioRISE Plan and any physician incentive plans the OhioRISE Plan operates;

aa. Process for requesting or accessing additional OhioRISE Plan information or services including, at a minimum:

i. Oral interpretation, oral translation, and auxiliary aids and services;

ii. Written information in the non-English languages identified as a member's primary language; and

iii. Written information in alternative formats.

bb. How to access the OhioRISE Plan's provider directory; and

cc. Access to provider panel information for members via the OhioRISE Plan's website and printed provider directories.

dd. If In Lieu of Services and Settings (ILOS) are added to the OhioRISE Plan's contract, the rights and protections in 42 CFR 438.3(e)(2)(ii) must be included in the member handbook.

iv. OhioRISE 1915(c) Waiver Member Handbook for OhioRISE 1915(c) Waiver Enrollees

1. The OhioRISE Plan must provide an OhioRISE 1915(c) waiver member handbook to each youth seeking enrollment onto the OhioRISE 1915(c) waiver.

2. The OhioRISE Plan must ensure each member enrolled in the OhioRISE 1915(c) waiver receives the OhioRISE 1915(c) waiver member handbook at the time of

the initial waiver assessment, and at the time of each annual waiver level of care redetermination, in the format and language of the member's choosing. The OhioRISE Plan must ensure the care coordinator verbally reviews the content of the OhioRISE 1915(c) waiver member handbook with each member prior to enrollment on the OhioRISE 1915(c) waiver, and the OhioRISE Plan must maintain documentation signed by the member acknowledging receipt of this information. The OhioRISE Plan must ensure paper copies of the OhioRISE 1915(c) waiver member handbook are available for all care coordinators who assist OhioRISE 1915(c) waiver enrollees to provide to OhioRISE 1915(c) waiver enrollees or potential waiver enrollees who request a paper copy.

3. The OhioRISE Plan must implement an ODM-developed Freedom of Choice form signed by each member enrolled in the OhioRISE 1915(c) waiver indicating they have chosen OhioRISE 1915(c) waiver services instead of institutional care. This form shall be signed at the time of the initial assessment for the waiver and annually thereafter at the time of reassessment of waiver eligibility and level of care redetermination. The OhioRISE Plan must ensure the member is given a copy of the signed form.

4. The OhioRISE Plan must ensure that the OhioRISE Waiver Member Handbook is available in the 15 non-English languages that are most prevalent in Ohio, and also in alternate formats, for any youth/potential member who requests it.

5. The OhioRISE Waiver Member Handbook must contain information on the following:

    a. OhioRISE 1915(c) waiver services, including any service limitations and other budgetary limitations such as the waiver cost cap;

    b. The requirements around the Child and Family-Centered Care Plan, including the timeframes for plan submission and approval;

    c. How to report an incident that meets the criteria for incident reporting as defined in Ohio Administrative Code 5160-44-05;

    d. The right to request a fair hearing, including information on the grievance process, the appeals process, and the state hearings system and process.

6. The OhioRISE Plan must ensure that members, families/guardians, as appropriate, are notified of the waiver enrollee's rights and protections, including freedom of choice of providers.

v. OhioRISE Plan Quick Guide

1. The OhioRISE Plan must create a quick guide version of its member handbook that includes but is not limited to the following information:

    a. A reference to 42 CFR 438.10 which outlines the information requirements for the PIHP ;

b. The process for requesting or accessing additional OhioRISE Plan information or services including, at a minimum:

    i. Oral interpretation, oral translation, and auxiliary aids and services;

    ii. Written information in the prevalent non-English languages; and

    iii. Written information in alternative formats.

c. A brief description of the roles of the OhioRISE Plan, CME, MCO, and SPBM;

d. A statement that the OhioRISE Plan provides covered services to members through a provider agreement with ODM, and how members can contact ODM;

e. Toll-free phone numbers critical to accessing care, including the member services, behavioral health crisis services, MCO's transportation services, MCO's member services numbers and websites, and the SPBM's member services number and website;

f. The benefits available through the OhioRISE Plan, how to obtain them, and any limits or prior authorization applied;

g. Information regarding emergency services, the procedures for accessing emergency services, and a statement that emergency services do not require prior authorization;

h. Information that indicates medically necessary health care services must be obtained through the providers in the OhioRISE Plan's provider network with any exceptions that apply, such as emergency care;

i. How to access the OhioRISE Plan's provider directory; and

j. The quick guide issuance date.

d. Issuance of New Member Materials

    i. The OhioRISE Plan must mail the new member letter, quick guide, and request mailer within ten business days of receiving the 834C enrollment file.

    ii. The OhioRISE Plan may mail ODM prior-approved mailers in lieu of mailing printed advance directives, directories, quick guides, and member handbooks. At a minimum, the mailers must advise members to call the OhioRISE Plan or return the mailer to request a printed advance directive, provider directory, quick guide, or member handbook. The mailer also must include a link to access the materials online.

iii. If the OhioRISE Plan does not use an ODM prior-approved mailer, the OhioRISE Plan must mail provider directories and member handbooks to all new members, within ten business days of receiving the 834C.

iv. If requested by a member, the OhioRISE Plan must send a printed advance directive, provider directory, and member handbook within seven calendar days of the request.

v. The OhioRISE Plan must designate two OhioRISE Plan staff members to receive a copy of the new member materials on a monthly basis in order to monitor the timely receipt of these materials. At least one of the staff members must receive the materials at their home address. The OhioRISE Plan must provide documentation to ODM upon request that demonstrates compliance with this requirement.

e. Provider Materials

i. General

1. Provider materials are those items developed by or on behalf of the OhioRISE Plan, which includes the CMEs, to fulfill OhioRISE Plan program requirements or to communicate to providers. Provider materials include provider education, program explanations, and manuals. Provider education and resource materials produced by a source other than the OhioRISE Plan and that do not include any reference to the OhioRISE Plan are not considered to be provider materials.

2. The OhioRISE Plan and the CMEs must follow templates and guidelines related to provider materials that are provided by ODM.

3. If the OhioRISE plan uses and/or distributes provider materials that have not been approved by ODM, ODM may issue compliance or the financial sanction listed in Appendix N.

ii. ODM Provider Material Approval

1. The OhioRISE Plan must submit all provider materials to ODM for approval prior to distribution providers. The OhioRISE Plan must submit the materials in a method identified by ODM.

2. The OhioRISE Plan and the CMEs must follow and comply with templates and guidelines that are provided by ODM.

3. CMEs must submit materials to the OhioRISE Plan for review and approval by ODM.

f. Marketing Materials for the Purpose of Education and Awareness

i. Marketing

1. Marketing for the OhioRISE Plan are any materials that educate and raise awareness of the program to the public or potential members, in order to increase membership.

2. The OhioRISE Plan can market to the public or potential members, if approved by ODM.

ii. General

1. If the OhioRISE Plan uses and/or distributes marketing materials that have not been approved by ODM, ODM may issue compliance or the financial sanction listed in Appendix N.

2. CMEs must submit materials to the OhioRISE Plan for review and approval by ODM.

3. The OhioRISE Plan must ensure that marketing materials do not include statements that are inaccurate, misleading, confusing, or otherwise misrepresentative, or that defraud eligible individuals or ODM.

iii. ODM Marketing Material Approval

1. The OhioRISE Plan must submit all marketing materials to ODM for approval prior to distribution and implementation. The OhioRISE Plan must submit the materials in a method identified by ODM.

2. The OhioRISE Plan and the CMEs must follow and comply with templates and guidelines that are provided by ODM.

iv. Alleged Marketing Violations

1. The OhioRISE Plan must immediately notify ODM in writing of its discovery of an alleged or suspected marketing violation. ODM will forward information pertaining to alleged marketing violations to the Ohio Department of Insurance (ODI) and the Medicaid Fraud Control Unit (MCFU) as appropriate.

2. ODM-Requested Member Notifications

a. The OhioRISE Plan must provide written notice to members as specified by ODM, including but not limited to notification of a change to member services or access to network providers.

APPENDIX F – PROVIDER NETWORK

1. General

a. The OhioRISE Plan must comply with all state and federal provider network requirements, including but not limited to OAC rule 5160-26-05, 42 CFR 438.206, 42 CFR 438.207, 42 CFR 438.602, and the requirements of this appendix.

b. In accordance with 42 CFR 438.206, the OhioRISE Plan must maintain a provider network that is sufficient to provide timely access to all medically necessary covered services stipulated in the OhioRISE Plan benefit package to all OhioRISE Plan-enrolled members, including those with limited English proficiency or physical or behavioral health disabilities. The OhioRISE Plan must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical or behavioral disabilities.

c. The OhioRISE Plan must monitor compliance with provider network requirements and take corrective action as needed.

d. At a minimum, 80 percent of new providers shall receive provider orientation and training within 75 calendar days of contracting with the OhioRISE plan.

e. ODM will screen, enroll, and credential all providers as necessary in accordance with 42 CFR 455 subpart E. The OhioRISE Plan shall review ODM's provider network management (PNM) module (the system of record) for eligible and active providers.

f. ODM will provide the OhioRISE Plan with an electronic Provider Master File (PMF) containing all Ohio Medicaid providers, which includes their Medicaid Provider Number, for current encounter data purposes. This file also includes NPI information when available.

g. The OhioRISE Plan must monitor access and availability using multiple data sources, including but not limited to member complaints, member grievances, appeals, member satisfaction surveys, provider complaints, quality data, performance measures, utilization data, demographic data, and results from other oversight and monitoring activities.

h. The OhioRISE Plan must comport with ODM's Substance Use Disorder 1115 waiver requirements, including American Society of Addiction Medicine (ASAM) levels of care as outlined in Table F.2.

2. Documentation of Network Capacity

a. In accordance with 42 CFR 438.207, the OhioRISE Plan must give assurance to ODM and provide supporting documentation that it has the capacity to serve the expected membership in accordance with the requirements of this Agreement.

b. In accordance with 42 CFR 438.207, the OhioRISE Plan must submit documentation to ODM, in a format specified by ODM, demonstrating that:

    i. The OhioRISE Plan offers an appropriate range of behavioral health services (including care coordination as offered through the care management entities [CMEs]) adequate for the anticipated number of members; and

ii. The OhioRISE Plan maintains a provider network sufficient in number, mix, and geographic distribution in accordance with any stipulated time and distance standards, contracting requirements and to directly meet the needs of the anticipated and existing members. This shall include providers in contiguous states needed for member access and care.

c. In accordance with 42 CFR 438.207, the OhioRISE Plan must submit such documentation at each of the following:

i. At the time the OhioRISE Plan enters into a contract with ODM;

ii. On a quarterly basis thereafter;

iii. At any time there is a significant change (as defined by ODM) in the OhioRISE Plan's operations that would affect adequate capacity and services, including but not limited to changes in services, benefits, service area, provider network, or payments;

iv. Any time there is enrollment of a new population in the OhioRISE Plan; and

v. As otherwise directed by ODM.

d. The OhioRISE Plan must develop and maintain a Network Development and Management Plan to demonstrate that it maintains a network of providers that is sufficient in number and mix in accordance with any stipulated time and distance standards and contracting requirements. The Network Development and Management Plan must also demonstrate that the OhioRISE Plan directly meets the needs of the anticipated and existing members in the service area and ensures the provision of covered services.

i. The Network Development and Management Plan must include the information specified by ODM, which may include but is not limited to:

1. Coordination with the MCO(s) on the behavioral health contracted continuum of care to minimize disruption of care as members transition between the OhioRISE Plan and MCO(s);

2. Addresses special considerations for children and youth that transition between FFS and the MCO(s) while also enrolled in the OhioRISE Plan (See Appendix D for more detail on transition requirements and plans);

3. Monitoring activities to ensure that access standards are met and that members have timely access to services;

4. Provider capacity issues by service and county, the OhioRISE Plan's remediation and quality improvement (QI) activities, and the targeted and actual completion dates for those activities;

5. Provider network deficiencies by service, stipulated time and distance standards (TDS) as specified in Tables F.2 and F.3, and interventions to address the deficiencies;

6. Ongoing activities for provider network development and expansion taking into consideration identified provider capacity, network deficiencies, service delivery issues, network continuity between with the MCOs, and current and future member needs; and

7. Collaboration and coordination with State's designated COE(s).

ii. The OhioRISE Plan must evaluate and update its Network Development and Management Plan on an annual basis and submit it to ODM as specified in Appendix P, Chart of Deliverables.

iii. The OhioRISE Plan's annual submission of the Network Development and Management Plan satisfies the annual documentation requirement for network capacity.

3. Provider Contracting

a. Provider Selection

i. In accordance with CFR 438.214 and OAC rule 5160-26-05, the OhioRISE Plan must have policies and procedures for selection and retention of network providers. This shall include policies and procedures on selective contracting for PRTFs and other providers upon approval by ODM.

ii. The OhioRISE Plan, at the direction of ODM, will:

1. Assist in developing program and administrative policies and requirements for CMEs in partnership with ODM, state child-serving agencies, the COE(s), and community stakeholders;

2. Selectively contract with CMEs and PRTFs that meet the State's policy objectives and meet the requirements developed in Section 3.a.i. of this appendix;

3. Provide technical assistance, in collaboration with ODM, state child-serving agencies and the COE(s), to support the establishment, development, and growth of CMEs;

4. Provide technical assistance, in collaboration with ODM and state child-serving agencies, to support the establishment and development of PRTFs.

b. Written Contracts and Medicaid Addendum

i. In accordance with CFR 438.206 and OAC rule 5160-26-05, the OhioRISE Plan must enter into written contracts with network providers.

ii. Pursuant to OAC rule 5160-26-05, network provider contracts must include the appropriate ODM-approved Model Medicaid Addendum, which incorporates all applicable OAC rule requirements. The OhioRISE Plan must not modify the Model Medicaid Addendum except to add personalizing information such as the OhioRISE Plan's name.

iii. The OhioRISE Plan must submit network provider contract templates to ODM for review prior to executing contracts using the applicable template.

iv. The OhioRISE Plan must completely and accurately respond to ODM's questions and requests for information about network provider contracts within the timeframes established by ODM.

v. Upon ODM's request, the OhioRISE Plan must disclose to ODM all financial and other terms that apply between the OhioRISE Plan and any network provider.

c. Contracting with ODM-Enrolled Providers

i. In accordance with 42 CFR 438.602 and this Agreement, the OhioRISE Plan must contract only with providers that are enrolled with or designated by ODM and are active providers in ODM's provider network management system.

ii. Prior to contracting with a provider or listing the provider as a network provider, and prior to furnishing OhioRISE 1915(c) waiver services, the OhioRISE Plan must verify that the provider is active in ODM's provider network management system and enrolled for the applicable service or specialty. If a provider is not active in ODM's provider network management system, the OhioRISE Plan must direct the provider to the ODM's portal to submit an application for screening, enrollment, and credentialing prior to contracting. Providers operating under single-case agreements with the OhioRISE Plan are not considered network providers.

iii. The OhioRISE Plan must conduct a daily (seven days per week) reconciliation of the OhioRISE Plan's provider network, and ODM's PNM system. The OhioRISE Plan must use PNM system data, the PMF, supplemental files generated by ODM systems, and any data elements as directed by ODM. Network providers and staff affiliations remain active and in alignment with ODM's PNM system.

iv. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must submit to ODM the Provider Visit report, which shows the provider outreach for contracting status, accurate information, policy clarification, etc.

d. Excluded Providers

i. The OhioRISE plan may not employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

ii. The OhioRISE plan must terminate any persons or providers of services terminated from participation under title XIX, title XVII, or title XXI from participating in their provider network.

e. Centralized Credentialing

i. If credentialing is required for a specific provider type, the OhioRISE Plan must only use providers credentialed or approved through ODM's process.

ii. A provider's credentialing status will be indicated in ODM's provider network management system.

iii. The OhioRISE Plan must accept ODM's credentialing status

iv. The OhioRISE Plan must not request any additional credentialing or re-credentialing information from an ODM-enrolled provider. The OhioRISE Plan may request information for initial and ongoing contracting and ongoing network management provided that the requested information is not available in ODM's provider network management system e.g. Transitional Services and Supports (TSS), Behavioral Health Respite, or others as specified by ODM.

v. The OhioRISE Plan must not credential or re-credential any ODM-enrolled providers for provision of services under this Agreement, including provider types that are not credentialed by ODM.

vi. The OhioRISE Plan must coordinate and cooperate with ODM in the credentialing and re-credentialing of the OhioRISE Plan's network providers.

vii. The OhioRISE Plan's Chief Medical Officer (CMO) must participate in ODM's credentialing committee, if requested by ODM.

f. OhioRISE Plan Provider Network Information

i. The OhioRISE Plan must submit provider network information, including provider additions and deletions, to ODM in the format and at the frequency specified by ODM to ODM's provider network management system.

ii. As directed by ODM, the OhioRISE Plan must provide documentation verifying the accuracy of information submitted to ODM's provider network management system.

iii. ODM will use the information provided by the OhioRISE Plan and uploaded into ODM's provider network management system to determine if the OhioRISE Plan meets the provider network access standards specified in this Agreement.

iv. The OhioRISE Plan must immediately notify ODM of any discrepancy between the OhioRISE Plan's provider network information in ODM's provider network management system and the OhioRISE Plan's system and resubmit the correct information within one business day of becoming aware of the discrepancy.

g. Sole Source Contracting

i. The OhioRISE Plan must receive ODM's approval prior to executing a sole source contract for any covered services or otherwise limiting the availability of any service to one provider.

ii. As part of its request for ODM prior approval, the OhioRISE Plan must include the information and documentation specified by ODM.

iii. If ODM approves a sole source contract, the OhioRISE Plan must ensure that providers and members are notified of the sole source contract and ensure an effective transition for members receiving services from another provider.

4. Provider Network Access Requirements

a. General

i. The OhioRISE Plan must comply, at a minimum, with the provider network access requirements specified in this appendix.

ii. If ODM determines that changes have occurred in the availability of specific provider types or in the number and composition of the eligible population, ODM will, via amendment to this Agreement, revise the provider network access requirements.

iii. The OhioRISE Plan must monitor compliance with provider network access requirements and take corrective action as needed to comply with this appendix.

iv. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must submit quarterly time and distance reports (Time and Distance Report) to ODM in the format specified by ODM.

v. ODM will use a time and distance geo mapping and statistical software that uses the Euclidean metric to measure the maximum time and distance for the OhioRISE Plan's membership and provider network. The OhioRISE Plan must ensure that at least 90% of the OhioRISE Plan's members residing in a given county have access to at least one provider/facility of each specialty type within the time and distance standards in Table F.2 as determined by ODM.

vi. The OhioRISE Plan must notify ODM within one business day of determining that the OhioRISE Plan is not in compliance with the provider network access requirements specified in this appendix.

b. Behavioral Health Providers

i. Child and Adolescent Needs and Strengths Providers

1. The OhioRISE Plan must contract with 90% of all willing providers identified by ODM in ODM's provider network management system as eligible to complete the ongoing Child and Adolescent Needs and Strengths (CANS) assessments for continued eligibility for OhioRISE Plan enrollment (CANS providers) except where there are documented instances of quality concerns. The OhioRISE Plan must notify ODM if it is not willing to contract with a particular CANS provider and must collaborate with ODM on next steps.

2. For CANS providers identified by ODM after the effective date of this Agreement, the OhioRISE Plan must contract with the identified provider no later than 90 calendar days from the provider being identified as a CANS provider in ODM's provider network management system.

3. The OhioRISE Plan must monitor CANS providers for compliance with ODM standards and guidance using a standardized protocol as specified by ODM. As directed by ODM, the OhioRISE Plan must coordinate monitoring with the MCO(s).

4. For the purposes of ongoing CANS assessment following enrollment in the OhioRISE Plan, the OhioRISE Plan must ensure and monitor that the CMEs have individuals trained in the administration of the CANS or have access to CANS assessors. The OhioRISE Plan must ensure the completion of the ongoing CANS

assessment within the CANS IT system every 90 days or when a change in members condition warrants a re-assessment.

5. The OhioRISE Plan must ensure 80% completion of the initial CANS assessment within 10 days of receipt of referral as outlined in the CANS Timely Completion Report within Appendix P, Chart of Deliverables.

ii. Providers of Mobile Response and Stabilization Services

1. The OhioRISE plan must ensure contracts are in place with all RMPs identified by ODM.

iii. Community Behavioral Health Services Providers

1. The OhioRISE Plan must contract with community behavioral health providers that meet the requirements in OAC Chapter 5160-27-01 that serve children, youth, and caregivers to ensure adequate provider network capacity to provide its members with reasonable and timely access to all covered behavioral health services.

2. Community behavioral health services providers count toward the time and distance standard in Table F.2 for Behavioral Health and Pediatric Behavioral Health providers.

iv. Substance Use Disorder Treatment Providers

1. The OhioRISE Plan must contract with substance use disorder (SUD) treatment providers that meet the requirements in 5160-27-01 that serve adolescents and ensure adequate provider network capacity to provide its members with reasonable and timely access to all covered SUD treatment services.

2. The OhioRISE Plan must apply the time and distance standards set forth in Table F.2 to contract with community behavioral health providers and other licensed practitioners in accordance with OAC Chapter 5160-27-01 and 5160-8-05 for each ASAM level of care.

v. Opioid Treatment Programs

1. The OhioRISE Plan must contract with 95% of all willing Opioid Treatment Programs (OTPs) licensed by OMHAS and certified by the United States Substance Abuse and Mental Health Services Administration (SAMHSA), except where there are documented instances of quality concerns. The OhioRISE Plan must notify ODM if it is not willing to contract with a particular OTP provider and must collaborate with ODM on next steps.

vi. Other Behavioral Health Providers

1. The OhioRISE Plan must contract with at least the minimum number of other behavioral health providers per the specified TDS in Table F.2.

2. For purposes of this standard, "other behavioral health providers" include medical group practices, clinics, FQHC/RHC, independent marriage and family therapists, licensed independent chemical dependency counselors, licensed independent social workers, psychologists, etc., who provide services outside of a community mental health services provider or SUD treatment provider that meet the requirements in OAC 5160-27-01.

3. For purposes of this standard, "other behavioral health providers" also include outpatient hospital providers that render behavioral health services.

vii. General and Child/Adolescent Psychiatrists and Psychiatric Advanced Practice Registered Nurses (APRN)

1. The OhioRISE Plan must contract with at least the minimum number of General and Child/Adolescent Psychiatrists and Psychiatric Advanced Practice Registered Nurses (APRN) per county specified in Table F.2.

viii. Psychiatric and General Acute Care Hospitals

1. The OhioRISE Plan must contract with at least the minimum number of hospitals by type per county specified in Table F.3. To meet these requirements, the OhioRISE Plan may contract with an out-of-state hospital located in a state bordering Ohio if necessary.

2. The OhioRISE Plan may contract with general acute care hospitals with psychiatric beds to meet the standard specified in Table F.3 or make arrangements for a special/single case agreement for hospital admissions. To meet these requirements, the OhioRISE Plan may contract with an out-of-state hospital located in a state bordering Ohio if necessary.

3. In the case where outpatient behavioral health services are provided within a hospital setting, the OhioRISE Plan must cover those services under the hospital contract or through a single case agreement resulting from an emergency.

1. If a hospital in the OhioRISE Plan's network elects not to provide specific covered services because of an objection on moral or religious grounds, the OhioRISE Plan must ensure these hospital services are available to its members through another network hospital in the specified county.

ix. Psychiatric Residential Treatment Facilities

1. The OhioRISE Plan will work with ODM to propose revisions to PRTF service standards, where necessary.

2. The OhioRISE Plan will ensure the following is in place prior to the proposed PRTF service delivery date:

a. PRTF licensing and certification through OHMAS;

b. PRTF provider enrollment through ODM; and

c. After completion of PRTF licensing and certification, satisfactory completion of the OhioRISE Plan PRTF readiness review at least 30 days prior to the proposed PRTF service delivery date.

3. The OhioRISE Plan will notify ODM of the PRTF service delivery begin date and the plan for frequency and timing of youth intake to the PRTF at least seven days prior to the proposed PRTF service delivery begin date for ODM approval.

4. The OhioRISE Plan will monitor PRTF provider compliance with PRTF provider contracts.

    a. PRTF contracts should include sufficient information to clearly identify the OhioRISE Plans specific contracts for PRTF capacity with the facility and, at a minimum, include:

        i. Bed capacity;

        ii. Expectations around availability of beds for the OhioRISE Plan;

        iii. Type of facility (PRTF, PRTF for co-occurring MH and ID, cottage, and/or cottage/co-occurring);

        iv. Service locations;

        v. The PRTF's admission criteria, (population served, including ages and gender of youth served and any special populations);

        vi. PRTF contracted rate (considering location, specialty populations, type of PRTF facility, etc.) and including any agreed upon standard rate add-ons (i.e., 1:1, CANS assessments, etc.);

        vii. Information about when a Single Case Agreement (SCA) would be appropriate and the process through which it is initiated; and

        viii. The PRTFs participation in learning communities, appropriate trainings, or other items identified by ODM.

5. The OhioRISE Plan will recommend and develop PRTF provider training with ODM, the COE, and other state partners.

6. The OhioRISE Plan will propose and work with ODM to develop a process to selectively contract with the appropriate mix and number of PRTFs.

x. Federally Qualified Health Centers/Rural Health Clinics

1. The OhioRISE Plan must support member access to any federally qualified health centers (FQHC)/rural health clinics (RHC) that offer behavioral health services, regardless of whether the FQHC/RHC is a network provider.

2. If no FQHC/RHC is available within a county, the OhioRISE Plan must cover behavioral health services provided by an FQHC/RHC outside of the county.

xi. OhioRISE 1915(c) Waiver Providers

1. The OhioRISE Plan must assist ODM with the enrollment of non-agency providers of TSS who meet the criteria of an independent practitioner or licensed psychologist as described in OAC rule 5160-8-05. The OhioRISE Plan must assist by obtaining a background check in accordance with OAC rule 5160-45-04 (generally through the Ohio Bureau of Criminal Investigation, and from the Federal Bureau of Investigation if the applicant has not maintained residency in the State of Ohio for the past five years) and matching the outcome of that background check against the allowable offenses as noted in OAC rule 5160-45-11 for a provider applicant to be approved to provide OhioRISE 1915(c) waiver services.

2. The OhioRISE Plan must contract with all 1915(c) waiver providers identified by ODM as eligible to provide Out-of-Home Respite and TSS, except where there are documented instances of quality concerns. The OhioRISE Plan must notify ODM if it is not willing to contract with a particular Out-of-Home respite or TSS provider and must collaborate with ODM to determine if additional measures should be taken to ensure access to Out-of-Home Respite or TSS services.

3. For TSS and Out-of-Home Respite providers identified by ODM after the effective date of this Agreement, the OhioRISE Plan must contract with the identified provider no later than 90 calendar days from the provider being identified as a TSS or out-of-home respite provider in ODM's provider network management system.

4. The OhioRISE Plan must assess and monitor TSS, Secondary Flex Funds, and Out-of-Home Respite providers for compliance with ODM standards (including but not limited to contracting requirements and conditions of participation), regulations, and guidance using a standardized protocol as specified by ODM. As directed by ODM, the OhioRISE Plan must coordinate monitoring activities with the MCOs. The OhioRISE Plan must notify ODM of any areas of non-compliance.

5. The FMS plan as contracted with the OhioRISE Plan as described in Appendix A must be enrolled as a Medicaid provider for Primary Flex Funds and Secondary Flex funds.

xii. Other

1. The OhioRISE Plan must provide all medically necessary covered services to its members; therefore, the OhioRISE Plan's provider network must include additional specialists and provider types not listed in this appendix, which pertains to the OhioRISE Plan-designated covered services and benefit package.

2. The OhioRISE Plan may contract with or make arrangements for a special/single case agreement with outpatient hospitals as they deem required to meet the behavioral health needs of its anticipated and existing members.

3. The OhioRISE Plan must provide reasonable and timely access to services provided by pharmacist providers for the treatment of mental health or SUD in accordance with OAC rule 5160-8-52; therefore, the OhioRISE Plan's provider network must include pharmacies.

5. Exception Process for Provider Network Access Requirements

a. Upon written request of the OhioRISE Plan, ODM will grant an exception to a provider network access requirement if action taken by ODM adversely impacted the OhioRISE Plan's ability to meet the requirement or if there is no provider available to meet the requirement.

b. ODM will consider an exception to a provider network access requirement for the inability to meet the requirement or if there is no provider available to meet the requirement. The written request should be submitted via the Exception Request Form, ODM 10262. One form per each provider category should be submitted for consideration no later than the 29th day of the first month of the quarter. Exception request forms should be submitted to ODM as soon as the OhioRISE plan becomes aware of the gap that cannot be filled.

6. Provider Network Changes

a. The OhioRISE Plan must comply with the provider network notification requirements in OAC rule 5160-26-05.

b. In addition to the notification requirements in OAC rule 5160-26-05, the OhioRISE Plan must notify ODM, as specified by ODM, within one business day of becoming aware that a network provider that is a CME , acute, or psychiatric hospital, or behavioral health facility that served 35or more of the OhioRISE Plan's members in the previous 12 months failed to notify the OhioRISE Plan that they are no longer available to serve as an OhioRISE Plan network provider.

c. In addition to the notification requirements in OAC rule 5160-26-05, the OhioRISE Plan must notify ODM no less than 90 calendar days before the end date of an OhioRISE Plan-initiated termination of a network provider contract when the provider is serving or has served 35 or more of the OhioRISE Plan's members in the previous 12 months. This includes individual practitioners in group practices that cumulatively have served 35 or more members in the previous 12 months. Unless otherwise approved by ODM, OhioRISE Plan-initiated terminations of network provider contracts that serve or could serve 35or more of the OhioRISE Plan's members shall not take effect until 90 calendar days after the open enrollment month ends.

d. In addition to the notification requirements in OAC rule 5160-26-05, the OhioRISE Plan must notify ODM at least 90 calendar days prior to implementing any OhioRISE Plan-initiated changes that may foreseeably result in the provider network being reduced by 10% or more of available network providers for one or more services or provider types. OhioRISE Plan-initiated changes include but are not limited to terminating or not renewing contracts, restricting or limiting contracts for a service or provider type, sole source contracting for a service or provider type, terminating or restricting a provider type or group of providers, or reducing payment rates for a service or provider type. Unless otherwise approved by ODM, OhioRISE Plan-initiated changes that could reduce the OhioRISE Plan's provider network by 10% or more may not take effect during the 90 calendar days after the open enrollment month ends.

e. In addition to the provisions in OAC rule 5160-26-05, the OhioRISE Plan must notify ODM within one business day of becoming aware of a provider-initiated hospital psychiatric unit/service closure or PRTF unit/service reduction or closure.

f. When the OhioRISE Plan has been notified of a general acute care hospital termination or hospital unit closure, the OhioRISE Plan may request ODM to approve an alternative notification of members, in accordance with OAC rule 5160-26-05. Upon request, ODM will respond no later than seven business days after receipt of the OhioRISE Plan's submission. The OhioRISE Plan must comply with the notification timelines outlined in OAC rule 5160-26-05 and is limited to those members receiving behavioral health and/or psychiatric services at the termed hospital within the last 12 months from the notification.

g. When submitting notification to ODM about provider network changes, the OhioRISE Plan must include, at a minimum, the following:

    i. For all terminations:

        1. Provider information, including name, provider type, address, and county where services were rendered;

        2. Copy of the termination notice, including the termination reason and the termination date;

        3. Number of members who used services from, or were assigned to, the provider in the previous 12 months; and

        4. Results of an evaluation of the remaining provider network contracts to assure adequate access, including the average and longest distance a member will need to travel to another provider, and the name, provider type, address, and county of the remaining network providers that can meet the access requirements.

h. When the OhioRISE Plan is notified by ODM or otherwise becomes aware of a current or planned loss of provider who delivers ongoing services to its members, the OhioRISE Plan must immediately identify any members being served by that provider and ensure that all health, safety, and welfare needs are met (e.g., securing informal support). The OhioRISE Plan must assist the member with selecting a new provider as expeditiously as possible and ensure documentation in the clinical record reflects the member’s choice of network providers.

i. The OhioRISE Plan must provide ODM with the monthly Change in Circumstance Report, as specified in Appendix P, Chart of Deliverables.

7. Timely Access

a. In accordance with 42 CFR 438.206:

    i. The OhioRISE Plan must ensure compliance with the appointment availability standards in this appendix.

ii. The OhioRISE Plan must ensure that network providers offer hours of operation no less than the hours of operation offered to commercial members or comparable to ODM fee-for-service (FFS), if the provider serves only Medicaid members.

iii. The OhioRISE Plan must ensure services are available 24 hours a day, seven days a week, when medically necessary.

iv. The OhioRISE Plan must establish mechanisms to ensure compliance with the requirements in this section, monitor network providers to determine compliance, and take corrective action as needed.

8. Appointment Availability

a. The OhioRISE Plan must ensure the availability of behavioral health care appointments.

b. At a minimum, the OhioRISE Plan must ensure compliance with the following appointment standards identified in Table F.1 below.

Table F.1 Appointment Standards

Type of Visit	Description	Minimum Standard
Emergency Service	Services needed to evaluate, treat, or stabilize an emergency as a result of a behavior health condition.	24 hours, 7 days/week
Urgent Care for Behavioral Health Conditions	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care. This includes acute illness or substance dependence that impacts the ability to function, but does not present imminent danger.	24 hours, 7 days/week within 48 hours of request
Behavioral Health Non-Life-Threatening Emergency	A non-life-threatening situation in which a member is exhibiting extreme emotional disturbance or behavioral distress, has a compromised ability to function, or is otherwise agitated and unable to be calmed.	Within 6 hours
Behavioral Health Routine Care	Requests for routine mental health or substance abuse treatment from behavioral health providers.	Within 10 business days or 14 calendar days, whichever is earlier
ASAM Residential/Inpatient Services – 3: 3.1, 3.5, 3.7	Initial screening, assessment and referral to treatment.	Within 48 hours of request
ASAM Medically Managed Intensive Inpatient Services – 4	Services needed to treat and stabilize a member's behavioral health condition.	24 hours, 7 days/week
Psychiatric Residential Treatment Facilities	Engagement of family/youth and establishment of admission date.	Within 48 hours of request

Type of Visit	Description	Minimum Standard
Specialty Behavioral Health Care Appointment	Care provided for a non-emergent/non-urgent illness requiring consultation, diagnosis, and/or treatment from a specialist (e.g., eating disorders, fire-setting).	Within 6 weeks

c. The OhioRISE Plan shall include in its provider contract that if the provider is unable to meet the standards above they must contact the OhioRISE Plan within three business days.

d. The OhioRISE Plan must disseminate the appointment standards to network providers and must educate network providers about the appointment standards.

e. The OhioRISE Plan must have and implement policies and procedures for triage to assist OhioRISE Plan staff and providers in determining whether a member's need is emergent, behavioral health non-life-threatening emergent, urgent, or routine, and to support member access to needed services based on the urgency of the member's need. The OhioRISE Plan's triage process must be transparent and compliant with Mental Health Parity and Addiction Equity Act (MHPAEA).

9. The OhioRISE Plan must conduct regular reviews of appointment availability. Telehealth

a. The OhioRISE Plan must offer, promote, support, and expand the appropriate and effective use of telehealth.

b. At a minimum, the OhioRISE Plan must follow OAC rule 5160-1-18 “Telemedicine”, including any emergency rule versions of OAC rule 5160-1-18, and any future telehealth rules or services developed during the time that this Agreement is in effect, but the OhioRISE Plan may be less restrictive if appropriate.

c. In addition to OAC rules mentioned above, the OhioRISE Plan must cover applicable behavioral health telehealth services as specified in the ODM *Telehealth Services: Guidelines for Managed Care Organizations* manual. The OhioRISE Plan must implement any changes outlined in the *Telehealth Services: Guidelines for Managed Care Organizations* manual within 30 calendar days of being notified by ODM of the change.

d. The OhioRISE Plan must educate members and providers about the availability of telehealth, considerations for using telehealth versus in-person visits, applicable requirements, and how to access telehealth options.

e. The OhioRISE Plan must ensure that telehealth does not replace provider choice or member preference for in-person service delivery.

f. ODM will not consider telehealth as an alternative to meeting provider network access requirements.

g. The OhioRISE Plan must support providers in offering telehealth, including providing "how to" guides on the technical requirements, workflows, and coding, and billing.

h. The OhioRISE Plan must ensure that providers comply with state requirements regarding telehealth, including but not limited to in OAC rule 5160-1-18.

i. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must submit an annual telehealth report (Telehealth Report) to ODM that includes but is not limited to:

i. The OhioRISE Plan's goals for telehealth and progress on meeting those goals, including performance measures;

ii. Barriers to increased use of telehealth and the OhioRISE Plan's strategies to overcome those barriers;

iii. Telehealth utilization, including any changes from the previous year;

iv. The OhioRISE Plan's activities to support increased use of telehealth, including any provider partnerships; and

v. Information regarding whether telehealth is improving access to needed services and/or helping make access more equitable.

10. Network and Workforce Development

a. The OhioRISE Plan must work with ODM, ODM-contracted managed care entities, the State's-designated COE(s), behavioral health network providers, child-serving provider associations, and other stakeholders to develop and implement workforce development and other initiatives designed to support provider network adequacy and access. This includes but is not limited to:

i. Identifying and implementing strategies that develop the network of new services or enhance the development of existing services in the OhioRISE Program including:

1. Developing and implementing initiatives that will assist providers in identifying and recruiting staff for key supervisory and direct service positions;

2. Creating opportunities for network providers to locate formal and informal supports for OhioRISE members with unique services and support needs; and

3. Partnering with providers to develop and implement innovative approaches to workforce and network development, including new service and payment strategies.

ii. Conducting and sharing workforce analyses as requested by ODM.

iii. Assisting ODM and state and local child-serving agencies with developing and implementing workforce development strategies, as specified by ODM.

11. Out-of-Network Requirements

a. In accordance with 42 CFR 438.206 and OAC rule 5160-59-03, if the OhioRISE Plan is unable to provide medically necessary covered services to a member in a timely manner through its provider network, the OhioRISE Plan must adequately and timely cover these services by an out-of-network provider for as long as the OhioRISE Plan's provider network is unable to provide the services.

b. In accordance with 42 CFR 438.206 and OAC rule 5160-26-05, the OhioRISE Plan must coordinate with the out-of-network provider with respect to payment and must ensure the cost

to the member is no greater than it would be if the services were furnished by a network provider.

c. If the out-of-network provider is not an active provider in ODM's provider network management system, the OhioRISE Plan must verify the provider's licensure and conduct federal database checks in accordance with 42 CFR 455.436, and must execute a single case agreement with the provider that includes the appropriate Model Medicaid Addendum.

d. The OhioRISE Plan must direct all out-of-network providers, whether out-of-state or unenrolled providers, who are not active providers in ODM's provider network management system to the ODM portal to submit an application for screening, enrollment, and credentialing (if applicable).

    i. If the unenrolled provider refuses to complete an on-line single case agreement provider enrollment application to ODM, the OhioRISE Plan can have them complete the ODM 10282 and 10283 forms to submit to the OhioRISE Plan. The OhioRISE Plan will then submit the completed forms to ODM, as directed by ODM. This will allow the provider to have a 5-year provider agreement.

    ii. If the unenrolled provider refuses to complete enrollment process or refuses to complete the ODM 10282 and 10283 forms, the OhioRISE Plan can have them complete the ODM 10295 form to submit to the OhioRISE Plan. The OhioRISE Plan will then submit the completed form to ODM, as directed by ODM. This will allow the provider to have a 120-day provider agreement. Providers can only have a single 120-day provider agreement. Once the 120-day provider agreement expires, provider would need to submit an application. If additional time is needed, the providers would need to submit an application.

e. The OhioRISE Plan must report all single case agreements with providers who are not active in ODM's provider network management system to ODM within seven calendar days of becoming aware of the need to execute a single case agreement with such a provider. If a provider who is not active in ODM's provider network management system is not willing or able to become an active provider, the OhioRISE Plan must terminate the single case agreement as directed by ODM and must not reimburse the provider for services provided after termination of the single case agreement.

12. Provider Payment

a. General

    i. Unless otherwise specified in this Agreement, the OhioRISE Plan is free to establish reimbursement methodologies with its network providers that result in payments that are sufficient to enlist enough providers so that medically necessary covered services are available to members as specified in this appendix. To the extent possible, payment arrangements should encourage and reward innovations and positive clinical outcomes (see Appendix H, Value-Based Payment).

    ii. If ODM determines that the OhioRISE Plan's reimbursement rate or rates for a program, service, or provider type is not sufficient, the OhioRISE Plan, as directed by ODM, must pay, at a minimum, the rate specified by ODM.

iii. If ODM adds a new program, service, or provider type after the contract start date to this Agreement, the OhioRISE Plan must pay, if so directed by ODM, no less than the rate established by ODM. If ODM establishes such a rate, it will evaluate the need to continue the rate no less often than every six months.

iv. The OhioRISE Plan must require, as a condition of payment, that a provider (network or out-of-network) accepts the amount paid by the OhioRISE Plan or appropriate denial made by the OhioRISE Plan (or, if applicable, payment by the OhioRISE Plan that is supplementary to the member's third party payor) and, in addition, any applicable co-payment or patient liability amount due from the member as payment in full for the service.

v. The OhioRISE Plan must ensure that members are held harmless by providers for the costs of medically necessary covered services and additional services offered by the OhioRISE Plan.

vi. The OhioRISE Plan must only pay providers for services performed while they are enrolled with ODM and are active in ODM's provider network management system, unless the provider is rendering service under a single case agreement or providing emergency services in accordance with 42 CFR 438.114. Except for emergency services, the OhioRISE Plan must not pay a provider for services provided when the provider has been terminated or suspended by ODM or has been terminated by Medicare, Medicaid, or the Children's Health Insurance Program.

vii. The OhioRISE Plan must make timely payments to providers in accordance with the timeliness standards in Appendix L, Payment and Financial Performance.

b. Rate Changes

i. The OhioRISE Plan must inform ODM of any rate changes that may adversely impact 50 or more network providers, prior to implementation of the rate change.

c. Child and Adolescent Needs and Strengths Assessments

i. The OhioRISE Plan must reimburse for Child and Adolescent Needs and Strengths (CANS) assessments conducted by CANS providers at a minimum of 100% of the current Medicaid fee schedule.

ii. The OhioRISE Plan must comply with ODM guidance for coding and billing requirements for CANS assessments.

iii. The OhioRISE Plan must reimburse CMEs for CANS assessments conducted for the purpose of determining the initial inpatient psychiatric level of care for OhioRISE 1915(c) waiver applicants when those applicants are not enrolled in Ohio Medicaid.

d. Mobile Response and Stabilization Services

i. The Single Funding Source Manager will administer the directed payment, as described in subsection s of this section, on behalf of the OhioRISE Plan for Mobile Response and Stablization Services (MRSS) rendered by Regional MRSS Providers (RMPs).

ii. The OhioRISE Plan and the Single Funding Source Manager must comply with all ODM guidance for coding and billing requirements for MRSS.

iii. The Single Funding Source Manager will collect extracted electronic health records (EHR) data provided by the RMPs and submit it as The Non-Medicaid Youth Flat File, monthly, as specified in Appendix P, Chart of Deliverables.

e. Intensive Home-Based Treatment

i. The OhioRISE Plan must reimburse for Intensive Home-Based Treatment (IHBT) rendered by IHBT providers at a minimum of 100% of the current Medicaid fee schedule.

ii. The OhioRISE Plan must comply with ODM guidance for coding and billing requirements for ICC and MCC.

f. Intensive Care Coordination (ICC) and Moderate Care Coordination (MCC)

i. The OhioRISE Plan must reimburse for ICC and MCC care coordination and home-based comprehensive assessments rendered by practitioners from Care Management Entities (CMEs) at a minimum of 100% of the current Medicaid fee schedule.

ii. The OhioRISE Plan must comply with ODM guidance for coding and billing requirements for ICC and MCC, including home-based comprehensive assessments.

g. Psychiatric Residential Treatment Facilities

i. The OhioRISE Plan must reimburse PRTF services specific to the type of PRTF identified in OAC 5160-59-03.6 at a minimum of 100% of the current Medicaid fee schedule and at a rate to ensure access to the service for members when medically necessary.

ii. The OhioRISE Plan must submit for review and approval coding and billing requirements for PRTF services.

h. Behavioral Health Respite

i. The OhioRISE Plan must develop adequate reimbursement for behavioral health respite to ensure access to the service for members when medically necessary.

ii. The OhioRISE Plan must consider the following when developing adequate reimbursement for behavioral health respite:

1. Eligible provider requirements and service specifications for behavioral health respite as described in OAC rule 5160-59-03.4.

2. Ohio Medicaid fee schedules for similar services, as well as any differences between those services' activities, eligible providers, and intended populations compared to the behavioral health respite service activities, eligible providers, and intended population.

i. Primary Flex Funds

i. In accordance with OAC rule 5160-59-03.5, the OhioRISE Plan must ensure that reimbursement for Primary Flex Funds per member does not exceed $1,500 in a 365-day period.

j. Out-of-Home Respite

i. The OhioRISE Plan must develop adequate reimbursement for out-of-home respite to ensure access to the service for members when medically necessary.

ii. The OhioRISE Plan must consider the following when developing adequate reimbursement for out-of-home respite:

1. Eligible provider requirements and service specifications for out-of-home respite as described in OAC rule 5160-59-05.1.

2. Ohio Medicaid fee schedules for similar services, as well as any differences between those services' activities, eligible providers, and intended populations compared to the OhioRISE out-of-home respite waiver service activities, eligible providers, and intended population.

k. Transitional Services and Supports

i. The OhioRISE Plan must develop adequate reimbursement for TSS to ensure access to the service for members when medically necessary.

ii. The OhioRISE Plan must consider the following when developing adequate reimbursement for TSS:

1. Eligible provider requirements and service specifications for TSS as described in OAC rule 5160-59-05.2.

2. Ohio Medicaid fee schedules for similar services, as well as any differences between those services' activities, eligible providers, and intended populations compared to the OhioRISE TSS waiver service activities, eligible providers, and intended population.

iii. The OhioRISE Plan has the authority to approve payment to relatives of members for rendering TSS in circumstances in which the relative holds the required certification and/or licensure and is credentialed through ODM. In this situation, the care coordinator must seek approval from the OhioRISE Plan prior to approving the service and rendering provider on the CFCP.

l. Secondary Flex Funds

i. In accordance with OAC rule 5160-59-05.3, the OhioRISE Plan must ensure that reimbursement for Secondary Flex Funds for a member who is an OhioRISE 1915(c) waiver enrollee does not exceed $3,000 in a 365-day period.

ii. Emergency funds, set at $2,000, are only available to a 1915(c) waiver-enrolled member when the member has exhausted $1,500 in primary flex funds as described in 5160-59-03.5 and $3,000 of secondary flex funds as described in OAC rule 5160-59-05.3, and still

have a demonstrated need which may be met through additional emergency funds available under secondary flex funds.

m. Hospital Payments

i. In accordance with Senate Bill 310 as passed by the 133rd General Assembly and upon directed payment approval from the Centers for Medicare and Medicaid Services (CMS), the OhioRISE Plan must pay in-state hospitals an added payment amount determined by ODM for members receiving hospital services (inpatient and outpatient). The payment amounts will be calculated on a quarterly basis using utilization data from a timeframe specified by ODM and later adjusted based on actual utilization during the quarter. Monetary differences because of the reconciliation will be adjusted, by hospital in subsequent quarters. OhioRISE Plan encounter data submitted to ODM will be used to identify service utilization for inpatient and outpatient services for enrollees. The payment will be made as a flat per discharge amount for inpatient services and a percentage increase applied to outpatient payments. Per discharge amounts and percentages will be evaluated each quarter. ODM estimates these payments will increase annual aggregate Medicaid expenditures for inpatient and outpatient hospital services. The directed payments are incorporated through separate payment terms and paid separately to the OhioRISE Plan outside of the monthly base capitation rate. The OhioRISE Plan must pay each hospital identified by ODM the allocated payment amount within seven business days of receiving funds from ODM.

ii. University of Cincinnati Medical Center (UCMC) Hospital Payments.

1. In accordance with House Bill 33 as passed by the 135th General Assembly and upon directed payment approval from the Centers for Medicare and Medicaid Services (CMS), the OhioRISE Plan must pay the University of Cincinnati Medical Center (UCMC) an added payment amount determined by ODM for members receiving hospital services (inpatient and outpatient).

2. The OhioRISE Plan must provide UCMC interim quarterly payments, and the allocated amount must be paid within seven business days of receiving funds from ODM. The interim quarterly payments to UCMC will be a uniform percentage increase of Medicaid for inpatient claims and outpatient claims and will be based on historical inpatient and outpatient utilization and OhioRISE Plan enrollment from a previous period as determined by ODM. Inpatient and outpatient service utilization underlying the interim payment will be reconciled by ODM. Inpatient and outpatient service utilization underlying the interim payment will be reconciled to actual service utilization following the rating period, and differences between interim payments and payments calculated using actual utilization will be reflected in payments for a future quarter.

3. After reconciliation, ODM will use the actual payment data to amend the OhioRISE Plan capitation rates such that the capitation rates include the actual payments on a per member per month (PMPM) basis. The directed payments are incorporated through separate payment terms and paid separately to the OhioRISE Plan outside of the monthly base capitation rate.

iii. University of Toledo Medical Center Hospital Payments

1. In accordance with House Bill 110 as passed by the 134th General Assembly and upon directed payment approval from the Centers for Medicare and Medicaid Services (CMS), the OhioRISE Plan must pay the University of Toledo Medical Center (UTMC) an added payment amount determined by ODM for members receiving hospital services (inpatient and outpatient).

2. The OhioRISE Plan must provide UTMC interim quarterly payments, and the allocated amount must be paid within seven business days of receiving funds from ODM. The interim quarterly payments to UTMC will be a uniform percentage increase of Medicaid for inpatient claims and outpatient claims and will be based on historical inpatient and outpatient utilization and OhioRISE Plan enrollment from a previous period as determined by ODM. Inpatient and outpatient service utilization underlying the interim payment will be reconciled by ODM. Inpatient and outpatient service utilization underlying the interim payment will be reconciled to actual service utilization following the rating period, and differences between interim payments and payments calculated using actual utilization will be reflected in payments for a future quarter.

3. After reconciliation, ODM will use the actual payment data to amend the OhioRISE Plan capitation rates such that the capitation rates include the actual payments on a per member per month (PMPM) basis. The directed payments are incorporated through separate payment terms and paid separately to the OhioRISE Plan outside of the monthly base capitation rate.

iv. Premier Health Payments

1. In accordance with the appropriation provided in House Bill 96 as passed by the 136th General Assembly and upon directed payment approval from the Centers for Medicare and Medicaid Services (CMS), the OhioRISE Plan must pay the Premier Health an added payment amount determined by ODM for members receiving hospital services (inpatient and outpatient).

2. The OhioRISE Plan must provide Premier Health interim quarterly payments, and the allocated amount must be paid within seven business days of receiving funds from ODM. The interim quarterly payments to Premier Health will be a uniform percentage increase of Medicaid for inpatient claims and outpatient claims and will be based on historical inpatient and outpatient utilization and OhioRISE Plan enrollment from a previous period as determined by ODM. Inpatient and outpatient service utilization underlying the interim payment will be reconciled by ODM. Inpatient and outpatient service utilization underlying the interim payment will be reconciled to actual service utilization following the rating period, and differences between interim payments and payments calculated using actual utilization will be reflected in payments for a future quarter.

3. After reconciliation, ODM will use the actual payment data to amend the OhioRISE Plan capitation rates such that the capitation rates include the actual payments on a per member per month (PMPM) basis. The directed payments

are incorporated through separate payment terms and paid separately to the OhioRISE Plan outside of the monthly base capitation rate.

v. University Hospitals Rainbow Babies Payments

1. In accordance with the appropriation provided in House Bill 96 as passed by the 136th General Assembly and upon directed payment approval from the Centers for Medicare and Medicaid Services (CMS), the OhioRISE Plan must pay the University Hospitals Rainbow Babies an added payment amount determined by ODM for members receiving hospital services (inpatient and outpatient).

2. The OhioRISE Plan must provide University Hospitals Rainbow Babies interim quarterly payments, and the allocated amount must be paid within seven business days of receiving funds from ODM. The interim quarterly payments to University Hospitals Rainbow Babies will be a uniform percentage increase of Medicaid for inpatient claims and outpatient claims and will be based on historical inpatient and outpatient utilization and OhioRISE Plan enrollment from a previous period as determined by ODM. Inpatient and outpatient service utilization underlying the interim payment will be reconciled by ODM. Inpatient and outpatient service utilization underlying the interim payment will be reconciled to actual service utilization following the rating period, and differences between interim payments and payments calculated using actual utilization will be reflected in payments for a future quarter.

3. After reconciliation, ODM will use the actual payment data to amend the OhioRISE Plan capitation rates such that the capitation rates include the actual payments on a per member per month (PMPM) basis. The directed payments are incorporated through separate payment terms and paid separately to the OhioRISE Plan outside of the monthly base capitation rate.

vi. Cincinnati Children's Payments

1. In accordance with the appropriation provided in House Bill 96 as passed by the 136th General Assembly and upon directed payment approval from the Centers for Medicare and Medicaid Services (CMS), the OhioRISE Plan must pay the Cincinnati Children's an added payment amount determined by ODM for members receiving hospital services (inpatient and outpatient).

2. The OhioRISE Plan must provide Cincinnati Children's interim quarterly payments, and the allocated amount must be paid within seven business days of receiving funds from ODM. The interim quarterly payments to Cincinnati Children's will be a uniform percentage increase of Medicaid for inpatient claims and outpatient claims and will be based on historical inpatient and outpatient utilization and OhioRISE Plan enrollment from a previous period as determined by ODM. Inpatient and outpatient service utilization underlying the interim payment will be reconciled by ODM. Inpatient and outpatient service utilization underlying the interim payment will be reconciled to actual service utilization following the rating period, and differences between interim payments and payments calculated using actual utilization will be reflected in payments for a future quarter.

3. After reconciliation, ODM will use the actual payment data to amend the OhioRISE Plan capitation rates such that the capitation rates include the actual payments on a per member per month (PMPM) basis. The directed payments are incorporated through separate payment terms and paid separately to the OhioRISE Plan outside of the monthly base capitation rate.

vii. The MetroHealth System Payments

1. In accordance with the appropriation provided in House Bill 96 as passed by the 136th General Assembly and upon directed payment approval from the Centers for Medicare and Medicaid Services (CMS), the OhioRISE Plan must pay the MetroHealth System an added payment amount determined by ODM for members receiving hospital services (inpatient and outpatient).

2. The OhioRISE Plan must provide MetroHealth System interim quarterly payments, and the allocated amount must be paid within seven business days of receiving funds from ODM. The interim quarterly payments to MetroHealth System will be a uniform percentage increase of Medicaid for inpatient claims and outpatient claims and will be based on historical inpatient and outpatient utilization and OhioRISE Plan enrollment from a previous period as determined by ODM. Inpatient and outpatient service utilization underlying the interim payment will be reconciled by ODM. Inpatient and outpatient service utilization underlying the interim payment will be reconciled to actual service utilization following the rating period, and differences between interim payments and payments calculated using actual utilization will be reflected in payments for a future quarter.

3. After reconciliation, ODM will use the actual payment data to amend the OhioRISE Plan capitation rates such that the capitation rates include the actual payments on a per member per month (PMPM) basis. The directed payments are incorporated through separate payment terms and paid separately to the OhioRISE Plan outside of the monthly base capitation rate.

viii. Firelands Health Payments

1. In accordance with the appropriation provided in House Bill 96 as passed by the 136th General Assembly and upon directed payment approval from the Centers for Medicare and Medicaid Services (CMS), the OhioRISE Plan must pay the Fireland's Health an added payment amount determined by ODM for members receiving hospital services (inpatient and outpatient).

2. The OhioRISE Plan must provide Fireland's Health interim quarterly payments, and the allocated amount must be paid within seven business days of receiving funds from ODM. The interim quarterly payments to Fireland's Health will be a uniform percentage increase of Medicaid for inpatient claims and outpatient claims and will be based on historical inpatient and outpatient utilization and OhioRISE Plan enrollment from a previous period as determined by ODM. Inpatient and outpatient service utilization underlying the interim payment will be reconciled by ODM. Inpatient and outpatient service utilization underlying the interim payment will be reconciled to actual service utilization following the

rating period, and differences between interim payments and payments calculated using actual utilization will be reflected in payments for a future quarter.

3. After reconciliation, ODM will use the actual payment data to amend the OhioRISE Plan capitation rates such that the capitation rates include the actual payments on a per member per month (PMPM) basis. The directed payments are incorporated through separate payment terms and paid separately to the OhioRISE Plan outside of the monthly base capitation rate.

ix. Rural Tax Hospitals Payment

1. In accordance with the appropriation provided in House Bill 96 as passed by the 136th General Assembly and upon directed payment approval from the Centers for Medicare and Medicaid Services (CMS), the OhioRISE Plan must pay Adena Fayette Medical Center, Adena Greenfield Medical Center, Adena Greenfield Medical Center, Adena Pike Medical Center, Beavercreek Medical Center d/b/a Soin Medical Center, Genesis HealthCare System, Greene Memorial Hospital, Inc., Highland District Hospital, Hocking Valley Community Hospital, King's Daughters Medical Center, Marietta Memorial Hospital, Selby General Hospital, and Southern Ohio Medical Center (herein after referred to as “Participating Rural Tax Providers”) an added payment amount determined by ODM for members receiving hospital services (inpatient and outpatient).

2. The OhioRISE Plan must provide Participating Rural Tax Providers interim quarterly payments, and the allocated amount must be paid within seven business days of receiving funds from ODM. The interim quarterly payments to Participating Rural Tax Providers will be a uniform percentage increase of Medicaid for inpatient claims and outpatient claims and will be based on historical inpatient and outpatient utilization and OhioRISE Plan enrollment from a previous period as determined by ODM. Inpatient and outpatient service utilization underlying the interim payment will be reconciled by ODM. Inpatient and outpatient service utilization underlying the interim payment will be reconciled to actual service utilization following the rating period, and differences between interim payments and payments calculated using actual utilization will be reflected in payments for a future quarter.

3. After reconciliation, ODM will use the actual payment data to amend the OhioRISE Plan capitation rates such that the capitation rates include the actual payments on a per member per month (PMPM) basis. The directed payments are incorporated through separate payment terms and paid separately to the OhioRISE Plan outside of the monthly base capitation rate.

x. Kettering Health Payments

1. In accordance with the appropriation provided in House Bill 96 as passed by the 136th General Assembly and upon directed payment approval from the Centers for Medicare and Medicaid Services (CMS), the OhioRISE Plan must pay the Kettering Health an added payment amount determined by ODM for members receiving physician and hospital services (inpatient and outpatient).

2. The OhioRISE Plan must provide Kettering Health interim quarterly payments, and the allocated amount must be paid within seven business days of receiving funds from ODM. The interim quarterly payments to Kettering Health will be a uniform percentage increase of Medicaid for inpatient claims and outpatient claims and will be based on historical inpatient and outpatient utilization and OhioRISE Plan enrollment from a previous period as determined by ODM. Inpatient and outpatient service utilization underlying the interim payment will be reconciled by ODM. Inpatient and outpatient service utilization underlying the interim payment will be reconciled to actual service utilization following the rating period, and differences between interim payments and payments calculated using actual utilization will be reflected in payments for a future quarter.

3. After reconciliation, ODM will use the actual payment data to amend the OhioRISE Plan capitation rates such that the capitation rates include the actual payments on a per member per month (PMPM) basis. The directed payments are incorporated through separate payment terms and paid separately to the OhioRISE Plan outside of the monthly base capitation rate.

n. American Rescue Plan Act (ARPA) Requirements

i. To ensure ODM's continued compliance with ARPA Section 9817, the OhioRISE Plan must:

1. Follow the Medicaid behavioral health coverage policies described in OAC chapter 5160-27, including utilization management requirements, except that the OhioRISE Plan may implement less restrictive policies than fee-for-service (FFS) for behavioral health services provided by a Community Behavioral Health Center (CBHC);

2. Maintain Medicaid FFS payment rates as a floor for behavioral health services implemented through behavioral health redesign on July 1, 2018, when the provider contracts are based on FFS rates for behavioral health services provided by a CBHC. This does not apply to CBHC Laboratories or services added to the behavioral health benefit package after May 1, 2020;

3. Prior authorize Assertive community treatment (ACT), intensive home-based treatment (IHBT), and substance use disorder (SUD) residential treatment (beginning with the third stay in a calendar year) as expeditiously as the member's health condition requires but no later than 48 hours after receipt of the request in accordance with OAC rules 5160-26-03.1, 5160-58-01.1, and 5160-59-03.1.

o. Federally Qualified Health Centers/Rural Health Clinics

i. To ensure a federally qualified health centers (FQHC) or rural health clinics (RHC) can submit a claim to ODM for the state's Wraparound payment per visit as defined in OAC rule 5160-28-01, the OhioRISE Plan must comply with the following for both network and out-of-network FQHCs/RHCs:

1. The OhioRISE Plan must provide expedited payment on a service-specific basis by procedure code (not bundled), in an amount no less than the payment made to other providers for the same or similar service.

2. If the OhioRISE Plan does not have a comparable service specific rate for the same or a similar service, the OhioRISE Plan must pay the FQHC/RHC no less than 100% of the current Medicaid fee schedule for the same or a similar service provided by a non-FQHC/RHC provider.

3. The OhioRISE Plan must provide FQHCs/RHCs the OhioRISE Plan's Medicaid provider number to enable FQHC/RHC providers to bill for the ODM wraparound payment as defined in OAC rule 5160-28-01.

p. Out-of-Network Emergency Services

   i. In accordance with 42 CFR 438.114 and OAC rule 5160-59-03, the OhioRISE Plan must reimburse out-of-network providers of emergency services either billed charges or 100% of the current Medicaid fee schedule, whichever is less.

q. Out-of-Network Psychiatric Hospital Referrals

   i. Pursuant to OAC rule 5160-59-03, if ODM approves a member's referral to certain out-of-network hospitals for psychiatric services, the OhioRISE Plan must reimburse the hospital at 100% of the current Medicaid fee schedule.

r. Out-of-Network Providers During Transition

   i. In accordance with Appendix C, Population Health and Quality, the OhioRISE Plan must reimburse out-of-network providers who provide services during the transition at 100% of the current Medicaid fee schedule.

s. Payments under the Regional Mobile Response and Stabilization Service Provider (RMP) structure

   i. The Single Funding Source Manager is responsible for collecting, pooling, and distributing Medicaid and non-Medicaid funds from all entities identified in the directed payment preprint approved under 42 CFR § 438.6(c).

   ii. The Single Funding Source Manager will pay network Regional MRSS Providers (RMPs) the Mobile Response and Stabilization Services (MRSS) directed payment amounts on a monthly basis in accordance with the directed payment preprint approved under 42 CFR § 438.6(c).

   iii. The Single Funding Source Manager will comply with all requirements described in the approved directed payment preprint and any additional policy and procedure guidance from ODM.

   iv. The OhioRISE Plan encounter data submitted to ODM will be used to identify service utilization for MRSS rendered to enrollees. The OhioRISE Plan and ODM will monitor the service delivery reports provided by the Regional MRSS Providers on at least a monthly basis.

v. The directed payments will be incorporated through a separate payment term and paid separately to the OhioRISE Plan outside of the monthly base capitation rate.

13. Provider Directory

a. General

i. The OhioRISE Plan's provider directory must include all of the OhioRISE Plan's network providers.

ii. The OhioRISE Plan must ensure that the information in the OhioRISE Plan's provider directory, at a minimum, matches the data in ODM's provider network management system for the OhioRISE Plan's network providers. The OhioRISE Plan may supplement ODM provider network management system data with OhioRISE Plan information to the extent needed to comply with the provider directory content requirements in this Agreement.

iii. The OhioRISE Plan's provider directory must be in the format specified by or otherwise prior approved by ODM.

iv. The OhioRISE Plan's provider directory must include information on how the member can locate available pharmacies. The OhioRISE Plan's provider directory must include links to the MCO's provider directories and ODM's provider directory, and how to contact the member's MCO or ODM's FFS vendor. The OhioRISE Plan's provider directory must include information on how the member can search for MCO network providers, including a link to ODM's provider directories, the MCOs' provider directories, and how to contact the MCOs.

b. Content

i. In accordance with 42 CFR 438.10 and this Agreement, the OhioRISE Plan's provider directory must include the following information about each provider:

1. Provider's name as well as any group affiliation;

2. Provider's street address or addresses;

3. Provider's telephone number or numbers;

4. Provider's website URL, as appropriate;

5. Provider's specialty, when applicable; and service-level information collected by the OhioRISE Plan, at a minimum to include distinct identification of providers of Behavioral Health Respite and Transitional Services and Supports services;

6. Indication of the provider's office/facility accessibility and accommodations (e.g., clinics, residential facilities), when applicable;

7. Indication of whether the provider offers telehealth, and if so, when telehealth is available;

8. Indication of whether the provider is accepting new members;

9. Indication of the provider's linguistic capabilities, including the specific language or languages offered, including American Sign Language (ASL), and whether they are offered by the provider or a skilled medical/behavioral health interpreter at the provider's office; and

10. Provider's cultural competence training status, when available.

ii. The OhioRISE Plan's provider directory must also include:

1. Instructions on how members may obtain directory information in alternate formats that takes into consideration the special needs of eligible individuals, including but not limited to visually-limited, limited English proficiency (LEP), and limited reading proficiency (LRP) eligible individuals; and

2. Detail on any sole-sourced or selectively contracted network providers. The description must clearly identify:

a. The services that must be obtained from the provider;

b. How to obtain the services;

c. How to contact the provider; and

d. How to obtain services to meet an urgent need.

c. Printed Provider Directory

i. The OhioRISE Plan's printed provider directory format must be approved by ODM prior to distribution. Once approved, in accordance with 42 CFR 438.10, the provider directory content may be updated with provider additions or deletions by the OhioRISE Plan without ODM prior approval. Any revisions to the printed provider directory format must be approved by ODM before distribution. The printed provider directory must be available for on-demand printing using the same data set as that supplying the online provider directory to ensure the same level of accuracy and timeliness of updates.

d. Online Provider Directory

i. The OhioRISE Plan's website must have a link to ODM's provider directory and PNM.

ii. The OhioRISE Plan's website must have links to the MCOs' provider directories.

iii. The OhioRISE Plan must have an internet-based provider directory.

iv. The OhioRISE Plan's internet-based provider directory must comply with 42 CFR 438.242 regarding a publicly accessible standard-based Application Programming Interface (API).

v. The OhioRISE Plan's internet-based provider directory must be updated at the same frequency as ODM's online provider directory so that the two are synchronized.

vi. The OhioRISE Plan's internet-based provider directory must be in a format prior approved by ODM. Any revisions to the internet provider directory format must be approved by ODM before implementation.

vii. The OhioRISE Plan's internet-based provider directory must be easy to understand, use, and allow members to electronically search for OhioRISE Plan network providers based on, at a minimum, name, provider type, provider specialty, geographic proximity, language, gender, and whether the provider is accepting new Medicaid members.

viii. If the OhioRISE Plan's internet-based provider directory includes information for both members enrolled pursuant to this Agreement and for those subject to another agreement with ODM, the OhioRISE Plan must ensure that the results of any search by a member enrolled pursuant to this Agreement only include providers available to such members.

14. Verification of Provider Network Information

a. General

i. ODM contracts with an external quality review organization to conduct telephone surveys of a statistically valid sample of providers' offices to verify information submitted to ODM's provider network management system. ODM will use these results to evaluate OhioRISE Plan performance.

ii. ODM will monitor the percentages of the CANS and OTP providers using the panel reports that are distributed weekly and take compliance the first Monday of January, April, July and October.

Table F.2 Time and Distance Standards

Specialty	Geographic Type			
	Large Metro	Metro	Micro	Rural
	Maximum Distance (miles)	Maximum Distance (miles)	Maximum Distance (miles)	Maximum Distance (miles)
Substance Use Treatment (provider types 54 and 95)	10	30	45	60
Counseling (provider types 37, 42, 47, and 52)	10	30	45	60
Ohio Department of Mental Health Provider (provider type 84)	10	30	45	60
Clinic (provider types 5 and 12)	10	30	45	60
Out-of-Home Respite (provider specialty code ORR)	10	30	45	60
Intensive Home-Based Treatment (provider specialty code 847)	10	30	45	60
Behavioral Health Respite (provider specialty code BHR)	10	30	45	60
Transitional Services and Supports (provider specialty code TSS)	10	30	45	60

Table F.2 Minimum Number of General Acute Care Hospital and Psychiatric Hospital Providers (includes Children, Adolescents, and Adults)

County	Inpatient Psych and General Hospital with Psych Units
ADAMS	0
ALLEN	0
ASHLAND	0
ASHTABULA	0
ATHENS	0
AUGLAIZE	0
BELMONT	0
BROWN	0
BUTLER	0
CARROLL	0
CHAMPAIGN	0
CLARK	0
CLERMONT	1

County	Inpatient Psych and General Hospital with Psych Units
HAMILTON	4
HANCOCK	0
HARDIN	0
HARRISON	0
HENRY	0
HIGHLAND	0
HOCKING	0
HOLMES	0
HURON	0
JACKSON	0
JEFFERSON	0
KNOX	0
LAKE	1

County	Inpatient Psych and General Hospital with Psych Units
NOBLE	0
OTTAWA	0
PAULDING	0
PERRY	0
PICKAWAY	0
PIKE	0
PORTAGE	0
PREBLE	0
PUTNAM	0
RICHLAND	1
ROSS	1
SANDUSKY	0
SCIOTO	0

CLINTON	0
COLUMBIANA	0
COSHOCTON	0
CRAWFORD	0
CUYAHOGA	7
DARKE	0
DEFIANCE	0
DELAWARE	0
ERIE	1
FAIRFIELD	0
FAYETTE	0
FRANKLIN	7
FULTON	0
GALLIA	0
GEAUGA	0
GREENE	0
GUERNSEY	0

LAWRENCE	0
LICKING	0
LOGAN	0
LORAIN	0
LUCAS	2
MADISON	0
MAHONING	1
MARION	0
MEDINA	0
MEIGS	0
MERCER	0
MIAMI	0
MONROE	0
MONTGOMERY	3
MORGAN	0
MORROW	0
MUSKINGUM	1

SENECA	0
SHELBY	0
STARK	0
SUMMIT	2
TRUMBULL	2
TUSCARAWAS	0
UNION	0
VANWERT	0
VINTON	0
WARREN	1
WASHINGTON	0
WAYNE	0
WILLIAMS	0
WOOD	0
WYANDOT	0

APPENDIX G – PROGRAM INTEGRITY

1. General

a. The OhioRISE Plan must comply with all applicable state and federal program integrity requirements, including but not limited to those specified in OAC rule 5160-26-06, 42 CFR Part 455, 42 CFR Part 1002, and 42 CFR Part 438 Subpart H.

b. The OhioRISE Plan must comply with and participate in ODM's program integrity initiatives.

2. Compliance Program

a. In accordance with 42 CFR 438.608(a)(1), the OhioRISE Plan must implement and maintain a compliance program.

b. The compliance program must include, at a minimum, all the following elements:

i. Written policies, procedures, and standards of conduct that demonstrate compliance with requirements and standards under this Agreement, and all applicable federal and state requirements;

ii. A designated Chief Compliance Officer who is responsible for developing and implementing policies and procedures designed to ensure compliance with this Agreement. The Chief Compliance Officer must report to the Chief Executive Officer and the Board of Directors;

iii. A Regulatory Compliance Committee, consisting of members of the Board of Directors and senior management, that is responsible for oversight of the OhioRISE Plan's compliance program and its compliance with this Agreement. This committee to meet at least on a quarterly basis, or more frequently as necessary, to ensure reasonable oversight of the compliance program. Meeting minutes must be available to ODM upon request;

iv. A system for training and education for the Chief Compliance Officer, the OhioRISE Plan's senior management, and the OhioRISE Plan's employees regarding the OhioRISE Plan's compliance program and the requirements of this Agreement;

v. Effective lines of communication between the Chief Compliance Officer and the OhioRISE Plan's employees;

vi. Enforcement of standards through well-publicized disciplinary guidelines;

vii. A system of designated staff with established and implemented procedures for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues, investigations of potential compliance problems identified in the course of self-evaluation and audits, prompt and thorough correction of identified compliance problems, and ongoing compliance with the requirements of this Agreement;

viii. Designated staff responsible for administering the plan and clear goals, milestones or objectives, measurements, key dates for achieving identified outcomes, and an

explanation of how the OhioRISE Plan will determine the effectiveness of the compliance plan;

ix. Education of staff, subcontractors, members, and providers about fraud, waste, and abuse and how to report suspected fraud, waste, and abuse to the OhioRISE Plan and ODM;

x. Establishment or modification of internal OhioRISE Plan controls to ensure the proper submission and payment of claims; and

xi. Prompt reporting to ODM of all instances of suspected fraud, waste, and abuse.

c. The OhioRISE Plan must develop an Ohio-specific compliance plan that describes the OhioRISE Plan's compliance program for this Agreement and includes the OhioRISE Plan's monitoring and auditing work plan for the upcoming year. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must submit its compliance plan (Compliance Plan), including annual updates, to ODM for approval.

3. Employee Education about False Claims Recovery

a. Pursuant to 42 CFR 438.608(a)(6), the OhioRISE Plan must provide written policies to all OhioRISE Plan employees, and the employees of any OhioRISE Plan subcontractor or agent, with detailed information about the Federal False Claims Act and other federal and state laws described in Section 1902(a)(68) of the Social Security Act, including the rights of employees to be protected as whistleblowers.

b. The OhioRISE Plan's policies must include the following whistleblower fraud and abuse reporting contacts:

i. Ohio Attorney General's Office Medicaid Fraud Control Unit (MFCU) by phone at 1-800-282-0515 or 614-466-0722 or online at http://www.ohioattorneygeneral.gov/Individuals-and-Families/Victims/Submit-a-Tip/Report-Medicaid-Fraud; and

ii. The Ohio Auditor of State (AOS) by phone at 1-866-FRAUD-OH or by email at fraudohio@ohioauditor.gov.

c. The OhioRISE Plan's policies must include detailed provisions regarding the OhioRISE Plan's policies and procedures for preventing and detecting fraud, waste, and abuse.

d. The OhioRISE Plan's policies must be included in the OhioRISE Plan's employee handbook.

e. The OhioRISE Plan must disseminate its policies to its subcontractors and agents and ensure that its subcontractors and agents abide by these policies.

4. OhioRISE Plan Disclosures

a. In accordance with 42 CFR 438.608, the OhioRISE Plan must disclose to ODM any prohibited affiliations under 42 CFR 438.610.

b. In accordance with 42 CFR 455.104 and OAC rule 5160-1-17.3, the OhioRISE Plan must disclose ownership and control information, including any change in this information.

c. In accordance with 42 CFR 438.602, the OhioRISE Plan must post on its website the name and title of individuals included in 42 CFR 438.604(a)(6).

d. In accordance with 42 CFR 455.105, the OhioRISE Plan must submit within 35 calendar days of the date requested by ODM or the U.S. Department of Health and Human Services full and complete information about:

   i. The ownership of any subcontractor with whom the OhioRISE Plan has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

   ii. Any significant business transactions between the OhioRISE Plan and any wholly owned supplier, or between the provider and any subcontractor, during the five-year period ending on the date of the request.

e. In accordance with 42 CFR 455.106, the OhioRISE Plan must disclose the identity of any person who:

   i. Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and

   ii. Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

5. ODM-Enrolled Providers

a. As specified in Appendix F, Provider Network, the OhioRISE Plan must only contract with and issue payment to providers for service provided when they are enrolled with ODM and are active providers in ODM's system.

b. Except as otherwise allowed by federal law or regulations for single case agreements and emergency services, in accordance with 42 CFR 455.410 and this Agreement, the OhioRISE Plan must ensure that any ordering or referring provider is enrolled with ODM and is an active provider in ODM's provider network management system.

c. In accordance with 42 CFR 438.602, the OhioRISE Plan may execute a temporary 120 calendar day network provider agreement pending the outcome of the ODM screening, enrollment and revalidation process. The OhioRISE Plan must immediately terminate the provider and notify affected members upon notification from ODM that the network provider cannot be enrolled or upon the expiration of one 120 calendar day period without enrollment of the provider in Ohio Medicaid. In this instance, no advance contract termination notice to the provider is required. If a provider applicant does not identify with a provider type that is available on the web application, they must complete the ODM form 10282 and the OhioRISE Plan must submit the ODM form 10282 to ODM for screening and enrollment. The application can be found at: http://www.medicaid.ohio.gov/Provider/EnrollmentandSupport/ProviderEnrollment

d. In accordance with 42 CFR 438.608, the OhioRISE Plan must notify ODM when it receives information about a change in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including when a provider contract is terminated.

e. The OhioRISE Plan must notify ODM when the OhioRISE Plan denies a request for a provider contract from a provider that is active in ODM's provider network management system, including the reason for the denial. The OhioRISE Plan must indicate the reason or reasons for the denial using ODM-specified reasons.

f. Except as otherwise provided in Appendix F, Provider Network, and as described in OAC 5160-26-05, the OhioRISE plan must notify ODM prior to the termination/non-renewal of a network provider contract, whether by the OhioRISE plan of the provider.

   i. The OhioRISE Plan must provide the reason for the termination/non-renewal using ODM specified reasons.

   ii. The OhioRISE Plan must only terminate or decline to renew provider contracts for cause, as defined by ODM.

   iii. The OhioRISE Plan must not suspend, terminate, or decline to renew a provider agreement when the OhioRISE Plan suspects fraud, waste, or abuse until it receives permission from ODM to proceed.

g. Except for emergency services, the OhioRISE Plan must not pay a provider for services provided when the provider has been terminated or suspended by ODM or has been terminated by Medicare, Medicaid, or the Children's Health Insurance Program (CHIP).

h. When ODM notifies the OhioRISE Plan that a provider has been suspended, the OhioRISE Plan must immediately suspend the provider, including any payments to the provider. The OhioRISE Plan must continue to suspend the provider until it receives notice from the ODM to lift the suspension. When ODM notifies the OhioRISE Plan that a provider is no longer suspended, the OhioRISE Plan must lift the suspension and process any suspended claims.

i. The OhioRISE Plan’s network provider contracts must include a provision for the return of episode, quality, or other value-based payments to the OhioRISE Plan when the provider is convicted of fraud and the time period of the fraudulent activity overlaps with the time period that the episode, quality, or other value-based payment is based.

j. The OhioRISE Plan must attempt to recover any payment made to a provider for services provided after the provider is terminated pursuant to the requirements in this appendix.

k. In accordance with 42 CFR 455.436, The OhioRISE Plan must routinely monitor the federal exclusion list for providers that have been excluded from Medicaid.

l. The OhioRISE Plan must routinely monitor The Ohio Suspension and Exclusion List for providers that have been excluded from Medicaid.

6. Data Certification

a. General

   i. In accordance with 42 CFR 438.604 and 42 CFR 438.606, the OhioRISE Plan must certify data, documentation, and information submitted to ODM.

b. Submissions

i. The OhioRISE Plan must submit the appropriate ODM-developed certification concurrently with the submission of the following data, documentation, or information:

1. Care coordination data, as specified in Appendix D, Care Coordination;
2. Health Care Effectiveness Data and Information Set (HEDIS) data and Consumer Assessment of Healthcare Providers (CAHPS) member experience survey data as specified in Appendix I, Quality Measures;
3. Encounter data as specified in Appendix K, Information Systems, Claims, and Data;
4. Prompt pay reports, cost reports, and medical loss ratio data, as specified in Appendix L, Payment and Financial Performance;
5. Data submitted to the Ohio Department of Insurance (ODI) to determine that the OhioRISE Plan has made adequate provisions against the risk of insolvency;
6. Documentation used by ODM to certify that the OhioRISE Plan has complied with ODM's requirements for availability and accessibility of services, including the adequacy of the provider network, as specified in Appendix F, Provider Network;
7. Information on ownership and control as specified in this appendix;
8. Information submitted in the program integrity quarterly inventory report as specified in this appendix; and
9. Any other data, documentation, or information related to the OhioRISE Plan's obligations under this Agreement as specified by ODM.

c. Source, Content, and Timing of Certification

i. The above OhioRISE Plan data submissions must be certified by one of the following:

1. The OhioRISE Plan's Chief Executive Officer (CEO);
2. The OhioRISE Plan's Chief Financial Officer (CFO); or
3. An individual who reports directly to the OhioRISE Plan's CEO or CFO with delegated authority to sign for the CEO or CFO so that the CEO or CFO is ultimately responsible for the certification.

ii. The certification must attest that, based on best information, knowledge, and belief, the data, documentation, and information is accurate, complete, and truthful.

iii. The OhioRISE Plan must submit the certification concurrently with the submission of the applicable data, documentation, or information.

7. Special Investigative Unit

a. The OhioRISE Plan must establish a special investigative unit (SIU). The SIU's responsibilities must include preventing and detecting fraud, waste, and abuse; referring potential fraud, waste, and abuse to ODM; conducting fraud, waste, and abuse investigations; documenting required investigations in Ohio's Incident Management System coordinating with law enforcement; cooperating with ODM and other state and federal authorities; and implementing the OhioRISE Plan's fraud, waste, and abuse plan.

b. The OhioRISE Plan's proposed SIU staffing must comply with the requirements in Appendix A, General Requirements, and must be included in the OhioRISE Plan's Ohio-specific fraud, waste, and abuse plan described in this appendix.

c. The OhioRISE Plan's SIU Lead will hold at least one monthly meeting with ODM and Law Enforcement and attend all Managed Care Program Integrity Group meetings or send a representative.

8. Fraud, Waste, and Abuse Plan

a. The OhioRISE Plan must have a program that includes administrative and management arrangements or procedures to prevent, detect, and report both internal (e.g., OhioRISE Plan staff) and external (e.g., provider, member, subcontractor) fraud, waste, and abuse.

b. The OhioRISE Plan must develop and implement an Ohio-specific fraud, waste, and abuse plan for Ohio Medicaid program that includes a risk-based assessment, designated staff responsible for administering the plan, clear goals, milestones or objectives, key dates for achieving identified outcomes, and an explanation of how the OhioRISE Plan will determine effectiveness of the plan.

c. The fraud, waste, and abuse plan must include but is not limited to the following:

   i. A risk-based assessment that includes the OhioRISE Plan's evaluation of its fraud, waste, and abuse processes and the risk for fraud, waste, and abuse in the provision of services to members;

   ii. An outline of activities proposed by the OhioRISE Plan for the next reporting year based on the results of the risk-based assessment, including the OhioRISE Plan's top five risk areas;

   iii. A description of the OhioRISE Plan's proposed activities related to provider education of federal and state laws and regulations related to Medicaid fraud, waste, and abuse and identifying and educating targeted providers with patterns of incorrect billing practices or overpayments;

   iv. A description of the specific controls in place for prevention and detection of potential or suspected fraud, waste, and abuse, such as:

      1. A description of all pre-payment review activities, including but not limited to pre-payment claims edits and claim reviews;

      2. A list of automated post payment claims edits;

3. A list of claims review algorithms;
4. Frequency and type of desk audits on post payment review of claims;
5. A list of reports of provider profiling used to aid program and payment reviews; and
6. A list of surveillance and utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services.

v. A description of the OhioRISE Plan's activities to prevent and detect fraud, waste, and abuse by providers who are reimbursed using value-based payment models such as incentive payments, shared savings, episode-based payments, and subcapitation;

vi. A description of how the OhioRISE Plan will manually review all claims for providers placed on pre-payment review and how the OhioRISE Plan will identify providers that should be placed on pre-payment review and place them on pre-payment review if deconfliction approved by ODM;

vii. A description of how the OhioRISE Plan will monitor activities on an ongoing basis to prevent and detect activities involving suspected fraud, embezzlement, and theft (e.g., by staff, providers, contractors);

viii. A description of how the OhioRISE Plan will vet every allegation of fraud, waste, or abuse and will investigate every allegation that passes vetting;

ix. A description of how the OhioRISE Plan will track and ensure that at least 3% of total expenditures are subject to a post-payment investigation, including investigations based on an internal (e.g., data mining) or an external referral, over the contract year;

x. A description of how the OhioRISE Plan will identify and correct claims submission and billing activities that are potentially fraudulent, including but not limited to double-billing and improper coding, such as upcoding and unbundling;

xi. A description of how the OhioRISE Plan will use utilization, service denial, appeals, incident reporting, provider complaint, and provider dispute resolution data to detect potential fraud, waste, or abuse;

xii. A description of how the OhioRISE Plan will identify and address overutilization, underutilization, or inappropriate utilization of covered services, including but not limited to review of the OhioRISE Plan's utilization management criteria and processes, service denials, appeals, and utilization data; and

xiii. Work plans and methodology for conducting both announced and unannounced provider site audits for providers identified as high risk by the OhioRISE Plan to ensure services are rendered and billed correctly.

d. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must submit its Fraud, Waste, and Abuse plan to ODM for approval on at least an annual basis.

9. Reporting and Investigating Fraud, Waste, and Abuse

a. General

i. The OhioRISE Plan must promptly report all instances of suspected provider and member fraud, waste, and abuse to ODM.

ii. The OhioRISE Plan must document in their case tracking system, and in the quarterly inventory report, an action or status update at least once every month for each investigation unless it has been sent as a referral to ODM/MFCU. If no new action has occurred in the investigation within the 30-day period, the MCE must document the status of the case and the reason for the lack of actions. If a referral has been sent to ODM/MFCU, then theOhioRISE Plan must update the status every 90 days.

b. Reporting and Retention of Recovery

i. If the OhioRISE Plan identifies and properly reports a case of suspected fraud, waste, or abuse before the suspected fraud, waste, or abuse is identified by state or federal authorities, the OhioRISE Plan may share in any recovery from the reported fraud, waste, or abuse. If the OhioRISE Plan fails to properly report a case of suspected fraud, waste, or abuse before the suspected fraud, waste, or abuse is identified by the state or federal authorities, it may not share in any portion of the recovery from the fraud, waste, or abuse.

c. Reporting Provider Fraud, Waste, or Abuse

i. The OhioRISE Plan must, within one business day of identifying suspected provider fraud, waste, or abuse, submit a referral to ODM using ODM’s Fraud Referral and Coordination system.

ii. ODM will review all fraud, waste, and abuse referrals to determine whether there is a credible allegation of fraud or if the allegation evidences abuse or waste.

iii. ODM will submit all fraud referrals to the MFCU and return the abuse and waste referrals to the OhioRISE Plan for additional investigation and recovery, if appropriate. The OhioRISE Plan must request deconfliction before beginning this investigation or recovery.

iv. ODM will distribute each fraud referral to the OhioRISE Plan.

v. The OhioRISE Plan must respond to all fraud referrals distributed by ODM pursuant to Section 10.c.iv above by submitting the ODM Attestation form to ODM through the Fraud Referral and Coordination system within 60 calendar days. The OhioRISE Plan's failure to file an attestation promptly, completely, and accurately waives the OhioRISE Plan's right to participate in any MFCU recoveries.

d. Reporting Member Fraud or Abuse

i. The OhioRISE Plan must, within one business day of learning of suspected member fraud or abuse, report suspected member fraud and abuse to ODM's Bureau of Program

Integrity (BPI) at Program_Integrity_County_Referral@medicaid.ohio.gov and copy the appropriate county department of job and family services (CDJFS).

e. Coordination with Law Enforcement

i. Stand Down

1. The OhioRISE Plan must stand down upon submission of either a fraud, waste, or abuse referral or a submission of a request for deconfliction. During stand down, the OhioRISE Plan must not take any action related to the referral/request for deconfliction, including but not limited to contacting the subject or any related parties (provider groups, patients, staff, family members, etc.) of the referral or deconfliction request about any matter related to the suspected fraud, waste, or abuse.

ii. Referrals

1. Upon OhioRISE Plan submission of a fraud, waste, or abuse referral to ODM, the OhioRISE Plan must stand down until notified by ODM that the stand down period has ended.

2. The stand down time period will last for the shortest of the following events:

a. ODM determines there is no credible allegation of fraud contained in the referral;

b. MFCU closes its investigation for lack of prosecutorial merit; or

c. An initial period of one year, starting when the referral is received by ODM, has passed; however, this period may be extended once for an additional six months at ODM's discretion.

iii. Deconflictions

1. The OhioRISE Plan must request deconfliction from ODM through ODM's Fraud Referral and Coordination system and stand down until it receives permission from ODM to proceed prior to taking any action that would alert the provider or any related parties (provider groups, patients, staff, family members, etc.) that they are the subject of:

a. Post payment audit, investigation, or review;

b. Recovery (recoupment or withhold) for any reason; with the exception of normal health plan operations including but not limited to retro-terms, configuration errors, rate changes, administrative type or third-party liability adjustments,

c. Prepayment claims review for any reason; with the exception of normal health plan operations, including but not limited to claims payment, utilization management, quality assurance or compliance activities.

Deconfliction for prepayment review requirements apply when the health plan singles out a provider for prepayment review or similar disruption to claims adjudication/payment for an extended period of time, and

d. Involuntary provider terminations for any reason.

2. ODM will either grant the deconfliction request or notify the OhioRISE Plan to stand down.

3. The stand down time period or the time period to conduct approved program activities will be valid for six months.

4. After the six-month period expires, the OhioRISE Plan must submit another deconfliction request.

5. ODM may extend the stand down for an additional six months upon the request of the MFCU and a showing that the extension is warranted. If requested to do so by ODM, the OhioRISE Plan must stand down for an additional six months.

    a. This provision does not apply to federal cases, joint task force cases, or other cases that are not under the MFCU's control. In those cases, the OhioRISE Plan must stand down until the case is closed or completed.

6. Should the OhioRISE Plan be found in violation of any parts of this section, the OhioRISE Plan will be subject to compliance actions outlined in Appendix N, Compliance Actions.

f. Coordinating Provider On-site Audits

    i. The OhioRISE Plan must coordinate on-site provider reviews/audits (announced or unannounced) with ODM and MCOs, and must participate in joint reviews/audits as requested by ODM.

g. ODM Investigation and Recovery

    i. ODM has the right to audit, review, investigate, and recover payment from the OhioRISE Plan's network providers at any time and without notice to the OhioRISE Plan.

10. Recovery of Provider Overpayments

a. Definition of Overpayment

    i. In accordance with 42 CFR 438.2, provider overpayment means any payment made to the provider by the OhioRISE Plan to which the provider is not entitled to under Title XIX of the Social Security Act.

b. General

i. In accordance with 42 CFR 438.608, the OhioRISE Plan must require network providers to report to the OhioRISE Plan when it has received an overpayment, to return the overpayment to the OhioRISE Plan within 60 calendar days after the date on which the overpayment was identified, and to notify the OhioRISE Plan in writing of the reason for the overpayment.

ii. If the MFCU has an open case on a provider, the OhioRISE Plan retains the right to recover any overpayments it identifies arising out of that provider's fraud, waste, or abuse, as defined by OAC rule 5160-26-01, in the following circumstances:

1. The OhioRISE Plan requested deconfliction and received leave to proceed, since there was not a conflict with an active law enforcement investigation; or

2. The date of the deconfliction occurred prior to the date that the MFCU opened its case on the same provider; and

3. The OhioRISE Plan submitted a referral regarding the same provider after completion of its previously approved audit, investigation, or review.

iii. The OhioRISE Plan must not act to recover overpayments if:

1. The overpayments were recovered from the provider by ODM, the state of Ohio, the federal government, or their designees as part of a criminal prosecution where the OhioRISE Plan had no right of participation; or

2. The improperly paid funds are currently being investigated by the state of Ohio, are the subject of pending federal or state litigation or investigation, or are being audited by ODM, the AOS, the Centers for Medicare and Medicaid Services (CMS), the Office of Inspector General (OIG), or their agents; or

3. The overpayments relate to fraud, waste, or abuse, and the OhioRISE Plan has not requested a deconfliction and received leave to proceed.

iv. If the OhioRISE Plan obtains funds in cases where recoupment is prohibited by Section 11.b.iii of this appendix, the OhioRISE Plan must notify ODM and take action in accordance with ODM's instructions, which may include forfeiture of the funds.

v. Absent any restrictions on recovery, the OhioRISE Plan may otherwise recover from a provider any amount collected from the OhioRISE Plan by ODM, the AOS, the federal government, any other regulatory agency, or their designees, relating to an improper payment to such provider by the OhioRISE Plan that resulted from an audit, review, or investigation of the provider. The OhioRISE Plan retains recovery rights to any amount paid to ODM when a provider self-reports an overpayment arising from a payment made by the OhioRISE Plan to the provider or from another reason.

vi. The OhioRISE Plan may recover overpayments made to providers if the overpayment is identified and the provider is notified within two years of the date the OhioRISE Plan improperly paid the provider, within 6 months of the MFCU returning a fraud referral to the OhioRISE Plan, within any applicable statute limitations for fraud, or if ODM recovers an overpayment made by the OhioRISE Plan to a provider directly from the OhioRISE

Plan, whichever is later. The two-year rule of identification and notification of overpayments stated above still applies to:

1. Referrals declined by the clearinghouse; and
2. Referrals declined by the MFCU at intake.

vii. ODM may recover overpayments (either from the OhioRISE Plan or directly from the provider) made by the OhioRISE Plan to a provider under the time limits in ORC section 5164.57.

c. Notice

i. Prior to recovering an overpayment from a provider, the OhioRISE Plan must give the provider a notice of intent to recover due to an overpayment.

ii. The OhioRISE Plan must submit the template for its notice of intent to recover an overpayment to ODM for review prior to use.

iii. Consistent with ORC section 5167.22, the notice must include but is not limited to the following:

1. The patient's name, date of birth, and Medicaid identification number;
2. The date or dates of services rendered;
3. The specific claims that are subject to recovery and the amount subject to recovery, including any interest charges, which may not exceed the amount specified in Ohio law or rule;
4. The specific reasons for making the recovery for each of the claims subject to recovery, including a citation to the applicable statute, rule, or manual section;
5. If the recovery is a result of member disenrollment from the OhioRISE Plan, the OhioRISE Plan must provide the effective date of disenrollment;
6. An explanation that if the provider does not submit a written response to the notice within 30 calendar days from receipt of the notice, the overpayments will be recovered from future claims;
7. How the provider may submit a written response disputing the overpayment; and
8. How the provider may submit a written request for an extended payment arrangement or settlement.

d. Dispute Process

i. The OhioRISE Plan must allow the provider 30 calendar days from receipt of the notice to submit a written response disputing the overpayment and/or requesting an extended payment arrangement or settlement. If the provider fails to submit a written response

within the time period provided, the OhioRISE Plan may execute the recovery as specified in the notice.

ii. Upon receipt of a written response disputing the overpayment, the OhioRISE Plan must, within 30 calendar days from the date the written response is received, consider the response, including any pertinent additional information submitted by the provider, together with any other material bearing upon the matter, and determine whether the facts justify recovery.

iii. The OhioRISE Plan must provide a written notice of determination that includes the rationale for the determination. If the OhioRISE Plan determines the facts justify the recovery, the OhioRISE Plan may execute the recovery within three business days of sending the notice of determination.

iv. The OhioRISE Plan must submit the template for its notice of determination to ODM for review and approval prior to use.

e. Extended Payment or Settlement

i. Upon receipt of a written response requesting an extended payment arrangement or settlement, the OhioRISE Plan must, within 30 calendar days from the date the written response is received, consider the response, including any pertinent additional information submitted by the provider, and determine whether to allow an extended payment arrangement or enter into settlement discussions. The OhioRISE Plan must provide a written notice of determination and, as applicable, the proposed extended payment arrangement or settlement terms.

1. The OhioRISE Plan must not settle for less than amount specified in the notice of intent to recover unless there is the inability to collect.

2. The OhioRISE Plan must submit any extended payment arrangement or settlement terms to ODM for prior approval.

3. The OhioRISE Plan must finalize any extended payment arrangement or settlement terms approved by ODM within 120 calendar days of sending the initial notice of intent to recover.

4. If the OhioRISE Plan settles for less than the amount specified in the notice of intent to recover, the OhioRISE Plan must report to ODM the amount specified in the notice and the settlement amount in the quarterly inventory report.

5. The provider can propose a new settlement, and negotiate with the OhioRISE Plan, or the OhioRISE Plan may move forward with reconsideration or collection of the overpayment. ODM may rejects a proposed settlement by the provider for an incomplete submission, including failure to provide documentation of income and expenses if requesting a reduction in principal, or failing to provide a reasonable basis for agreeing to the extended payment terms or reduction in amount owed.

6. The OhioRISE Plan should allow the provider to request reconsideration while the parties are negotiating the settlement/waiting for ODM approval, and the

OhioRISE Plan may toll its 30 days to respond to the reconsideration request until after ODM responds to the settlement approval request.

f. Accounting

i. The OhioRISE Plan must maintain a detailed accounting of identified overpayments by provider and track recoveries, with the ability to report to ODM at any time the status of recovery for individual or cumulative recoveries.

g. Claims Adjustment

i. The OhioRISE Plan must void or adjust (as applicable) all claims to reflect any identified provider overpayments, regardless of whether they have been recovered. This provision does not apply to recoveries due to settlement or statistical sampling of claims and extrapolation where identification of individual claims is impossible.

h. ODM Recovery of Provider Overpayments Identified by ODM

i. If ODM identifies a provider overpayment, ODM will notify the OhioRISE Plan if its intent to recover the overpayment from the OhioRISE Planor from the provider.

1. If ODM recovers directly from the provider, the recovery will be effectuated as a remittance by the provider or a claims payment offset. ODM will retain the overpayment collected. The OhioRISE Plan will be precluded from adjudicating an audit or taking any other collection action related to the overpayment discovered and recovered by ODM directly from the provider.

2. If ODM recovers directly from the OhioRISE Plan, the recovery will be effectuated as a remittance by theOhioRISE Plan, or a capitation payment offset. The OhioRISE Plan may recover the overpayment from the provider.

ii. In accordance with 42 CFR 438.608, provisions regarding treatment of recoveries of provider overpayments made by the OhioRISE Plan do not apply to any amount of a recovery to be retained under the federal False Claims Act cases or through other investigations.

i. Program Integrity Provider Audits and Compliance Review Findings

i. Within ODM's Bureau of Program Integrity, the Provider Audits and Compliance Review (PACR) section evaluates Medicaid providers who are either new participants to Ohio Medicaid or whose billing practices have identified them as potential outliers. The PACR section will communicate to the OhioRISE Plan the provider billing errors identified during the post payment review of the identified provider.
When these billing errors are identified:

1. ODM will notify the provider and allow 60 days for the provider to submit claim adjustments to the OhioRISE Plan.

2. If the provider has not adjusted the identified claims within 90 days of the provider notification, the OhioRISE Plan should contact ODM at

PACRProgramIntegrity@medicaid.ohio.gov for a determination if ODM or the OhioRISE Plan will recover the overpayment.

3. Regardless of ODM or OhioRISE Plan recoupment, the OhioRISE Plan must ensure the identified billing errors are corrected as described in paragraph g of this provider agreement

4. Identified overpayments and recoupment information shall be included in the program integrity quarterly inventory report

ii. If the PACR identifies a provider as high-risk for potential fraud, waste and abuse, ODM will notify the OhioRISE Plan and the OhioRISE Plan must complete a review. Within six months of notification, the OhioRISE Plan must provide its review findings to PACRProgramIntegrity@medicaid.ohio.gov. This review, along with any overpayment identified and recouped, and any provider education provided, must be included in the quarterly inventory report.

11. Recovery of OhioRISE Plan Overpayments

a. In accordance with 42 CFR 438.2, OhioRISE Plan overpayment means any payment made to the OhioRISE Plan by the state of Ohio to which the OhioRISE Plan is not entitled to under Title XIX of the Social Security Act. OhioRISE Plan overpayments include but are not limited to capitation payments made for members who are retroactively disenrolled.

b. In accordance with 42 CFR 438.608, the OhioRISE Plan must report any OhioRISE Plan overpayments to ODM within 60 calendar days of identifying the overpayment.

c. ODM may recover overpayments made to the OhioRISE Plan under the time limits in ORC section 5164.57.

d. ODM will recover OhioRISE Plan overpayments. Recovery will, at ODM's discretion, be effectuated as a remittance by the OhioRISE Plan or a reduction to future capitation payments.

e. The OhioRISE Plan may recover payments made to a provider for services rendered to a member who was retroactively disenrolled from the OhioRISE Plan in accordance with the following.

i. The OhioRISE Plan must initiate such recovery within 30 calendar days of notice of the capitation recovery.

ii. If the recovery is for payments made more than two years from the date of payment of the provider, the OhioRISE Plan must notify ODM and receive permission to proceed with the recovery.

iii. The OhioRISE Plan's recovery process must comply with the requirements for recovery of overpayments as described in this appendix. In addition, the OhioRISE Plan must notify the provider of the option to submit a claim to ODM for services rendered to a member who was retroactively disenrolled from the OhioRISE Plan.

iv. The OhioRISE Plan must not recover payments from a provider beyond two years from the date of payment of the claim due to a member's retroactive disenrollment from the OhioRISE Plan, unless the OhioRISE Plan is directed to do so by CMS or ODM.

12. Cooperation with State and Federal Authorities

a. The OhioRISE Plan must cooperate fully and promptly with state and federal authorities, including but not limited to ODM, the Ohio Attorney General, the OAS, law enforcement, and the U. S. Department of Health and Human Services.

b. The OhioRISE Plan must maintain confidentiality of any information shared at SIU Lead meetings or other meetings involving Medicaid Fraud Control Unit of the Ohio Attorney General's Office. The OhioRISE Plan may not share information provided concerning law enforcement investigations or associated matters beyond the participants in the meeting.

c. The OhioRISE Plan must respond to requests from state or federal authorities within one business day of such request.

d. At the request of a state or federal authority, the OhioRISE Plan must produce copies of all OhioRISE Plan fraud, waste, and abuse investigatory files and data (including but not limited to records of member and provider interviews) in the manner and format requested at no charge to the requestor. Unless otherwise specified in the request, the OhioRISE Plan must provide this information within 30 calendar days of the request.

e. The OhioRISE Plan must provide all other data, documentation, and other information requested by state or federal authorities, in the manner and format requested at no charge to the requestor. Unless otherwise specified in the request, the OhioRISE Plan must provide the requested data, documentation, or other information within 30 calendar days of the request.

f. The OhioRISE Plan must cooperate fully in any investigation or prosecution by any state or federal authority, whether administrative, civil, or criminal at no charge to the requestor. This includes but is not limited to:

    i. Actively participating in meetings;

    ii. Providing requested information and access to requested records;

    iii. Providing access to interview OhioRISE Plan employees, subcontractors, and consultants; and

    iv. Providing qualified individuals to testify at or be a witness at any hearings, trials, or other judicial or administrative proceedings.

g. The OhioRISE Plan must maintain confidentiality of law enforcement discussions and information provided at SIU Lead meetings.

h. Upon request, the OhioRISE Plan must make available to state and federal authorities any and all administrative, financial, and medical data, documentation, and other information relating to the delivery of items or services under this Agreement. The OhioRISE Plan must provide such data, documentation, and other information at no cost to the requesting entity. The OhioRISE Plan must inform ODM before providing Ohio Medicaid related information to state and federal authorities.

13. Additional Reporting Requirements

a. Pursuant to OAC rule 5160-26-06 and as specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must submit an annual fraud, waste, and abuse report (Fraud, Waste, and Abuse Report) to ODM that summarizes the OhioRISE Plan's fraud, waste, and abuse activities for the year and identifies any proposed changes for the coming year. This report must include the information specified by ODM, including but not limited to the OhioRISE Plan's prevention actions; referrals, reviews, and recoveries; provider terminations; and meeting attendance.

b. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must provide to ODM a quarterly "inventory" report on fraud, waste, and abuse activities (the Fraud, Waste, and Abuse Inventory Report). The report must include the information specified by ODM, including but not limited to tips received; investigations and audits started; provider referrals; overpayments identified; overpayments recovered; program integrity actions taken against providers; denied network applications; member fraud referrals; cost avoidance as a result of pre-payment review activities; and planned fraud, waste, and abuse activities for the upcoming quarter.

c. The OhioRISE Plan must regularly communicate with ODM about the OhioRISE Plan's program integrity work through the OhioRISE Plan's annual and quarterly reports, regular meetings, and, as needed, additional communications. The OhioRISE Plan must adjust its program integrity work based on ODM's directions and feedback following ODM's review of the annual and quarterly reports, meetings, or otherwise.

APPENDIX H – VALUE-BASED PAYMENT

1. Value-Based Payment

a. The OhioRISE Plan must design and implement value-based care and payment reform initiatives to drive the transformation of the health care delivery system to improve individual and population health outcomes, improve member experience, and contain the cost of health care through the reward of innovation and results over volume of services provided.

b. The OhioRISE Plan's value-based payment efforts must include the following:

i. Value-Oriented Payment

1. The OhioRISE Plan must design and implement payment methodologies with its network providers to enhance population health and wellness outcomes for its members in alignment with ODM's population health strategy by improving all of the following:

a. Delivery of effective and efficient health care;

b. Opportunities for practice transformation and new flexibilities for network providers; and

c. Value for the Medicaid program.

2. For the purposes of this Agreement, payments that promote the "delivery of effective and efficient health care by their design" reduce unnecessary payment and unnecessary care (e.g., unnecessary non-emergent use of hospital emergency departments due to behavioral health conditions), shift utilization to more evidence-based practices for children, reduce the use of out-of-state placements, and reduce inpatient or PRTF days.

a. The OhioRISE Plan must provide feedback to network providers on their performance. The OhioRISE Plan must propose a list of key performance indicators (KPIs), (e.g., out-of-home placements and out-of-state placements), for each provider type to ODM for approval. The OhioRISE Plan must send the approved list of KPIs to network providers as feedback no less frequently than semi-annually.

b. The OhioRISE Plan must support providers in understanding how to use the KPIs to improve performance on a path towards value-based contracting.

3. For the purposes of this Agreement, "opportunities for practice transformation and added flexibilities for network providers" involve the use of financial incentives, including risk arrangements that can help providers improve outcomes and reduce costs in sustainable ways.

4. For purposes of this Agreement, "value for the Medicaid program" means the level of the quality of care in return for the amount of payment to an individual provider or a network of providers. Payments designed to reflect value are

those tied to provider performance or efficiency; payments may rise or fall in a predetermined fashion commensurate with the level of performance assessed against standard quality measures.

ii. Transparency

1. The OhioRISE Plan must participate in ODM initiatives to design and implement member-accessible comparisons of provider information, including quality, cost, and member experience among providers.

2. The OhioRISE Plan must contribute to the design of ODM initiatives, provide data as specified by ODM, and publish results in accordance with standards established by ODM.

iii. Provider Partnerships

1. The OhioRISE Plan must encourage provider participation in value-based payment initiatives, and partner with providers to support the success of these initiatives. Provider partnership includes but is not limited to:

    a. Supporting provider-led innovation by:

        i. Working directly with providers to develop and implement value-based purchasing pilots, and

        ii. Soliciting new value-based payment initiative and implementation ideas from the Provider Advisory Council.

        iii. Sponsoring provider cultural transformation and workforce development;

        iv. Developing APM funding arrangements to retain and train providers, especially related to certification to advance their technical skills; and

        v. Building capacity for value-based arrangements in underserved and at-risk regions.

    b. Supporting provider readiness (e.g., data and analytic capabilities, financial stability);

    c. Recognizing that the OhioRISE Plan's payment reform strategies (i.e., Health Care Payment Learning Action Network's Alternative Payment Model Framework) must be tailored to different provider types (e.g., care management entities [CMEs], Mobile Response and Stabilization Services [MRSS], in home behavioral therapy providers) and for different provider characteristics (e.g., small providers, rural providers, hospital systems);

    d. Assisting providers to identify and address barriers; and

e. Encouraging member utilization of providers that demonstrate value and quality.

iv. Payer Partnerships

1. The OhioRISE Plan may initiate, or ODM may require, value-based payment initiatives in coordination with ODM, the MCOs, or the single pharmacy benefit manager (SPBM) for special projects or pilot programs that depend on participation across ODM-contracted managed care entities. OhioRISE Plan-initiated value-based payment initiatives that involve the MCOs or the SPBM require prior approval by ODM.

v. OhioRISE Plan Strategy for APM Requirements

1. The OhioRISE Plan must develop a written APM strategy to meet value-based payment requirements and APM targets as outlined in this agreement and submit the strategy to ODM as specified in Appendix P, Chart of Deliverables.

a. The OhioRISE Plan's strategy must include but are not limited to the following:

i. Paying providers differentially according to performance (and reinforcing with benefit design);

ii. Designing approaches to payment that maintain or improve quality and/or reduce waste;

iii. Designing payments to encourage adherence to clinical guidelines;

iv. Developing payment strategies to reduce unwarranted price variation, such as reference or value pricing (e.g., analyzing price variation among network providers by procedure and service types, piloting value pricing programs, promoting center of excellence pricing, and rebalancing payment between primary and specialty care).

2. Alternative Payment Methodology Targets

a. ODM may impose alternative payment methodology (APM) targets in future years of this Agreement at its sole discretion. Targets may be based on a percentage of overall expenditures by provider type (e.g., 30% of spending on outpatient claims must be tied to an APM).

b. ODM will notify the OhioRISE Plan at least six months prior to the implementation of any APM targets to allow the OhioRISE Plan to change needed provider agreements.

3. Reporting

a. The OhioRISE Plan must submit a *Value-Based Payment Progress Report* annually that addresses the OhioRISE Plan's progress towards meeting the requirements for value-based payment and APM targets outlined above. The OhioRISE Plan must use the ODM-provided template and

submit the report as specified in Appendix P, Chart of Deliverables. Reporting elements for each *Value-Based Payment Progress Report* include:

i. Description of the OhioRISE Plan's value-based payment strategy;

ii. Summary of the OhioRISE Plan's performance regarding reaching objectives of the OhioRISE Plan's value-based payment strategy

iii. An effectiveness evaluation of all APMs submitted as part of the Value-Based Progress Report; Insights learned to inform future value-based activities;

iv. Changes to the OhioRISE Plan's value-based payment strategy based on insights learned.

v. Type and size of providers and provider networks;

vi. Type of value-based payment arrangement as specified by the Health Care Payment Learning and Action Network framework (e.g., 3A or 3B);

vii. Sum of total medical spend; and

viii. Sum of total net payments.

b. Beginning 1/1/2026, the OhioRISE Plan must submit the Value-based Payment Data Set quarterly to ODM in accordance with *The Ohio Department of Medicaid's Alternative Payment Model (APM) Measure Methodology*.

b. General

i. The OhioRISE Plan must implement the value-based initiatives as required in this section of this appendix as directed by ODM.

c. Care Coordination Payments

i. The OhioRISE Plan must pay CME providers no less than the rates specified in the Medicaid state plan for at least the first two years of the term of this Agreement for Tier 3 – Intensive Care Coordination and Tier 2 – Moderate Care Coordination, unless otherwise approved by ODM. ODM may, at its sole discretion, choose to extend this requirement into future contracting years.

ii. The OhioRISE Plan is encouraged to immediately pursue value-based payment arrangements with CMEs. Within the first three years of the term of this Agreement, value-based payment arrangements for CMEs that differ from the Medicaid state plan payment rates must be approved by ODM prior to implementation.

iii. For value-based arrangements with CMEs beginning July 1, 2024 and later, structural, process, and outcome measures tied to value-based payment for CME providers must include:

1. Key metrics assessed using the National Wraparound Initiative and Ohio-specific ICC and MCC standards, a core set of which should be selected in partnership with the COE and for use in all CME value-based arrangements

2. Timeliness in delivering ICC and MCC services, consistent with standards defined in the OhioRISE CME Manual;

3. Reduction in length of stay related to both PRTF and inpatient hospital stays;

4. Reduction in PRTF and inpatient hospital psychiatric and SUD readmissions;

5. Increases in use of community-based and in-home care for the CME's assigned members; some measures may include but are not limited to:

    i. The amount of community-based services that are delivered to members, consistent with the scope, amount, and duration identified in the members' CFCPs;

    ii. The percentage of assigned members' CFCPs that include at least 50% of services categorized as natural supports; and

    iii. The percentage of members and their families that report a greater ability to manage their (or their child's / youth's) behavioral health needs in their home and community environments.

6. Improvement in functional outcomes identified from an evidence-based functional assessment.

d. Intensive Home-Based Treatment

    i. The OhioRISE Plan must pay Intensive Home-Based Treatment (IHBT) providers no less than the rates specified in the Medicaid state plan for at least the first two years of the contract term for these services, unless otherwise approved by ODM. ODM may, at its sole discretion, choose to extend this requirement into future contracting years.

    ii. The OhioRISE Plan is encouraged to pursue value-based payment arrangements with IHBT Providers. Within the first three years of the contract term, value-based payment arrangements and associated outcome measures for IHBT providers that differ from the Medicaid state plan payment rates must be approved by ODM prior to implementation. Outcome measures for IHBT value-based payment must support OhioRISE program goals.

APPENDIX I – QUALITY MEASURES

1. General

a. ODM uses the quality measures and standards shown in Table I.1 of this appendix to evaluate OhioRISE Plan performance in key program areas (e.g., access, clinical quality, member satisfaction). The selected measures align with specific priorities, goals, and focus areas of the ODM Quality Strategy.

b. The measures utilized for performance evaluation include measures in national measurement sets (e.g., HEDIS, CAHPS, Agency for Healthcare Research and Quality [AHRQ]), widely used for evaluation of Medicaid and/or managed care. Other measures utilized for OhioRISE Plan performance evaluation derive from national Systems of Care implementation in Medicaid, and Medicaid managed care, in other jurisdictions. For these measures, the OhioRISE Plan must report valid and reliable results in accordance with associated measure specifications as applicable.

c. As part of ODM's Quality Strategy, the OhioRISE Plan must collaborate with the MCOs to improve performance measure results on all applicable physical and behavioral health measures for OhioRISE members. The OhioRISE Plan must share data with MCOs and ODM as needed to achieve ODM targets for the MCO performance measures.

d. The OhioRISE Plan must collaborate with MCOs regarding Care Management Entities' (CME) activities related to the applicable measures specified in Table I.1 to support members and promote their overall health (e.g., well child and adolescent visits, dental visits, immunization status). The MCO/OhioRISE Plan Model Agreement (referenced in Appendix A, General Requirements) executed with each MCO will establish a process for the MCOs to provide information regarding the measures in Table I.1 to the OhioRISE Plan for their members, as applicable.

e. OhioRISE Plan performance measures and any established minimum performance standards are subject to ODM change based on the revision or update of applicable national measures, methods, benchmarks, or other factors as determined by ODM.

f. MCO performance measures, any established standards, and the responsibilities of the OhioRISE Plan to collaborate with ODM and the MCOs on MCO performance measures are subject to change by ODM based on the revision or update of applicable national measures, methods, benchmarks, or other factors as determined by ODM.

g. The establishment of quality measures and standards in this appendix does not limit ODM's evaluation and compliance assessments of other indicators of OhioRISE Plan performance under this Agreement.

h. ODM will assess and report OhioRISE Plan performance on multiple measures to the OhioRISE Plan and others, including Medicaid members.

2. OhioRISE Plan Quality Measures (Table I.1)

a. ODM will evaluate the OhioRISE Plan on each measure in Table I.1 using statewide results unless otherwise specified.

b. ODM will use performance measure results to assess the quality of care provided by the OhioRISE Plan to the enrolled population and ODM may use OhioRISE Plan results for federal reporting and ODM public reporting purposes (e.g., OhioRISE Program report card).

c. The OhioRISE Plan must submit aggregated and member-level self-reported and audited data to ODM as described in this appendix.

d. All measures in Table I.1 will be reported in accordance with the methodology and time period defined for each measure.

e. Minimum performance standards (MSP), incentives, and withholds may be established at the discretion of ODM for any Table I.1 measure. ODM will actively seek opportunities to incentivize the OhioRISE Plan for its performance in areas that demonstrate access to and appropriate use of community-based behavioral health services.

f. The methodology for non-HEDIS and CAHPS Experience of Care and Health Oucomes (ECHO) survey measures is posted on the ODM website. The HEDIS measures in Table I.1 are reported in accordance with *National Committee for Quality Assurance's (NCQA) Volume 2: Technical Specifications. The CAHPS ECHO survey results are reported in accordance with the OhioRISE Population CAHPS Experience of Care and Health Outcomes Survey Administration and Data Submission Specifications.*

g. For the applicable measures specified in Table I.1 (indicated by footnote [1]), the OhioRISE Plan must provide guidance to the CMEs regarding strategies for enhancing performance on these measures for OhioRISE Plan members. The OhioRISE Plan agreements with the contracted CMEs must specifically reference the applicable measures in Table I.1 (by measurement year). The OhioRISE plan will report results relative to the minimum performance standards for the applicable measures to CMEs by CME catchment area.

h. The OhioRISE Plan and MCO must develop strategies to share data and reports that allow the OhioRISE Plan to develop and oversee CME performance for the applicable measures in Table I.1.

3. OhioRISE 1915(c) Waiver Performance Measures (Table I.2)

a. ODM must submit evidence to CMS regarding the State's ability to adhere to the six federal waiver assurances for operating a 1915(c) waiver annually. The six assurances include level of care, service planning, qualified providers, health and welfare, financial accountability, and administrative authority. CMS has established a minimum threshold of 86% per measure. If the threshold is not achieved, ODM is subject to a CMS-issued corrective action plan.

b. The OhioRISE Plan must achieve a minimum performance standard of 86% for each measure to align with federal requirements. Failure to meet the minimum performance standard may result in the assessment of sanctions as specified in Appendix N, Compliance Actions.

   i. Measure: Percentage calculated for each OhioRISE1915(c) waiver performance measure.

   ii. Measurement Periods: Beginning in SFY 2023, and then each fiscal year thereafter, the measurement period for each measure specified in Table I.2 below will the previous fiscal year.

iii. Minimum Performance Standard: 86%.

Table I.1. OhioRISE Plan Measures. Measurement Years 2022, 2023, 2024, 2025, and 2026 Performance Measures, Measurements Sets, and Measurement Time Periods

Measure	Measurement Set	MY 2023 Minimum Perf. Std.	MY 2023 Measurement Year	MY 2024 Minimum Perf. Std.	MY 2024 Measurement Year	MY 2025 Minimum Perf. Std.	MY 2025 Measurement Year	MY 2026 Minimum Perf. Std.	MY 2026 Measurement Year
Rate of Out-of-Home Placement: Rate of children in out-of-home placement per 1,000 eligible beneficiaries for each quarter of the measurement year (MY) and annual Methodology: # of enrolled children with a claim for an out-of- home placement X/total # of eligible beneficiaries * 1,000	Steward: ODM Source: JFS/SACWIS data, ODM enrollment Reported by: ODM	Reporting Only	Quarterly 2023 Annual 2023	Reporting Only (Quarterly) Reporting Only (Annual)	Quarterly 2024 Annual 2024	Reporting Only (Quarterly) Reporting Only (Annual)	Quarterly 2025 Annual 2025	Reporting Only (Quarterly) Reporting Only (Annual)	Quarterly 2026 Annual 2026
Rate of Out-of-State Residential Placements Methodology: Year One (first complete measurement year): Rate of children in out-of-state placement per 1,000 eligible beneficiaries for each quarter of the measurement year (MY) and annual. Year 2 ODM will develop the specifications for this measure from baseline data collected in Year	Steward: ODM Source: JFS/SACWIS data, ODM enrollment Reported by: ODM	Reporting Only	Quarterly 2023 Annual 2023	Reporting Only (Quarterly) Reporting Only (Annual)	Quarterly 2024 Annual 2024	Reporting Only (Quarterly) Reporting Only (Annual)	Quarterly 2025 Annual 2025	Reporting Only (Quarterly) Reporting Only (Annual)	Quarterly 2026 Annual 2026
Length of Stay (LOS) for Behavioral Health (BH) Inpatient Hospitals: Average LOS for BH Inpatient Hospital stays for each quarter of the MY and annual Methodology: Total # of days covered for BH inpatient stays/# of BH inpatient stays with an end date in the measurement period	Steward: ODM Source: Claims Reported by: ODM	Reporting Only	Quarterly 2023 Annual 2023	Reporting Only (Quarterly) Reporting Only (Annual)	Quarterly 2024 Annual 2024	Reporting Only (Quarterly) Reporting Only (Annual)	Quarterly 2025 Annual 2025	Reporting Only (Quarterly) Reporting Only (Annual)	Quarterly 2026 Annual 2026

Measure	Measurement Set	MY 2023 Minimum Perf. Std.	MY 2023 Measurement Year	MY 2024 Minimum Perf. Std.	MY 2024 Measurement Year	MY 2025 Minimum Perf. Std.	MY 2025 Measurement Year	MY 2026 Minimum Perf. Std.	MY 2026 Measurement Year
LOS for Psychiatric Residential Treatment Facility (PRTF): Average LOS for PRTF stays for each quarter of the MY and annual Methodology: Total number of days covered for PRTF stays /# of PRTF stays with an end date in the measurement period	Steward: ODM Source: Claims Reported by: ODM	Reporting Only	Quarterly 2023 Annual 2023	Reporting Only (Quarterly) Reporting Only (Annual)	Quarterly 2024 Annual 2024	Reporting Only (Quarterly) Reporting Only(Annual)	Quarterly 2025 Annual 2025	Reporting Only (Quarterly) Reporting Only(Annual)	Quarterly 2026 Annual 2026
Emergency Department (ED) Utilization: Rate of children with a claim for an ED encounter for BH related issue per 1,000 eligible beneficiaries for each quarter of the MY and annual Methodology: # of enrolled children with a claim for an ED encounter for BH/# of enrolled beneficiaries * 1,000	ODM Source: Claims Reported by: ODM	Reporting Only	Quarterly 2023 Annual 2023	Reporting Only (Quarterly) Reporting Only(Annual)	Quarterly 2024 Annual 2024	Reporting Only (Quarterly) Reporting Only (Annual)	Quarterly 2025 Annual 2025	Reporting Only (Quarterly) Reporting Only (Annual)	Quarterly 2026 Annual 2026
Antipsychotic Medications: Rate of children on 2 or more antipsychotics per 1,000 eligible beneficiaries stratified by age for each quarter of the MY and annual Methodology: # of enrolled children on 2 or more antipsychotics/# of eligible beneficiaries * 1,000 Ages 0 – 6, 7 – 12, 13 – 17, 18 – 21	Steward: ODM Source: SPBM/Claims Reported by: ODM	Reporting Only	Quarterly 2023 Annual 2023	Reporting Only (Quarterly) Reporting Only (Annual)	Quarterly 2024 Annual 2024	Reporting Only (Quarterly) Reporting Only (Annual)	Quarterly 2025 Annual 2025	Reporting Only (Quarterly) Reporting Only (Annual)	Quarterly 2026 Annual 2026
Follow-Up After Hospitalization for Mental Illness	Steward: NCQA / HEDIS Reported by: OhioRISE Plan	7-Day Follow-up: Ages 6 – 17, Ages 18-64, Reporting Only	MY 2023	7-Day Follow-up: Ages 6 – 17, Ages 18-64 Reporting Only	MY 2024	7-Day Follow-up: Ages 6 – 17 Reporting Only Ages 18-64 Reporting Only	MY 2025	7-Day Follow-up: Ages 6 – 17 Reporting Only Ages 18-64 Reporting Only	MY 2026

Measure	Measurement Set	MY 2023 Minimum Perf. Std.	MY 2023 Measurement Year	MY 2024 Minimum Perf. Std.	MY 2024 Measurement Year	MY 2025 Minimum Perf. Std.	MY 2025 Measurement Year	MY 2026 Minimum Perf. Std.	MY 2026 Measurement Year
Follow-Up After ED Visit for Mental Illness	Steward: NCQA / HEDIS Reported by: OhioRISE Plan	7-Day Follow-up: Ages 6 – 17, Ages 18-64, Reporting Only	MY 2023	7-Day Follow-up: Ages 6 – 17, Ages 18-64, Reporting Only	MY 2024	7-Day Follow-up: Ages 6 – 17 & Ages 18 -64 Reporting Only	MY 2025	7-Day Follow-up: Ages 6 – 17 and Ages 18 - 64 Reporting Only	MY 2026
		30-Day Follow-up: Ages 6 – 17, Ages 18-64, Reporting Only		30-Day Follow-up: Ages 6 – 17, Ages 18-64 Reporting Only		30-Day Follow-up: Ages 6 – 17 Reporting Only Ages 18-64 Reporting Only		30-Day Follow-up: Ages 6 – 17 Reporting Only Ages 18-64 Reporting Only	
General Child Rating of Health Plan (CAHPS Health Plan Survey)	Steward: NCQA/ HEDIS/ CAHPS Reported by: OhioRISE Plan	Reporting Only	MY 2023 (Survey conducted in CY 2024)	Reporting Only	MY 2024 (Survey conducted in CY 2025)	N/A	N/A	N/A	N/A
Overall rating of the health plan (CAHPS ECHO MCO Survey)	Steward: CAHPS Reported by: OhioRISE Plan					Reporting Only	MY 2025 (Survey conducted in CY 2026)	Reporting Only	MY 2026 (Survey conducted in CY 2027)
Satisfaction: Satisfaction Survey of OhioRISE Plan providers[2]	Steward: ODM or designee Data Source: ODM or designee Reported By: ODM or designee	Reporting Only	Annual	MPS TBD	Annual	Reporting Only	Annual		
Initiation and Engagement of Substance Use Disorder Treatment	Data Steward: NCQA/ HEDIS Reported by: OhioRISE Plan	Initiation Total Reporting Only	MY 2023	Initiation Total (Ages 13-17) Reporting Only	MY 2024	Initiation Total (Ages 13-17MPS ≥ 55.68%	MY 2025	Initiation Total (Ages 13-17 MPS ≥ 55.94%	MY 2026

Measure	Measurement Set	MY 2023 Minimum Perf. Std.	MY 2023 Measurement Year	MY 2024 Minimum Perf. Std.	MY 2024 Measurement Year	MY 2025 Minimum Perf. Std.	MY 2025 Measurement Year	MY 2026 Minimum Perf. Std.	MY 2026 Measurement Year
		Engagement Ages 13-17, Ages 18 - 64 Reporting Only		Engagement Ages 13 - 17, Ages 18 – 64 Reporting Only		Engagement Ages 13 - 17 MPS ≥ 16.67% Ages 18 – 64 MPS ≥ 30.31%		Engage-ment Ages 13 - 17 MPS ≥ 20.00% Ages 18 – 64 MPS ≥ 20.32%	
Antidepressant Medication Management — Effective Acute Phase Treatment, Effective Continuation Phase Treatment	Data Steward: NCQA/ HEDIS Reported by: OhioRISE Plan	Acute Phase Engagement Ages 17 and younger, Ages 18 and older Reporting Only	MY 2023	Acute Phase Engagement Ages 17 and younger, Ages 18 – and older Reporting ONly Reporting Only	MY 2024	N/A	MY 2025	N/A	N/A
		Continuation Phase Engagement Ages 17 and younger, Ages 18 and older Reporting Only		Continuation Phase Engagement Ages 17 and younger, Ages 18 – and older Reporting Only Reporting Only		N/A			
Follow-up After Emergency Department Visit for Substance Use	Data Steward: NCQA/ HEDIS Reported by: OhioRISE Plan	30-Day Follow-Up Ages 13-17, Ages 18 and older, Total Reporting Only	MY 2023	30-Day Follow-Up Ages 13 - 17, Ages 18 and older Total Reporting Only	MY 2024	30-Day Follow-Up Ages 13 - 17 Reporting Only Ages 18 and older Reporting Only Total Reporting Only 7-Day Follow-Up Ages 13-17 Reporting Only	MY 2025	30-Day Follow-Up Ages 13 - 17 Reporting Only Ages 18-64 Reporting Only Total Reporting Only 7-Day Follow-Up Ages 13-17 Reporting Only	MY 2026

Measure	Measurement Set	MY 2023 Minimum Perf. Std.	MY 2023 Measurement Year	MY 2024 Minimum Perf. Std.	MY 2024 Measurement Year	MY 2025 Minimum Perf. Std.	MY 2025 Measurement Year	MY 2026 Minimum Perf. Std.	MY 2026 Measurement Year
						7-Day Follow-Up Ages 18-64 Reporting Only		7-Day Follow-Up Ages 18-64 Reporting Only	
1 - 7 Day Follow-up Visit After ED Encounter for Substance Use, Ages 10 - 17[HE]	Data Steward: ODM	N/A	N/A	N/A	N/A	Overall (All Children) Reporting Only Population-specific (Black Children) Reporting Only	MY 2025	All Children ≥ 62.90% SAG	MY 2026
1 - 7 Day Follow-up Visit After ED Encounter for Mental Illness, Ages 17 and Younger[HE]	Data Steward: ODM	N/A	N/A	N/A	N/A	Overall (All Children) Reporting Only Population-specific (Black Children) Reporting Only	MY 2025	All Children ≥ 74.02% SAG	MY 2026
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics, Total	Steward: NCQA/ HEDIS Reported by: OhioRISE Plan	Reporting Only	MY 2023	Reporting Only	MY 2024	Reporting Only	MY 2025	Reporting Only	MY 2026
Metabolic Monitoring for Children and Adolescents on Antipsychotics[E]	Steward: NCQA/ HEDIS Reported by: OhioRISE Plan	Reporting Only	MY 2023	Reporting Only	MY 2024	Blood Glucose & Cholesterol Testing MPS ≥ 23.33%	MY 2025	Blood Glucose & Cholesterol Testing MPS ≥ 41.52%	MY 2026
Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication — Initiation Phase & Continuation and Management Phase[E]	Steward: NCQA/ HEDIS Reported by: OhioRISE Plan	Reporting Only	MY 2023	Reporting Only	MY 2024	Reporting Only	MY 2025	Reporting Only	MY 2026
Tobacco Use: Screening and Cessation (Ages 12 – 17)	Steward: ODM/AMA-PCPI Source: Claims Reported by: ODM	N/A	N/A	Reporting Only	MY 2024	Reporting Only	MY 2025	Reporting Only	MY 2026

Measure	Measurement Set	MY 2023 Minimum Perf. Std.	MY 2023 Measurement Year	MY 2024 Minimum Perf. Std.	MY 2024 Measurement Year	MY 2025 Minimum Perf. Std.	MY 2025 Measurement Year	MY 2026 Minimum Perf. Std.	MY 2026 Measurement Year
Well-Child Visits in the First 30 Months of Life: Well-Child Visits in the First 15 Months[HE],	Steward: NCQA/ HEDIS Reported by: OhioRISE Plan	Reporting Only	MY 2023	N/A	MY 2024	N/A	MY 2025	N/A	MY 2026
Well-Child Visits in the First 30 Months of Life: Well-Child Visits in the First 15 Months, Well-Child Visits for Age 15 Months – 30 Months	Steward: NCQA/ HEDIS Reported by: OhioRISE Plan	Reporting Only	MY 2023	N/A	MY 2024	N/A	MY 2025	N/A	MY 2026
Child and Adolescent Well-Care Visits: 3-11 years	Steward: NCQA/ HEDIS Reported by: OhioRISE Plan	Reporting Only	MY 2023	Reporting Only	MY 2024	MPS ≥ 52.40%	MY 2025	MPS ≥ 62.00%	MY 2026
Child and Adolescent Well-Care Visits: 12 – 17 years[HE]	Steward: NCQA/ HEDIS Reported by: OhioRISE Plan	Reporting Only	MY 2023	Reporting Only	MY 2024	Overall[STW] (All Children)≥ 53.10%	MY 2025	Overall[STW] (All Children)≥ 54.76%	MY 2026
		N/A	N/A	N/A	N/A	Population-specific (Black Children)≥ 54.81%		Population-specific (Black Children)≥ 55.97%	
Child and Adolescent Well-Care Visits: 18 – 21 years	Steward: NCQA/ HEDIS Reported by: OhioRISE Plan	Reporting Only	MY 2023	Reporting Only	MY 2024	MPS ≥ 25.08%	MY 2025	MPS ≥ 32.01%	MY 2026
Asthma Medication Ratio, Ages 5 – 11[HE]	Steward: NCQA/ HEDIS Reported by: OhioRISE Plan	N/A	N/A	N/A	N/A	Overall[STW] (All Children)≥ 79.70%	MY 2025	N/A	N/A
						Population-specific (Black Children)≥ 74.50%			
Asthma Medication Ratio, Ages 12 – 18[HE]	Steward: NCQA/ HEDIS Reported by: OhioRISE Plan	N/A	N/A	N/A	N/A	Overall[STW] (All Children)≥ 73.37%	MY 2025	N/A	N/A
						Population-specific (Black Children)≥ 71.22%			

Measure	Measurement Set	MY 2023 Minimum Perf. Std.	MY 2023 Measurement Year	MY 2024 Minimum Perf. Std.	MY 2024 Measurement Year	MY 2025 Minimum Perf. Std.	MY 2025 Measurement Year	MY 2026 Minimum Perf. Std.	MY 2026 Measurement Year
Asthma Controller Medication, Ages 5-11	ODM	N/A	N/A	N/A	N/A	Overall Reporting Only Population-specific (Black Children) Reporting Only	MY 2025	Overall Reporting Only Population-specific (Black Children) Reporting Only	MY 2026
Asthma Controller Medication, Ages 12-18	ODM	N/A	N/A	N/A	N/A	Overall Reporting Only Population-specific (Black Children) Reporting Only	MY 2025	Overall Reporting Only Population-specific (Black Children) Reporting Only	MY 2026
Kindergarten Readiness[1]	Steward: ODM Data Source: ODE Reported by: ODM	Reporting Only	SFY 2023	Reporting Only	SFY 2024	Reporting Only	SFY 2025	Reporting Only	SFY 2026
Chronic Absenteeism[1]	Steward: ODM Data Source: ODE Reported by: ODM	Reporting Only	SFY 2023	Reporting Only	SFY 2024	Reporting Only	SFY 2025	Reporting Only	SFY 2026
3rd Grade Reading[1]	Steward: ODM Data Source: ODE Reported by: ODM	Reporting Only	SFY 2023	Reporting Only	SFY 2024	Reporting Only	SFY 2025	Reporting Only	SFY 2026
Graduation Rates[1]	Steward: ODM	Reporting Only	SFY 2023	Reporting Only	SFY 2024	Reporting Only	SFY 2025	Reporting Only	SFY 2026

Note: No standard will be established, or compliance assessed, for the measures designated 'Reporting Only' in the Minimum Performance Standard column for the corresponding year.
N/A = Measure is not required to be reported for the specified measurement year
TBD = Minimum Performance Standard is yet to be determined
NCQA HEDIS/CAHPS=data source is specified in the measure technical specification
E = HEDIS ECDS reporting method effective beginning MY 2024
SAG = OAK (Outcomes Acceleration for Kids) SMART Aim Goal (SAG). MCO performance for measures that include an SAG will not be subject to MPS compliance assessment as specified in Appendix N, Compliance Actions.

Table I.2. OhioRISE Plan OhioRISE 1915(c) Waiver Measures. Measurement Years 2022, 2023, 2024, and 2025 Performance Measures, Measurements Sets, and Measurement Time Periods

Performance Measure	Measurement Set	MY/SFY 2023 Minimum Perf. Std.	MY/SFY 2023 Measurement Year	MY /SFY 2024 Minimum Perf. Std.	MY/SFY 2024 Measurement Year	MY/SFY 2025 Minimum Perf. Std.	MY/SFY 2025 Measurement Year	MY/SFY 2026 Minimum Perf. Std.	MY/SFY 2026 Measurement Year
Percent of sampled OhioRISE waiver participants reviewed each year who are verified to meet Level of Care eligibility requirements	Responsible Party for data collection/generation: OhioRISE Plan Steward: ODM Source: CANS Responsible Party for data aggregation and analysis (Reported by): ODM	86%	Quarterly & Annually	86%	Quarterly & Annually	86%	Quarterly & Annually	86%	Quarterly & Annually
Number and percent of OhioRISE waiver participants reviewed who had their level of care (LOC) determined or redetermined within the past 12 months	Responsible Party for data collection/generation: OhioRISE Plan Steward: ODM Source: CANS Responsible Party for data aggregation and analysis (Reported by): ODM	86%	Quarterly & Annually	86%	Quarterly & Annually	86%	Quarterly & Annually	86%	Quarterly & Annually
Number and percent of required reports submitted by the OhioRISE Plan in a complete and timely manner	Responsible Party for data collection/generation: OhioRISE Plan Steward: ODM Source: OhioRISE Plan Responsible Party for data aggregation and analysis (Reported by): ODM	86%	Other: as specified for each performance measure	86%	Other: as specified for each performance measure	86%	Other: as specified for each performance measure	86%	Other: as specified for each performance measure

Performance Measure	Measurement Set	MY/SFY 2023 Minimum Perf. Std.	MY/SFY 2023 Measurement Year	MY /SFY 2024 Minimum Perf. Std.	MY/SFY 2024 Measurement Year	MY/SFY 2025 Minimum Perf. Std.	MY/SFY 2025 Measurement Year	MY/SFY 2026 Minimum Perf. Std.	MY/SFY 2026 Measurement Year
Number and percent of findings of the OhioRISE Plan's noncompliance that were remediated through an approved CAP or other method as required by the ODM/OhioRISE provider agreement	Responsible Party for data collection/generation: ODM Steward: ODM Source: ODM Responsible Party for data aggregation and analysis (Reported by): ODM	86%	Other: As determined by ODM based on trends of non-compliance	86%	Other: As determined by ODM based on trends of non-compliance	86%	Other: As determined by ODM based on trends of non-compliance	86%	Other: As determined by ODM based on trends of non-compliance
Number and percent of new OhioRISE waiver participants who had a level of care (LOC) indicating a need for institutional LOC prior to receipt of waiver services	Responsible Party for data collection/generation: OhioRISE Plan Steward: ODM Source: CANS Responsible Party for data aggregation and analysis (Reported by): ODM	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually
The number and percent of sampled OhioRISE waiver participants whose reassessment of level of care (LOC) were completed with ODM-approved processes and instruments	Responsible Party for data collection/generation: OhioRISE Plan Steward: ODM Source: CANS Responsible Party for data aggregation and analysis (Reportedby): ODM	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually
The number and percent of OhioRISE waiver participants whose initial level of care (LOC) determinations were completed with ODM-approved processes and instruments	Responsible Party for data collection/generation: OhioRISE Plan Steward: ODM Source: CANS Responsible Party for data aggregation and analysis (Reported by): ODM	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually

Performance Measure	Measurement Set	MY/SFY 2023 Minimum Perf. Std.	MY/SFY 2023 Measurement Year	MY /SFY 2024 Minimum Perf. Std.	MY/SFY 2024 Measurement Year	MY/SFY 2025 Minimum Perf. Std.	MY/SFY 2025 Measurement Year	MY/SFY 2026 Minimum Perf. Std.	MY/SFY 2026 Measurement Year
The number and percent of new independent OhioRISE waiver providers who meet provider enrollment requirements prior to providing waiver services	Responsible Party for data collection/generation: ODM Steward: ODM Source: ODM PNM data Responsible Party for data aggregation and analysis (Reported by): ODM	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually
The number and percent of new OhioRISE waiver agency providers that meet provider enrollment requirements prior to providing waiver services	Responsible Party for data collection/generation: ODM Steward: ODM Source: ODM PNM data Responsible Party for aggregation and analysis (Reported by): ODM	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually
The number and percent of waiver providers that have an active Medicaid provider agreement with ODM prior to the OhioRISE Plan authorizing the provider to provide waiver services	Responsible Party for data collection/generation: OhioRISE Plan/ODM Steward: ODM Source: ODM PNM/OhioRISE Plan data Responsible Party for data aggregation and analysis (Reported by): ODM	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually

Performance Measure	Measurement Set	MY/SFY 2023 Minimum Perf. Std.	MY/SFY 2023 Measurement Year	MY /SFY 2024 Minimum Perf. Std.	MY/SFY 2024 Measurement Year	MY/SFY 2025 Minimum Perf. Std.	MY/SFY 2025 Measurement Year	MY/SFY 2026 Minimum Perf. Std.	MY/SFY 2026 Measurement Year
Number and percent of independent OhioRISE waiver providers who were certified because they met training requirements	Responsible Party for data collection/generation: ODM Steward: ODM Source: ODM PNM data Responsible Party for data aggregation and analysis (Reported by): ODM	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually
Number and percent of agency OhioRISE waiver providers who were certified because they met training requirements	Responsible Party for data collection/generation: ODM Steward: ODM Source: ODM PNM data Responsible Party for data aggregation and analysis (Reported by): ODM	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually
The number and percent of OhioRISE waiver participants reviewed whose waiver service plans adequately address their assessed needs	Responsible Party for data collection/generation: OhioRISE Plan Steward: ODM Source: ODM Responsible Party for data aggregation and analysis (Reported by): ODM	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually
The number and percent of OhioRISE waiver participants reviewed whose waiver service plans have strategies to address and mitigate their identified health and welfare risk factors	Responsible Party for data collection/generation: OhioRISE Plan Steward: ODM Source: ODM Responsible Party for data aggregation and analysis (Reported by): ODM	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually

Performance Measure	Measurement Set	MY/SFY 2023 Minimum Perf. Std.	MY/SFY 2023 Measurement Year	MY /SFY 2024 Minimum Perf. Std.	MY/SFY 2024 Measurement Year	MY/SFY 2025 Minimum Perf. Std.	MY/SFY 2025 Measurement Year	MY/SFY 2026 Minimum Perf. Std.	MY/SFY 2026 Measurement Year
The number and percent of waiver service plans reviewed that address members' personal goals	Responsible Party for data collection/generation: OhioRISE Plan Steward: ODM Source: ODM Responsible Party for data aggregation and analysis (Reported by): ODM	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually
Number and percent of service plans that were developed according to policies and procedures as described in the approved waiver	Responsible Party for data collection/generation: OhioRISE Plan Steward: ODM Source: ODM Responsible Party for data aggregation and analysis (Reported by): ODM	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually
The number and percent of sampled OhioRISE waiver participants whose service plans were revised, as needed, to address changing needs	Responsible Party for data collection/generation: OhioRISE Plan Steward: ODM Source: ODM Responsible Party for data aggregation and analysis (Reported by): ODM	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually
The number and percent of OhioRISE waiver participants reviewed whose waiver service plans were updated at least once in the past 12 months	Responsible Party for data collection/generation: OhioRISE Plan Steward: ODM Source: ODM Responsible Party for data aggregation and analysis (Reported by): ODM	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually

Performance Measure	Measurement Set	MY/SFY 2023 Minimum Perf. Std.	MY/SFY 2023 Measurement Year	MY /SFY 2024 Minimum Perf. Std.	MY/SFY 2024 Measurement Year	MY/SFY 2025 Minimum Perf. Std.	MY/SFY 2025 Measurement Year	MY/SFY 2026 Minimum Perf. Std.	MY/SFY 2026 Measurement Year
The number and percent of OhioRISE waiver participants reviewed who received services in the type, scope, amount and frequency specified in their service plan.	Responsible Party for data collection/generation: OhioRISE Plan Steward: ODM Source: ODM Responsible Party for data aggregation and analysis (Reported by): ODM	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually
The number and percent of OhioRISE waiver participants reviewed whose records contained a document signed by the member to indicate their choice to receive waiver services instead of institutional care	Responsible Party for data collection/generation: OhioRISE Plan Steward: ODM Source: ODM Responsible Party for data aggregation and analysis (Reported by): ODM	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually
Number and percent of Abuse (physical, verbal, emotional, sexual), Neglect, Exploitation, and Misappropriation Incidents (over $500) reported into the ODM approved incident management system(s) within the required timeframe	Responsible Party for data collection/generation: ODM Steward: ODM Source: IMS Responsible Party for data aggregation and analysis (Reported by): ODM	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually
Number and percent of deaths with a required need for review for which an investigation was completed according to established requirements	Responsible Party for data collection/generation: ODM Steward: ODM Source: IMS Responsible Party for data aggregation and analysis (Reported by): ODM	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually

Performance Measure	Measurement Set	MY/SFY 2023 Minimum Perf. Std.	MY/SFY 2023 Measurement Year	MY /SFY 2024 Minimum Perf. Std.	MY/SFY 2024 Measurement Year	MY/SFY 2025 Minimum Perf. Std.	MY/SFY 2025 Measurement Year	MY/SFY 2026 Minimum Perf. Std.	MY/SFY 2026 Measurement Year
Number and percent of Abuse (physical, verbal, emotional, sexual), Neglect, Exploitation, and Misappropriation Incidents (over $500) incident reviews that were completed according to established requirements	Responsible Party for data collection/generation: ODM Steward: ODM Source: IMS Responsible Party for data aggregation and analysis (Reported by): ODM	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually
Number and percent of substantiated Abuse (physical, verbal, emotional, sexual), Neglect, Exploitation, and Misappropriation Incidents (over $500) with a prevention plan developed as a result of the incident	Responsible Party for data collection/generation: ODM Steward: ODM Source: IMS Responsible Party for data aggregation and analysis (Reported by): ODM	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually
Number and percent of substantiated unauthorized (or unapproved) restraint, seclusion or other restrictive intervention incidents with a prevention plan developed as a result of the incident	Responsible Party for data collection/generation: ODM Steward: ODM Source: IMS Responsible Party for data aggregation and analysis (Reported by): ODM	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually
Number and percent of incidents reviewed for Abuse (physical, verbal, emotional, sexual), Neglect, Exploitation, and all Misappropriation (over $500) that involved paid caregivers	Responsible Party for data collection/generation: ODM Steward: ODM Source: IMS Responsible Party for data aggregation and analysis (Reported by): ODM	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually

Performance Measure	Measurement Set	MY/SFY 2023 Minimum Perf. Std.	MY/SFY 2023 Measurement Year	MY /SFY 2024 Minimum Perf. Std.	MY/SFY 2024 Measurement Year	MY/SFY 2025 Minimum Perf. Std.	MY/SFY 2025 Measurement Year	MY/SFY 2026 Minimum Perf. Std.	MY/SFY 2026 Measurement Year
[4]The number and percent of claims verified through a review of provider documentation to have been paid in accordance with members' waiver service plans	Responsible Party for data collection/generation: OhioRISE Plan Steward: ODM Source: OhioRISE Plan Responsible Party for data aggregation and analysis (Reported by): ODM	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually
The number and percent of claims sampled in PM #1 that were found to be unsupported claims for waiver services for which payment was recouped	Responsible Party for data collection/generation: OhioRISE Plan Steward: ODM Source: OhioRISE Plan Responsible Party for data aggregation and analysis (Reported by): ODM	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually	86%	Quarterly/ Annually

4. Data and Reporting

a. OhioRISE Plan Table I.1 HEDIS/CAHPS ECHO Survey Measures

i. Annual Submission of Data

1. The OhioRISE Plan must collect, report, and submit self-reported, audited data to ODM (see ODM Specifications for the Submission of OhioRISE Plan Self-Reported, Audited HEDIS Results and ODM Specifications for the Submission of OhioRISE Population CAHPS ECHO Survey Administration and Data Submission Specifications on ODM's website) for the full set of measures in Table I.1 reported by the OhioRISE Plan for enrolled members. The OhioRISE Plan must submit its self-reported, audited data to ODM as specified in Appendix P, Chart of Deliverables.

ii. Annual Submission of HEDIS Final Audit Report

[4] PM #1

1. The OhioRISE Plan must submit its HEDIS Final Audit Report that contains the audited results for the HEDIS measures in Table I.1 for members to ODM (see *ODM Specifications for the Submission of OhioRISE Plan Self-Reported, Audited HEDIS Results* on ODM's website). The OhioRISE Plan must submit its HEDIS Final Audit Report to ODM as specified in Appendix P, Chart of Deliverables.

b. OhioRISE Plan Table I.2 OhioRISE 1915(c) Waiver Performance Measures

   i. Submission of Data

      1. The OhioRISE Plan must collect and report data to ODM (see ODM specifications for the submission of data/deliverables of the OhioRISE Plan) for measures in Table I.2 where the OhioRISE Plan Is the responsible party of data collection/generation for OhioRISE 1915(c) waiver members. The OhioRISE Plan must submit data to ODM as specified in Appendix P, Chart of Deliverables.

      2. ODM will assess OhioRISE Plan performance using ODM calculated performance measurement data. The measures in this appendix are calculated in accordance with CMS' approved reporting requirements.

c. OhioRISE Plan Table I.1 Care Management Entity Measures

   i. Care Management Entity Performance Measures

      1. The OhioRISE Plan must routinely confirm that performance measurement data has been supplied to the CMEs in a timely manner and in accordance with the OhioRISE Plan's contract with the CMEs. The OhioRISE Plan must submit its confirmation of submission of the required performance measure information to the CMEs as specified in Appendix P, Chart of Deliverables.

d. Satisfaction Surveys of Families and Youth Receiving MRSS, ICC, and IHIT

   i. Biannual and Annual Submission of Data

      1. The OhioRISE Plan will conduct a service-specific survey of families and youth of MRSS, Tier 2 and Tier 3 care coordination, and IHBT to assess satisfaction, access, and quality of services received. The survey tool will be developed in conjunction with ODM, its Member and Family Advisory Council, and others as determined and approved by ODM. OhioRISE Plan must collect, report, and submit self-reported, audited data to ODM (see *ODM Specifications for the Submission of OhioRISE Plan Self-Reported, Audited Results* on ODM's website). The OhioRISE Plan must submit its self-reported, audited data to ODM as specified in Appendix P, Chart of Deliverables.

e. Satisfaction Survey of Providers

   i. Annual Submission of Data

      1. The OhioRISE Plan will implement a survey of providers to assess satisfaction, access, quality, and provider guidance needed. The survey tool will be developed in conjunction with ODM, its Provider Advisory Council; and approved by ODM. OhioRISE Plan must collect, report, and submit self-reported,

audited data to ODM (see *ODM Specifications for the Submission of OhioRISE Plan Self-Reported, Audited Results* on ODM's website). The OhioRISE Plan must submit its self-reported, audited data to ODM as specified in Appendix P, Chart of Deliverables.

2.

f. Data Certification Requirements for HEDIS Interactive Data Storage System Data and HEDIS Final Audit Report

i. General

1. In accordance with 42 CFR 438.604 and 42 CFR 438.606 and ODM requirements, the OhioRISE Plan must submit a signed data certification letter to ODM attesting to the accuracy and completeness of its audited HEDIS Interactive Data Storage System (IDSS) data and of its HEDIS Final Audit Report submitted to ODM.

2. The OhioRISE Plan must submit these data certification letters per the instructions and by the due dates provided in the *ODM Specifications for the Submission of OhioRISE Plan Self-Reported, Audited HEDIS Results*.

3. In accordance with 42 CFR 438.606 and Appendix G, Program Integrity, each data certification letter must be signed by the OhioRISE Plan's Chief Executive Officer (CEO), Chief Finance Officer (CFO) or an individual who reports directly to the OhioRISE Plan's CEO or CFO with delegated authority to sign for the CEO or CFO so that the CEO or CFO is ultimately responsible for the certification.

5. Additional Operational Considerations

a. Measures and Measurement Periods

i. ODM reserves the right to revise the measures and measurement time periods established in this appendix (and any corresponding compliance periods) as needed. Unless otherwise noted, the most recent report or study finalized prior to the end of the contract period will be used in determining the OhioRISE Plan's performance level for that contract period.

b. Termination or Non-Renewal – Compliance Determination

i. If this Agreement is terminated or not renewed, ODM will determine OhioRISE Plan compliance for the most recent measurement year prior to termination or non-renewal. If ODM determines that the OhioRISE Plan is not in compliance with a standard set forth in this appendix during that period, ODM will take compliance actions in accordance with Appendix N, Compliance Actions.

c. Performance Standards – Compliance Determination

i. In the event that the OhioRISE Plan's performance cannot be evaluated for a performance measure and measurement time period established in Table I.1 of this appendix, ODM in its sole discretion will determine whether the OhioRISE Plan has or has not met the standard(s) for that particular measure and measurement time period

depending on the circumstances involved. For example, if ODM assigned a "Not Report" audit result on a measure on the OhioRISE Plan's Final Audit Report and the "Not Report" designation was determined to be the result of a material bias caused by the OhioRISE Plan, ODM would deem the OhioRISE Plan not to have met the standard(s) for that measure and measurement time period.

d. Performance Standards – Retrospective Adjustment

    i. ODM will implement the use of a uniform methodology as needed for the retrospective adjustment of any MPS listed in Table I.1 of this appendix, except for the CAHPS ECHO measure standards. ODM will implement this methodology at ODM's sole discretion.

APPENDIX J – QUALITY WITHHOLD OR INCENTIVE

1. Quality Withhold or Incentive Program

a. ODM is imposing a quality withhold program on the OhioRISE Plan beginning in state fiscal year (SFY) 2026.

b. ODM's Quality Withhold Program will be conducted in accordance with 42 CFR 438.6(b)(2) and (3).

c. ODM will withhold a specified percentage for each applicable state fiscal year (SFY) for use in ODM's Quality Withhold Program. The amount to be withheld will be 1.5% of the capitation and delivery payments.

d. Any quality withhold or incentive program will be designed to improve quality measure outcomes tied to the goals and objectives described in Appendix C, Population Health and Quality, and Appendix I, Quality Measures, of this Agreement.

e. ODM will use the health improvement activities identified within each applicable SFY quality withhold payout determination to calculate the amount of the withhold payout. Health improvement activities will be comprised of multiple quality improvement projects related to ODM's population health strategy. Health improvement activities will measure the effectiveness of the OhioRISE plan's quality improvement program to impact population health outcomes.

f. ODM will assess the OhioRISE plan's performance according to the measurement periods described in Section 2 below for purposes of determining quality withhold payouts.

c. ODM will use the Quality Withhold QI Template and other related documentation to evaluate the OhioRISE plan's performance related to the Quality Withhold Program.

g. ODM will determine the quality withhold payout as specified in this appendix.

h. Quality Withhold Innovation Fund

i. The OhioRISE plan must collaborate with the MCOs to establish a Quality Withhold Innovation Fund (Fund). The OhioRISE plan must contribute to the Fund 75% of capitation payments it receives during the measurement period that are attributable to the 'Quality Withhold Functions' non-benefit expense category as identified in the capitation rate certification. The OhioRISE plan must enter into an ODM-approved joint agreement with the MCOs which establishes expectations for timing of the MCO and the OhioRISE plan contributions, fund governance, and use of the funds. The OhioRISE Plan must work collaboratively with all the MCOs to use contributions to the Fund in a collective manner that follows the quality withhold processes designed to meet meaningful goals for the Medicaid population put forth by ODM. The OhioRISE plan must not use monies in the Fund for any of the following:

1. The OhioRISE plan costs related to administration, management, or support of the Quality Withhold Program;

2. The OhioRISE plan's IT System changes associated with interventions or other QI processes;

3. Paying for Medicaid-covered services under an existing context through traditional payment arrangements.

4. Projects or interventions not expressly included in the Quality Withhold Program; or

5. Activities that take place before or after the measurement period of the Quality Withhold Projects.

ii. Plans to spend monies from the Fund must be presented to ODM for review and expenditures from the Fund may not be made until ODM's review has been completed. Any interest earned from monies in the Fund must remain in the Fund. Unspent funds collected in a measurement period must be carried over to the next measurement period. As specified by ODM, deposits, expenditures, including expenses related to administration and management of the Fund, and balances must be reported to ODM, as specified in Appendix P, Chart of Deliverables.

1. In the event the Quality Withhold Innovation Fund is no longer required under this Agreement, the monies remaining the Fund will be distributed as follows:

2. Monies derived from monetary sanctions which were deposited into the Fund and monies from Quality Withhold Reinvestment amounts must be returned to ODM. Monies from other sources such as interest earned on the Fund or sources attributable to the 'Quality Withhold Functions' non-benefit expense category as identified in the capitation rate certification, may be distributed to the OhioRISE plan in a manner proportional to its individual deposits or as otherwise determined by the ODM-approved joint agreement with the MCOs.

2. **Quality Withhold 2026 – 2027 (QW26-27)**

a. Quality Withhold Payout Determination

i. For the purpose of determining the return of the quality withhold, ODM will use the performance of the OhioRISE plan's efforts to advance ODM's population health strategy using improvement tools such as the Model for Improvement. This includes investing in assessing, designing, and building the necessary internal and external infrastructures for efficient collaborative quality improvement work and developing collaborative partnerships with health systems, clinics, and providers, e.g., Pediatric ACOs, school-based health centers, and academic centers. The OhioRISE plan must assess the effectiveness of quality improvement collaborations, determine changes needed to enhance care efficiency and accelerate improving health outcomes, and implement these changes (e.g., enhance funding for interventions, increase staffing with appropriate knowledge and skills, improve communications, streamline documentation of work completed, develop a collaboration-wide quality improvement capacity development plan, etc.). The OhioRISE plan must follow the organization, policies, and procedures specified in the Quality Withhold Governance for 2026 – 2027 document.

b. <u>Quality Improvement Projects</u>

i. In 2025, the OhioRISE plan must participate and contribute to the development of the QW26-27 Program. This includes conducting foundational research and analysis, staffing appropriately to initiate QW26-27 Projects, establishing needed partnerships in the community, and building appropriate infrastructure to launch the QW26-27 Program on 1/1/2026.

3. Additional Considerations

a. Quality Withhold Payout

i. The Quality Withhold payout is comprised of two components, i.e., the Quality Withhold Retention amount and Quality Withhold Reinvestment amount. The sum of both amounts will equal the total amount withheld for the measurement period.

ii. The Quality Withhold Retention amount will be based on the OhioRISE plan's performance for the measurement period as specified in this appendix and may be retained by the OhioRISE plan. ODM will pay the Quality Withhold Retention amount to OhioRISE regardless of the balance of the Quality Withhold Innovation Fund balance.

iii. At ODM's discretion, ODM may pay the Quality Withhold Reinvestment amount to the OhioRISE plan. If ODM pays the Quality Withhold Reinvestment amount to the OhioRISE plan, the OhioRISE plan must reinvest the Quality Withhold Reinvestment amount into the Quality Withhold Reinvest Innovation Fund within 30 days of receipt from ODM. Upon request from ODM proof of deposit must be sent to ODM to demonstrate timely payment. If the balance of the Quality Withhold Innovation Fund is greater than $100 million, ODM may not pay the Quality Withhold Reinvestment amount to the OhioRISE plan.

b. Timing of Quality Withhold Program Determinations

i. ODM will issue results for each Quality Withhold Program determination to OhioRISE within 12 months of the end of each established report period. ODM reserves the right to revise the timeframe in which the Quality Withhold Program determination is issued (i.e., the determination may be made more than 12 months after the end of the contract period).

c. Agreement Termination or Non-Renewal

i. Upon termination or non-renewal of this Agreement, the incentive or withhold amount will be retained or awarded by ODM in accordance with Appendix O, OhioRISE Termination and Non-Renewal.

d. Quality Withhold Measures, Requirements, and Measurement Years

i. ODM reserves the right to revise quality withhold measures, standards, benchmarks, requirements, and measurement years, as needed.

ii. Unless otherwise noted, the most recent report or study finalized prior to the end of the contract period will be used in determining the OhioRISE plan's overall performance level for that contract period.

APPENDIX K – INFORMATION SYSTEMS, CLAIMS, AND DATA

1. Health Information System Requirements

a. Federal Requirements

i. As required by 42 CFR 438.242:

1. The OhioRISE Plan must maintain a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas, including but not limited to utilization, grievances and appeals, and OhioRISE Plan membership terminations for reasons other than loss of Medicaid eligibility.

2. The OhioRISE Plan must comply with section 6504(a) of the Affordable Care Act, which requires that state claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the state to meet the requirements of Section 1903(r)(1)(F) of the Social Security Act.

3. The OhioRISE Plan must collect data on member and provider characteristics and on all services furnished to its members.

4. The OhioRISE Plan must ensure data received from providers is accurate and complete by verifying the accuracy and timeliness of reported data, screening the data for completeness, logic, and consistency, and collecting service information in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies used for ODM's quality improvement and care coordination efforts.

5. The OhioRISE Plan must make all collected data available upon request by ODM or the Centers for Medicare and Medicaid Services (CMS).

b. ODM Access to the OhioRISE Plan's Systems and Data

i. The OhioRISE Plan must provide ODM with table level access (remote connectivity) to all data relevant to care provided to members, including but not limited to encounter, care management, and utilization management (UM) information. The OhioRISE Plan must provide ODM the schematic, data dictionary, and other systems documentation necessary for ODM to interpret and use the data.

ii. The OhioRISE Plan (including subcontractors) must provide ODM staff query access to real-time operational data and information relevant to members.

iii. The OhioRISE Plan's system must have the ability to exchange files through secure file transfer protocol (SFTP) with other systems through the state's file transfer protocol (FTP)/SFTP service.

c. The OhioRISE Plan Access to ODM Systems and Data

i. The OhioRISE Plan may be provided access to ODM systems and data only after following the processes established pursuant to Appendix A, Paragraph 4, Subparagraph f.

ii. ODM may establish a centralized point of access for all member and provider data. Both aggregate and member-level data may be accessible to all MCEs. This data may only be accessed, used, or disclosed to support collaborative work across the MCEs for population health management and quality improvement efforts.

iii. The OhioRISE Plan's use or disclosure of data obtained from ODM is subject to compliance with State and Federal law, and all required administrative, technical, and physical safeguards. See Appendix A, Paragraph 3.

d. Data and Systems Integration

i. The OhioRISE Plan must have an integrated system that allows the different OhioRISE Plan functions to work seamlessly within the OhioRISE Plan.

ii. If the OhioRISE Plan has separate claims processing systems for physical and behavioral health, the OhioRISE Plan must have appropriate front-end routing logic to ensure the provider's claim is seamlessly routed to the correct claims system based upon the provider type, services, and diagnoses. If the OhioRISE Plan receives claims containing both physical and behavioral health services, the OhioRISE Plan must adjudicate both service types without requiring resubmission.

iii. The OhioRISE Plan must collect and use data from all subcontractors relevant to care of its members and integrate that data into the OhioRISE Plan's systems.

iv. The OhioRISE Plan's system must capture and maintain all ODM-identified data necessary to support business functions.

v. The OhioRISE Plan's system must integrate data with all Ohio Medicaid Enterprise System (OMES) modules (e.g., member module, provider module, fiscal intermediary module), through the systems integrator in real-time and batch (based on data currency needs), to support the Ohio Medicaid managed care program.

vi. The OhioRISE Plan's system must integrate with Ohio's Identity and Access Management System, the Innovate Ohio Platform, to provide single sign on services for all authorized users identified by the OhioRISE Plan or ODM.

vii. The OhioRISE Plan's system must use role-based authorization and access to ensure minimal necessary access to data and screens.

viii. The OhioRISE Plan must have the ability to submit, accept, and integrate all data transmission protocols necessary to support the Ohio Medicaid managed care program, including internal and external entities.

ix. The OhioRISE Plan must comply with the population health information system and data requirements in Appendix C, Population Health and Quality.

x. The OhioRISE Plan must comply with the care coordination information system and data requirements in Appendix D, Care Coordination.

xi. The OhioRISE Plan must accept, maintain, and use data received from ODM or the MCOs related to behavioral health services provided to members who are enrolled in the MCO and OhioRISE Plan. This includes but is not limited to care coordination data, including the name of the member's care coordinator(s) and contact information, assessments, care plans, critical incidents, and admission, discharge, and transfer (ADT) data; prior authorization data; and claims adjudication data. The OhioRISE Plan must use this data to support its responsibilities under this Agreement, including but not limited to ensuring members are receiving necessary services, informing the OhioRISE Plan's efforts to assist MCOs with their population health activities, risk stratification, supporting care coordination activities, and informing quality improvement (QI) activities.

xii. The OhioRISE Plan must provide data to the MCOs and/or ODM as directed by ODM. This data may include but is not limited to assessment data, child and family-centered care plans (CFCPs), population health data, care coordination data, prior authorization data, admission, discharge, and transfer (ADT) data, and claims data.

xiii. The OhioRISE Plan must accept, maintain, and use pharmacy data received from ODM, the MCO, or the single pharmacy benefit manager (SPBM). This includes but is not limited to real-time access to view targeted member pharmacy data, including claims adjudication and prior authorization data, daily pharmacy claims data, and daily prior authorization data. The OhioRISE Plan must use this data to support its responsibilities under this Agreement, including but not limited to ensuring members are receiving necessary pharmacy services, developing and monitoring medication therapy management (MTM) activities, informing the OhioRISE Plan's efforts to assist the MCO's with their population health activities, risk stratification, identifying members in need of care coordination, assisting ODM, MCOs and SPBM with prescriber education, supporting care coordination activities, and informing QI activities.

xiv. The OhioRISE Plan must accept, maintain, and use administrative data from ODM or its designee, including, but not limited to, the medical, pharmacy, and institutional claims extracts for currently and newly enrolled members. The OhioRISE Plan must integrate this data into its claim system, such that appropriate staff will be able to view this data to assist with care coordination, care management, provider network development, and population health improvement. This data must also be loaded into the OhioRISE Plan’s data warehouse and made available to appropriate staff for reporting purposes.

xv.

e. The OhioRISE Plan must provide data to the SPBM, the MCOs, and/or ODM as directed by ODM. This data may include but is not limited to population health data, care coordination data, MTM data, claims data, diagnosis codes on claims and prior authorization data. General

   i. If the OhioRISE Plan has systems and information technology staff and operations supported at the enterprise-level, the OhioRISE Plan must ensure that required information technology changes, fixes, and enhancements are prioritized and resolved in a manner that meets ODM's contractual and performance expectations.

   ii. When considering making system or software changes, or engaging with new subcontractors or modifying the responsibilities of existing subcontractors, the OhioRISE Plan must provide a description of proposed changes to ODM, for its review and approval, at least 30 calendar days prior to implementation. In this document, the OhioRISE plan must:

      1. Describe the proposed change(s);

      2. Explain why the change is being made;

      3. Identify what OhioRISE Plan systems, subcontractor systems, and OMES modules will be impacted and indicate whether other system changes are being made simultaneously by its parent company, subcontractors, ODM, or ODM vendors that may impact the same population or process;

      4. Indicate the proposed project timeline;

      5. Explain the plan for testing;

      6. Explain the plan for communicating these changes to those impacted by the change; and

      7. Explain what staff training will occur regarding the change. If significant issues are encountered during testing or implementation, such as project delays or impacts on members or providers, the OhioRISE plan must notify ODM within three business days and provide any corresponding mitigation plans.

   iii. The OhioRISE Plan must conduct thorough end-to-end testing for all new program implementations, system upgrades, software updates, and new or revised data requirements.

iv. The OhioRISE Plan's technical security standards must include permission and role-based access mechanisms to monitor for unauthorized access, two-factor authentication, virus protection software, up-to-date security patch installation, encryption protection at the operating system level, and virtual private networks (VPNs) for remote users.

v. The OhioRISE Plan's systems and user environment must comply with National Institute of Standards and Technology (NIST) 800-53 R4 (or current release) moderate baseline and Minimum Acceptable Risk Standards for Exchanges (MARS-e) 2.0 (or current release) or a similar standard that demonstrates comparable controls by mapping a crosswalk to NIST 800-53 and MARS-e.

vi. The OhioRISE Plan's application systems foundation must employ a relational data model in its architecture (RDBMS). The OhioRISE Plan's application systems must support query access using Structure Query Language. The OhioRISE Plan's application systems must support open database connectivity (ODBC) and/or Object Linking and Embedding (OLE).

vii. The OhioRISE Plan must implement updates to national standard code sets as of their effective date. The OhioRISE Plan must implement any other ODM specified updates within 30 calendar days unless otherwise specified by ODM.

viii. The OhioRISE Plan must comply with all relevant federal and state information technology standards, information security standards, and privacy standards.

2. Information Systems Review

a. ODM or its designee may review the information system capabilities of the OhioRISE Plan prior to implementation and when the OhioRISE Plan undergoes a major information system upgrade or change, when there is identification of significant information system problems, or at ODM's discretion.

b. The OhioRISE Plan must support the needs of reviewers.

c. The review will assess the extent to which the OhioRISE Plan is capable of maintaining a health information system, including producing valid encounter data, performance measures, and other data necessary to support quality assessment and improvement, as well as managing the care delivered to its members.

d. The following activities, at a minimum, will be carried out during the review. ODM or its designee will:

i. Review the Information Systems Capabilities Assessment (ISCA) forms, as developed by CMS, which the OhioRISE Plan must complete;

ii. Review the completed ISCA and accompanying documents;

iii. Conduct interviews with OhioRISE Plan staff responsible for completing the ISCA, as well as staff responsible for the OhioRISE Plan's information systems;

iv. Analyze the information obtained through the ISCA, conduct follow-up interviews with OhioRISE Plan staff, and write a statement of findings about the OhioRISE Plan's information system;

v. Assess the ability of the OhioRISE Plan to link data from multiple sources;

vi. Examine OhioRISE Plan processes for data transfers;

vii. If the OhioRISE Plan has a data warehouse, evaluate its structure and reporting capabilities;

viii. Review OhioRISE Plan processes, documentation, and data files to ensure they comply with state and federal specifications for encounter data submissions; and

ix. Assess the claims adjudication process and capabilities of the OhioRISE Plan.

e. No later than 60 days after receiving the ISCA findings, the OhioRISE Plan must develop an action plan to address any quality improvement opportunities outlined in the report and submit this report to ODM for its review and approval.

3. Business Continuity and Disaster Recovery

a. The OhioRISE Plan must develop and be continually ready to invoke a comprehensive business continuity and disaster recovery (BC-DR) plan that addresses operations, staff, and systems that support this Agreement.

b. The BC-DR plan must comply with NIST 800-34. https://nvlpubs.nist.gov/nistpubs/Legacy/SP/nistspecialpublication800-34r1.pdf.

c. The OhioRISE Plan's BC-DR plan, and any significant updates to the plan, must be submitted to ODM for review 60 calendar days prior to its effective date.

d. The OhioRISE Plan must periodically, but not less than annually, test its BC-DR plan through simulated disasters and lower level failures.

i. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must provide a summary of its BC-DR test results (Summary of BC-DR Plan Test Results), including any corrective actions, to ODM within 30 calendar days of receiving the results.

4. Acceptance Testing

a. General

i. Before the OhioRISE Plan may submit production filed to ODM, the OhioRISE Plan must conduct acceptance testing of any data electronically submitted to ODM as follows:

1. Whenever the OhioRISE Plan changes the method, preparer, or file layout of the electronic data; and/or

2. When ODM determines that the OhioRISE Plan's data submissions have an error or failure rate of 2% or higher.

b. New or Modified Information System

i. The OhioRISE Plan must include ODM in user acceptance testing and end-to-end integration testing when significant system changes are made that impact the user experience and/or end-to-end data flow. System changes include any of the following:

1. Existing system updates;

2. New system implementations (replacing system or components with another);

3. New infrastructure support systems (replacing an infrastructure component, [e.g., SFTP or electronic data interchange [EDI] system]);

4. File format changes; and

5. File transmission protocol changes.

ii. User acceptance testing must include training if there is a perceivable change to workflows or user screens.

iii. Data files that are submitted to ODM must be tested and accepted prior to implementing in production. ODM will notify the OhioRISE Plan in writing when a test has been deemed successful and the changes are approved.

iv. ODM reserves the right to verify the OhioRISE Plan's capability to report elements in the minimum data set prior to executing the provider agreement for the next contract period.

5. Claims Adjudication and Payment Processing Requirements

a. Timely Filing

i. The OhioRISE Plan must accept claims for 365 calendar days from the date of service, as described in OAC rule 5160-1-19. In addition, the OhioRISE Plan must follow the overpaid claims and timely filing exceptions described in the rule.

b. Claims Adjudication

i. The OhioRISE Plan must integrate with the OMES for claims, third party liability (TPL), authorizations, and any other types of data or processes as directed by ODM.

ii. The OhioRISE Plan must electronically accept claims from the OMES and adjudicate all claims to final status (payment or denial) within the timeframes specified in Appendix L, Payment and Financial Performance. The diagram in Exhibit K.1 provides a high-level overview of the claims flow.

iii. All claims forwarded from the OMES to the OhioRISE Plan for processing are to be considered clean as these claims meet the threshold edits applied at the submission of the claim through the EDI and meet the X12/TR3 standard. If the claim forwarded from the OMES to the OhioRISE Plan does not have the necessary documentation to adjudicate the claim, the OhioRISE Plan may suspend the claim until documentation is provided. If system changes are required to properly adjudicate claims, the OhioRISE Plan must notify ODM of the intent to suspend claims for programmatic and/or systems concerns via their compliance mailbox and follow the Claims Payment Systemic Errors requirements to report of any potential impact to providers as outlined in this appendix.

iv. If there is information on the provider network management (PNM) system generated provider master file (PMF) or any other supplemental file generated by an ODM system to support claims payment, the OhioRISE Plan must use the PMF or other ODM system generated supplemental file information to adjudicate the claim(s).

v. The OhioRISE Plan must utilize the ODM PNM as the system of record and reconcile claims against the ODM PNM data points as directed by ODM.

vi. The OhioRISE Plan must provide updated claim status demonstrating all claims activity daily to ODM.

vii. The OhioRISE Plan must provide its network providers detailed instructions on claims submission procedures, including information provided by ODM about the role of ODM's OMES.

viii. The OhioRISE Plan must provide out-of-network providers detailed instructions on claims submission procedures, including information provided by ODM about the role of ODM's OMES, within one business day of receiving a request from an out-of-network provider or becoming aware that an out-of-network provider has rendered services to a member.

ix. The OhioRISE Plan must notify providers via ODM's OMES, who have submitted claims of claim status (paid, denied, and all claims not in a final paid or denied adjudicated status [hereinafter referred to as "suspended"]) within 30 calendar days of receipt by the OhioRISE Plan or its designee. Such notification may be in the form of a claim payment/remittance advice produced on a routine monthly or more frequent basis.

x. If a provider and/or a provider's clearinghouse submits a Health Insurance Portability and Accountability Act (HIPAA) compliant 276 electronic data interchange (EDI) transaction to the OhioRISE Plan and/or the OhioRISE Plan's clearinghouse via ODM's OMES, the OhioRISE Plan/clearinghouse must respond with a complete HIPAA compliant 277 EDI transaction within the required Council for Affordable Quality Healthcare, Inc. (CAQH) Committee on Operating Rules for Information Exchange (CORE) timeframes with the HIPAA compliant claim status category code(s) and claim status code(s) that will provide information on all denied, paid, or suspended claims to the submitter.

xi. The OhioRISE Plan must accept and use, and must require its providers to use, third party liability (TPL) data maintained by ODM's OMES for the OhioRISE Plan's and provider's TPL activities.

c. Edits

i. The OhioRISE Plan must implement claims edits (e.g., Strategic National Implementation Process [SNIP], National Correct Coding Initiative [NCCI]) at the direction of ODM.

d. Grouping Methodology

i. When the OhioRISE Plan uses a grouping methodology to pay inpatient and/or outpatient hospital claims the OhioRISE Plan is expected to use the same grouper software and inpatient only procedure listing (determined by Medicare, 3M, or other grouping product) that ODM uses to process fee-for-service (FFS) claims.

e. Systems Audit

i. The OhioRISE Plan and any subcontractor systems must undergo an annual third-party audit that confirms that the OhioRISE Plan's systems and environment comply with the NIST 800-53 Rev 4 (or current release) moderate baseline.

ii. The OhioRISE Plan and any subcontractor systems must also utilize a third party to determine compliance with MARS-E 2.0 (or current release) standards.

iii. If the OhioRISE Plan or any subcontractor systems utilizes a cloud hosting provider, the cloud provider must be Fed-RAMP certified or undergo an annual third-party audit that certifies compliance with NIST 800-53 Rev 4 (or current version) moderate baseline.

iv. The OhioRISE Plan, and any subcontractors that adjudicate claims, must undergo a System and Organizational Control (SOC) 2 Type II or an alternative privacy and security systems audit that is prior approved by ODM. This audit must be completed prior to implementation and at least annually thereafter.

v. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must submit the results of the systems audit (Systems Audit Results), including any corrective action, to ODM within two weeks of receiving the final report.

f. Claims Payment Systemic Errors

i. For the purpose of this appendix, a claims payment systemic error (CPSE) is defined as the OhioRISE Plan's claims adjudication incorrectly underpaying, overpaying, denying, or suspending claims that impact five or more providers.

ii. The OhioRISE Plan must submit the OhioRISE Plan's CPSE report (CPSE Report) to ODM as specified in Appendix P, Chart of Deliverables.

iii. The OhioRISE Plan must submit all communications regarding CPSEs to MedicaidCPSE@medicaid.ohio.gov, unless otherwise directed by ODM.

iv. The OhioRISE Plan must follow all CPSE instructions as directed by ODM, including the CPSE reporting template instructions and guidelines.

v. The OhioRISE Plan must ensure each identified error has a unique error ID to tie each reported line to a specific error the OhioRISE Plan is addressing. For each error, the OhioRISE Plan must provide a specified begin date, and when resolved, a definitive end date. For each CPSE, the following information is required:

1. A detailed description and scope of all active CPSEs;
2. The date the CPSE was first identified;
3. The type(s) of all provider(s) impacted;
4. The number of providers impacted;
5. The timeline for fixing the CPSE;
6. The number of claims impacted; and
7. The date of claims adjustments or required provider action.

vi. The OhioRISE Plan must report all CPSEs on a monthly CPSE report posted on the OhioRISE Plan's Ohio Medicaid website.

1. The CPSE report must be public facing for anyone to view.
2. The OhioRISE Plan must post the online CPSE report as specified in Appendix P, Chart of Deliverables, and must label the report to reflect the updated date.

3. The OhioRISE Plan's CPSE online report must include, at a minimum, the following information:
    a. A detailed description and scope of all CPSEs;
    b. The date of first identification;
    c. The type(s) of provider(s) impacted;
    d. The timeline for fixing the CPSE; and
    e. The date of claims adjustments or required provider action.

vii. The OhioRISE Plan must have policies and procedures to identify, communicate, and correct CPSEs. The OhioRISE Plan must keep its CPSE policies and procedures current to reflect the CPSE requirements. Upon request, the OhioRISE Plan must submit its CPSE policies and procedures to ODM for review. ODM reserves the right to request changes if necessary.

viii. The OhioRISE Plan's CPSE policies and procedures must include, at a minimum:

1. The use of input from internal and/or external sources to identify a CPSE, including but not limited to:
    a. User acceptance testing activities;
    b. Claims processing activities;
    c. Provider complaints/inquiries; and
    d. ODM inquiries.
2. The identification of issues impacting smaller provider types (e.g., independent providers);
3. A description of the process, including timelines, to escalate from initial identification to definition of the error;
4. A full description of the root cause analysis conducted when issues or defects are found, and the software development life cycle (SDLC) processes followed, including timelines;
5. The timeframe to re-adjudicate claims, if applicable, or notify providers of an overpayment and the process for providers to dispute those actions in accordance with the requirements of this Agreement; and
6. A description of the process to complete and submit a completed CPSE report monthly to ODM.

g. Non-CPSE Errors

i. The OhioRISE Plan must correct errors in provider payments that do not meet the definition of claims payment systematic errors per this appendix within 30 calendar days from the date of identification of the error.

h. Software Updates

i. The OhioRISE Plan's claims adjudication systems must apply software updates based on a validated risk analysis and no less frequently than quarterly. The OhioRISE Plan must implement major software version releases based on a validated risk analysis and not more than 180 calendar days from release date. If the OhioRISE Plan maintains its own software, the schedule and description of changes for future updates must be provided to ODM for review and approval.

i. Implementing ODM Rate Changes

i. The OhioRISE Plan must load ODM rate changes into applicable systems by either the rate change implementation date or within 20 calendar days of being notified by ODM of the change, whichever date is later. The effective date of the rate change must be the date specified by ODM, regardless of when the OhioRISE Plan's system(s) are updated. If necessary, the OhioRISE Plan must back date the effective date and reprocess claims to ensure any claim received after the specified date of the rate change is adjudicated accurately. If the OhioRISE Plan is unable to load rate changes timely, the OhioRISE Plan must report the issue on the CPSE report.

j. Processing Delays

i. The OhioRISE Plan must not engage in any practice that unfairly or unnecessarily delays the processing or payment of any claim for services to a member.

k. Notice to Providers

i. The OhioRISE Plan must provide a 30 calendar day advance notice to providers of any new edits or system changes related to claims adjudication or payments processing.

ii. The OhioRISE Plan must provide a notice of intent to recover an overpayment in accordance with Appendix G, Program Integrity.

6. Electronic Data Interchange

a. The OhioRISE Plan's technology strategy and systems must have the capability to accept and transmit real-time transactions as directed by ODM.

b. The OhioRISE Plan must comply with all applicable provisions of HIPAA, including EDI standards for code sets and the following electronic transactions:

   i. ASC X12 837 – Health care claims (institutional, professional, and dental);

   ii. ASC X12 837 Post-adjudicated claims data reporting (PACDR) — Health care claims (institutional, professional, and dental);

   iii. ASC X12 270/271 – Eligibility and benefit verification and response;

   iv. ASC X12 276/277 – Health care claim status request and response;

   v. ASC X12 Unsolicited 277 Claim Status transaction and/or the 277 Claim Acknowledgement (CA);

   vi. ASC X12 269 – Health care benefit coordination verification;

   vii. ASC X12 274 – Health care provider information/directory;

   viii. ASC X12 275 – Patient information;

   ix. ASC X12 278 – Authorization/referral request and response;

   x. ASC X12 824 – Application Advice; and

   xi. ASC X12 835 – Health care payment and remittance status (or electronic funds transfer).

c. The OhioRISE Plan must implement EDI transactions in conformance with the appropriate version of the transaction implementation guide, as specified by applicable federal requirements.

d. The OhioRISE Plan must be able to accept, send, and process multiple versions of X12 transactions concurrently.

e. The OhioRISE Plan must have the capacity to accept the following transactions consistent with EDI processing specifications in the transaction implementation guides and in conformance with the Companion Guides issued by ODM:

   i. ASC X12 837 – Health care claims (institutional, professional, and dental);

   ii. ASC X12 270/271 – Eligibility and benefit verification and response;

   iii. ASC X12 276/277 – Health care claim status request and response;

iv. ASC X12 278 – Authorization/referral request and response;

v. ASC X12 275 – Patient information;

vi. ASC X12 820 – Payroll deducted and other group premium payment for insurance products; and

vii. ASC X12 834 – Benefit enrollment and maintenance.

f. The OhioRISE Plan must comply with the HIPAA-mandated EDI transaction standards and code sets as set forth in federal requirements. The OhioRISE Plan must keep codes up to date and meet all implementation dates as directed by ODM.

g. The capacity of the OhioRISE Plan and/or applicable trading partners and business associates to electronically conduct claims processing and related transactions must be demonstrated to the satisfaction of ODM.

h. The OhioRISE Plan must complete and submit to ODM an EDI trading partner agreement by the timeframe and in a format specified by ODM.

i. If the OhioRISE Plan fails to identify an error on its behalf with EDI transactions within two business days and/or correct it within three months, it may be liable for the cost incurred by ODM for additional transaction fees if it must correct and retransmit EDI transactions due to the error at any time thereafter.

j. The OhioRISE Plan must connect a production mirror to the EDI CERT Region.by March1, 2024. The EDI CERT region will be used to add new trading partners and to allow trading partners to test in accordance with OAC rule 5160-1-20 requirements before they are authorized for production (PROD). The OhioRISE Plan must collaborate with ODM for adequate testing and validation for new transactions, policy changes, and other changes before running in PROD.

7. Encounter Data Submission Requirements

a. The OhioRISE Plan must collect data on services furnished to members through a claims system and must report encounter data to ODM. The OhioRISE Plan must submit encounters electronically to ODM as specified in this appendix.

b. Information concerning the proper submission of electronic data interchange (EDI) encounter transactions is available on ODM's website. ODM's website contains Encounter Data Companion Guides for the Managed Care 837 professional, and institutional transactions. Additional Companion Guides for transactions that should be used in conjunction with encounters, including the U277 Unsolicited Claim/Encounter Status Notifications, the 824 Application Advice, and the TA1 Transmission Acknowledgement are also available on ODM's website. The OhioRISE Plan must use the Encounter Data Companion Guides in conjunction with the X12 Implementation Guides for EDI transactions.

c. The OhioRISE Plan must submit a test file in the ODM-specified medium in the required formats as directed by ODM. Test files must be submitted, reviewed, and approved by ODM prior to the OhioRISE Plan submitting production encounter data files.

d. For subcontracted payment arrangements in which the subcontractor directly pays particular claims (i.e., delegated arrangements in which the delegate is responsible for paying claims on behalf of the OhioRISE Plan to providers), the OhioRISE Plan must submit encounters that include the amounts paid by the subcontractor to the provider and include claim-level detailed information.

e. For subcapitated payment arrangements (i.e., the vendor/provider is paid a fixed amount regardless of whether or what services are rendered), the OhioRISE Plan must shadow price the encounter and submit encounters that include the amount that would have been paid if the vendor/provider was not capitated and include claim-level detailed information.

f. The OhioRISE Plan must submit encounters no later than seven calendar days from completion of the claim (i.e., remittance advice generated). The OhioRISE Plan must submit encounters for capitated providers within seven calendar days of receipt of the encounter.

g. As specified in Appendix G, Program Integrity, in accordance with 42 CFR 438.604 and 42 CFR 438.606, the OhioRISE Plan must submit a certification letter with the submission of an encounter data file.

h. The OhioRISE Plan must submit valid encounter submissions that include the application of specific edits, including checking for member eligibility, OhioRISE Plan enrollment, valid current procedural terminology (CPT) codes, cross field editing, and include valid line-level detail with meaningful claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) accurately reflecting the data submitted to the provider indicating final status of adjudication. ODM reserves the right to direct the OhioRISE Plan's editing and payment.

i. The OhioRISE Plan must submit valid claim and line-level denials that reflect the data submitted on the claim and accurately reflect the adjudication results.

j. The OhioRISE Plan must submit encounters for all claim activities, including instances when the OhioRISE Plan applies adjustments at the individual line level or in a mass adjustment update. Encounter submissions must reflect all claims activity.

k. The OhioRISE Plan must have software edits that check for and prevent duplicates on encounter data submissions.

l. The OhioRISE Plan must follow the 837 PACDR standards for professional, and institutional encounter data submissions, including allowed amount and paid amount in accordance with 42 CFR 438.242(c)(3).

m. The OhioRISE Plan must have processes and staffing to ensure that if ODM discovers errors or a conflict with a previously adjudicated encounter or claim, the OhioRISE Plan is able to adjust or void the encounter within the specified number of days as directed by ODM.

n. The OhioRISE Plan must comply with the encounter data quality measures as calculated by ODM. Information concerning ODM's encounter data quality measures, including the methodology, is available in the Methodology for Encounter Data Quality Measures document located on the ODM website. ODM reserves the right to revise this document as needed.

o. Exceptions to any of the requirements in this section must be prior approved by ODM.

8. Non-Claims Data Submission Requirements

a. All data on any services provided to members that are not reflected as claims or encounters will be submitted through the Managed Care Entity Non-Claims Reporting Template as specified in Appendix P, Chart of Deliverables. This includes but is not limited to value-added/or additional services.

9. Electronic Health Records

a. The OhioRISE Plan must encourage, support, and facilitate its network providers' adoption and effective use of electronic health records (EHRs), including for population health and quality improvement.

b. The OhioRISE Plan must identify, and track internally which network providers have or have not adopted EHRs and how effectively they use EHRs including for population health and quality improvement.

10. Health Information Exchanges

a. The OhioRISE Plan must participate with both of Ohio's health information exchanges (HIEs) and be capable of exchanging protected health information, connecting to inpatient and ambulatory electronic health records, connecting to care coordination information technology system records, and supporting secure messaging or electronic querying between providers, patients, and the OhioRISE Plan. This must include but is not limited to using the HIEs for admission, discharge, and transfer (ADT) data and closing referral loops for social determinants of health (SDOH).

b. The OhioRISE Plan will be required to assess each CME’s ability to provide data in an electronic format (e.g., EHR) to the OhioRISE portal and provide the necessary technical assistance to CMEs to participate with Ohio’s two HIEs.

c. The OhioRISE Plan must require its network hospitals to provide ADT data to both HIEs.

d. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must submit an annual report (Network Provider HIE Participation Report) to ODM providing the number and percentage of network providers, by provider type, connected to one or both HIEs and the type of participation.

e. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must submit to ODM an annual plan to support use of EHRs and HIEs (EHR and HIE Provider Support Plan), including, for example, offering incentives for providers to join an HIE.

11. Interoperability

a. In accordance with 42 CFR 438.242, the OhioRISE Plan must implement and maintain an application programming interface (API) that permits third party applications to retrieve, with the approval and at the direction of a member, member health information and data maintained by the OhioRISE Plan.

b. In accordance with 42 CFR 438.62, the OhioRISE Plan must implement a process for the electronic exchange of the United States core data for interoperability (USCDI) data classes and elements with MCOs, the SPBM, ODM, and any other payer designated by the member.

c. The OhioRISE Plan must implement a process for the electronic exchange of the USCDI data classes and elements with care coordination entities and providers serving the member.

12. Artificial Intelligence and Machine Learning

a. All systems using Artificial Intelligence (AI) or Machine Learning (ML) technology must incorporate core principles of fairness, accountability, security and privacy, transparency, and human centeredness.

i. Fairness

1. Performance of systems and tools must be assessed for potential bias or disparate impact prior to implementation.

ii. Accountability

1. Systems and tools must by subject to governance, including a human in the loop or human on the loop, as appropriate.

iii. Security and Privacy

1. Systems and tools must comply with all legal, regulatory, and other relevant portions of this agreement as it relates to information security and privacy. Member PHI and PII shall not be provided to unconstrained tools or systems, publicly accessible service or training models.

iv. Transparency

1. Systems and tools must be explainable in their operation and output.

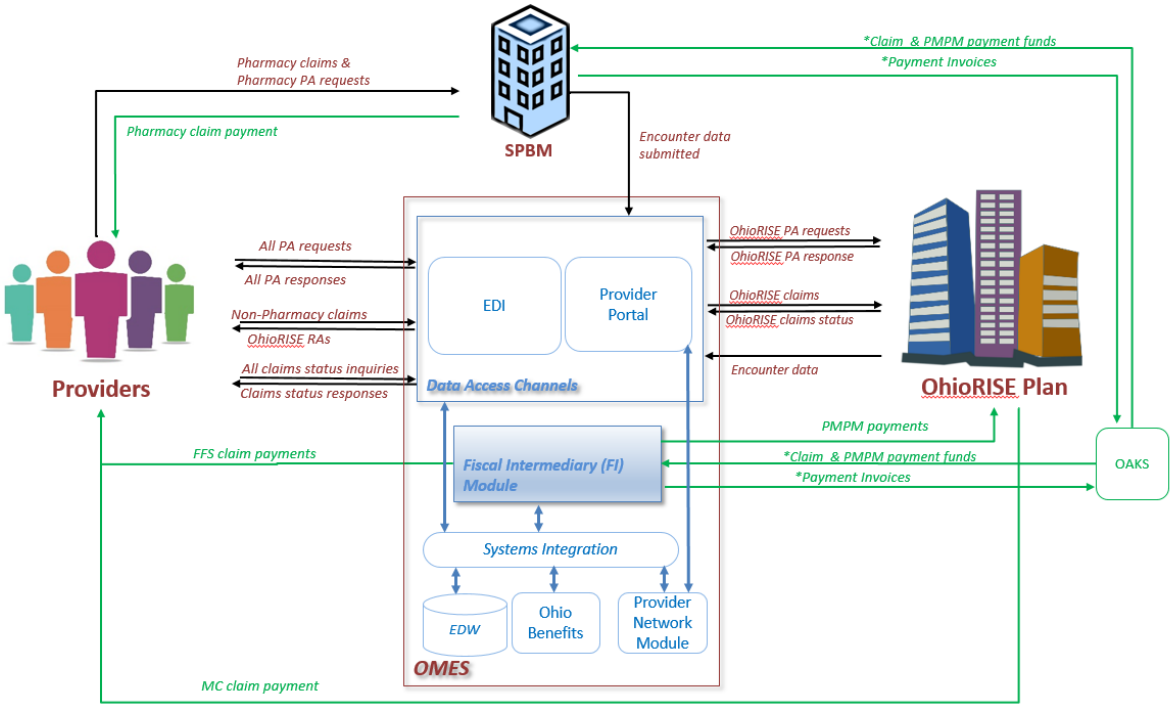
v. Human Centeredness

1. Systems and tools must prioritize member needs, values, and capabilities.

b. An up-to-date inventory of AI or ML models and tools must be maintained by the plan and provided to ODM upon request.

c. ODM may provide additional requirements regarding specific uses of AI tools or software.

Exhibit K.1 Claims High-Level Message Flow



APPENDIX L – PAYMENT AND FINANCIAL PERFORMANCE

1. Monthly Premium Payment

a. ODM will remit payment to the OhioRISE Plan via an electronic funds transfer (EFT), or at the discretion of ODM, by paper warrant.

b. ODM will confirm all premium payments paid to the OhioRISE Plan during the month via a monthly remittance advice (RA).

c. ODM will provide a record of each recipient detail level payment via Health Insurance Portability and Accountability Act (HIPAA) compliant 820 transactions.

2. Submission of Financial Statements

a. Quarterly and Annual NAIC Financial Statements

i. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must submit quarterly and annual National Association of Insurance Commissioners (NAIC) financial statements (NAIC Quarterly Financial Statement and NAIC Annual Financial Statement) to ODM.

ii. The NAIC financial statements must include all required filings, schedules, exhibits, and components as stated in the NAIC health statement instructions.

iii. The OhioRISE Plan must provide ODM with an electronic copy of the NAIC statements in the NAIC-approved format.

iv. The OhioRISE Plan must submit NAIC financial statements to ODM even if the Ohio Department of Insurance (ODI) does not require the OhioRISE Plan to submit these statements to ODI.

b. Annual Audit Report

i. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must submit a copy of its annual audit report (Annual Audit Report) required by ODI in accordance with ORC section 1751.321.

c. Annual NAIC/Cost Report Reconciliation

i. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must submit an annual NAIC/cost report reconciliation (NAIC/Cost Report Reconciliation).

d. Health Insuring Corporation Tax

i. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must submit quarterly Health Insuring Corporation (HIC) tax reports (HIC Tax Report) to ODM.

e. Other Financial Reports and Information

i. The OhioRISE Plan must submit, upon ODM's request, information that shows all profit and losses at the entity level for administrative or health care services provided through

a subcontract, first tier, downstream, and related entities (FDR) agreement, or cost allocation agreement with an entity that is a related party (Related Party Profit and Loss Report).

ii. The OhioRISE Plan must maintain a system to evaluate and monitor the financial viability of all risk bearing subcontractors, FDRs, or network providers, including but not limited to accountable care organizations (ACOs), health maintenance organizations (HMOs), and all other risk-bearing OhioRISE Plan subcontractors.

iii. The OhioRISE Plan must provide any financial reports and information as deemed necessary by ODM, in a format determined by ODM, to properly monitor the financial condition of the OhioRISE Plan, its subcontractors, FDRs, and network providers.

3. Financial Performance Measures and Standards

a. The OhioRISE Plan must comply with the following financial performance measures and standards.

i. Current Ratio

1. The OhioRISE Plan's current ratio, calculated in accordance with the ODM Methods for Financial Performance Measures, must not fall below 1.00.

ii. Medical Loss Ratio

1. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must submit an annual medical loss ratio (MLR) reporting tool and documentation (MLR Reporting Tool and Documentation).

iii. Defensive Interval

1. The OhioRISE Plan's defensive interval, calculated in accordance with the ODM Methods for Financial Performance Measures, must not fall below 30 calendar days.

4. Insurance Requirements

a. General

i. The OhioRISE Plan must procure and maintain, for the duration of this Agreement, insurance against claims for injuries to persons or damages to property that may arise from or in connection with the OhioRISE Plan's performance under this Agreement.

ii. The OhioRISE Plan must procure and maintain, for the duration of this Agreement, insurance for claims arising out of its performance under this Agreement, including but not limited to loss, damage, theft, or other misuse of data, infringement of intellectual property, invasion of privacy, and breach of data.

b. Minimum Scope and Limit of Insurance

i. The OhioRISE Plan's coverage must be at least as broad as:

1. Commercial General Liability (CGL): written on an "occurrence" basis, including products, completed operations, property damage, bodily injury, and personal and advertising injury with limits no less than $1,000,000 per occurrence. If a general aggregate limit applies, either the general aggregate limit must apply separately to this Agreement or the general aggregate limit must be twice the required occurrence limit. Defense costs must be outside the policy limit.

2. Automobile Liability: covering Code 1 (any auto), or if the OhioRISE Plan has no owned autos, Code 8 (hired) and 9 (non-owned), with a limit no less than $1,000,000 per accident for bodily injury and property damage.

3. Workers' Compensation insurance: as required by the state of Ohio, or the state in which the work will be performed, that meets statutory limits, and employer's liability insurance with a limit of no less than $1,000,000 per accident for bodily injury or disease. If the OhioRISE Plan is a sole proprietor, partnership, or has no statutory requirement for workers' compensation, the OhioRISE Plan must provide a letter stating that it is exempt and agreeing to hold the state of Ohio harmless from loss or liability for such.

4. Professional Liability insurance: covering all staff with a minimum limit of $1,000,000 per incident and a minimum aggregate of $3,000,000. If the OhioRISE Plan's policy is written on a "claims made" basis, the OhioRISE Plan must provide ODM with proof of continuous coverage at the time the policy is renewed. If for any reason the policy expires, or coverage is terminated, the OhioRISE Plan must purchase and maintain "tail" coverage through the applicable statute of limitations.

5. Technology Professional Liability (Errors and Omissions) insurance: appropriate to the OhioRISE Plan's professional services provided under this Agreement, with limits of not less than $2,000,000 per occurrence or claim, $2,000,000 aggregate. Coverage must be sufficiently broad to respond to the duties and obligations as is undertaken by the OhioRISE Plan in this Agreement and must cover all applicable OhioRISE Plan personnel who perform professional services under this Agreement.

6. Cyber Liability (first and third party): coverage, with limits not less than $5,000,000 per claim, $10,000,000 aggregate, must be sufficiently broad to respond to the duties and obligations as is undertaken by the OhioRISE Plan in this Agreement and must include but not be limited to claims involving infringement of intellectual property, including but not limited to infringement of copyright, trademark, trade dress, invasion of privacy violations, information theft, damage to or destruction of electronic information, release of private information, alteration of electronic information, extortion, and network security. The coverage must provide for breach response costs, as well as regulatory fines and penalties and credit monitoring expenses, with limits sufficient to respond to these obligations.

ii. The insurance obligations under this Agreement are the minimum insurance coverage requirements and/or limits for this Agreement. Any insurance proceeds in excess of or

broader than the minimum required coverage and/or minimum required limits, which are applicable to a given loss, must be available to ODM.

iii. No representation is made that the minimum insurance requirements of this Agreement are sufficient to cover the obligations of the OhioRISE Plan under this Agreement.

c. Required Provisions

i. The OhioRISE Plan's insurance policies must contain, or be endorsed to contain, the following provisions:

1. Additional Insured Status

a. Except for Workers' Compensation and Professional Liability insurance, the state of Ohio, its officers, officials, and employees must be covered as additional insureds with respect to liability arising out of work or operations performed by or on behalf of the OhioRISE Plan under this Agreement, including materials, parts, or equipment furnished in connection with such work or operations.

b. Coverage can be provided in the form of an endorsement to the OhioRISE Plan's insurance.

2. Primary Coverage

a. For any claims related to this Agreement, the OhioRISE Plan's insurance coverage must be primary insurance. Any insurance or self-insurance maintained by the state of Ohio, its officers, officials, and employees must be in excess of the OhioRISE Plan's insurance and must not contribute with it.

3. Umbrella or Excess Insurance Policies

a. The OhioRISE Plan may use umbrella or excess commercial liability policies in combination with primary policies to satisfy the limit requirements above. Such umbrella or excess commercial liability policies must apply without any gaps in the limits of coverage and be at least as broad as and follow the form of the underlying primary coverage required above.

d. Notice of Cancellation

i. The OhioRISE Plan must provide ODM with a written notice of cancellation or material change to any insurance policy required above 30 calendar days in advance, except for non-payment cancellation.

ii. Material change is defined as any change to the insurance limits, terms, or conditions that would limit or alter ODM's available recovery under any of the policies required above.

iii. A lapse in any required insurance coverage during this Agreement will be a breach of this Agreement.

e. Waiver of Subrogation

i. The OhioRISE Plan must grant to the state of Ohio a waiver of any right to subrogation, which any insurer of the OhioRISE Plan may acquire against the state of Ohio by virtue of the payment of any loss under such insurance.

ii. The OhioRISE Plan must obtain any endorsement necessary to affect this waiver of subrogation; however, the waiver of subrogation provision applies regardless of whether or not the state of Ohio has received a waiver of subrogation endorsement from the insurer.

f. Deductibles and Self-Insured Retentions

i. Deductibles and self-insured retentions must be declared to and approved by ODM. ODM may require the OhioRISE Plan to provide proof of ability to pay losses and related investigations, claims administration, and defense expenses within the retention. The policy language must provide, or be endorsed to provide, that the deductible or self-insured retention may be satisfied by either the named insured or ODM.

g. Claims Made Policies

i. If any of the required policies provide coverage on a claims-made basis:

1. The retroactive date must be shown and must be before the date of this Agreement or the beginning of performance under this Agreement.

2. Insurance must be maintained, and evidence of insurance must be provided for at least five years after completion of this Agreement.

3. If coverage is canceled or non-renewed, and not replaced with another claims-made policy form with a retroactive date prior to effective date of this Agreement, the OhioRISE Plan must purchase "extended reporting" coverage for a minimum of five years after completion of performance under this Agreement. The discovery period must be active during the extended reporting period.

h. Verification of Coverage

i. The OhioRISE Plan must furnish ODM with original certificates and amendatory endorsements or copies of the applicable policy language effecting coverage required by this section.

ii. All certificates and endorsements must be received and approved by ODM before work commences under this Agreement. However, failure to obtain the required documents prior to the work beginning will not waive the OhioRISE Plan's obligation to provide them.

iii. ODM reserves the right to require complete, certified copies of all required insurance policies, including endorsements required by this section, at any time.

i. Subcontractors

i. The OhioRISE Plan must require and verify that all subcontractors maintain insurance meeting all the requirements stated herein, and the OhioRISE Plan must ensure that ODM is an additional insured on insurance required from subcontractors.

j. Special Risks or Circumstances

i. ODM reserves the right to modify these requirements, including limits, based on the nature of the risk, prior experience, insurer, coverage, or other special circumstances.

5. Reinsurance Requirements

a. General

i. The OhioRISE Plan must carry reinsurance coverage from a licensed commercial carrier to protect against catastrophic inpatient-related behavioral health expenses (including PRTF incurred by members.

ii. To the extent that the risk for inpatient-related medical expenses is transferred to a subcontractor or FDR, the OhioRISE Plan must provide proof of reinsurance coverage for that subcontractor or FDR.

iii. The OhioRISE Plan's reinsurance coverage must remain in force during the term of this Agreement and must contain adequate provisions for contract extensions.

iv. In the event of termination of the reinsurance agreement due to insolvency of the OhioRISE Plan or the reinsurance carrier, the OhioRISE Plan must be fully responsible for all pending or unpaid claims, and any reinsurance agreements that cover expenses to be paid for continued benefits in the event of insolvency must include Medicaid members as a covered class.

b. Deductible and Coverage

i. The OhioRISE Plan's annual deductible or retention amount for such insurance must be specified in the reinsurance agreement and must not exceed $100,000, unless ODM has provided the OhioRISE Plan with prior approval in writing for a higher deductible amount or alternate reinsurance arrangement. The OhioRISE Plan's reinsurance must cover, at a minimum, 80% of inpatient costs (including PRTF) incurred by one member in one year in excess of $100,000, unless ODM has provided the OhioRISE Plan with prior approval in writing for a higher deductible amount or alternate reinsurance arrangement. The OhioRISE Plan may request a higher deductible amount and/or that the reinsurance covers less than 80% of inpatient costs in excess of the deductible amount. If the OhioRISE Plan has less than one year of Ohio Medicaid managed care contracting experience, the OhioRISE Plan must demonstrate sufficient capital resources, as determined by ODM.

c. Reinsurance Documentation Requirements

i. In determining whether or not a change in reinsurance is required or a request for alternate reinsurance requirements will be approved, ODM may consider:

1. Whether the OhioRISE Plan has sufficient reserves available to pay unexpected claims;

2. The OhioRISE Plan's history in complying with financial indicators as specified in this appendix;

3. The number of members covered by the OhioRISE Plan;

4. The length of time the OhioRISE Plan has been covering Medicaid or other members on a full or partial risk basis;

5. A risk-based capital ratio greater than 2.5 or higher calculated from the last annual ODI financial statement; and/or

6. A scatter diagram or bar graph from the last calendar year that shows the number of reinsurance claims that exceeded the current reinsurance deductible graph/chart showing the claims history for reinsurance above the previously approved deductible from the last calendar year.

d. ODM Notification of Claims

i. If directed by ODM, the OhioRISE Plan must provide documentation specifying the dates of admission, diagnoses, and estimates of the total claims incurred for all Medicaid members for which reinsurance claims have been submitted.

e. Submission of Reinsurance Agreements to ODM

i. The OhioRISE Plan must submit fully executed reinsurance agreements to ODM prior to the effective date of this Agreement.

ii. The OhioRISE Plan must submit any proposed changes or modifications to a reinsurance agreement to ODM in writing for review and approval 30 calendar days prior to the intended effective date and must include the complete and exact text of the proposed change. The OhioRISE Plan must provide copies of new or modified reinsurance agreements to ODM within 30 calendar days of execution.

6. Prompt Pay Requirements

a. Standard

i. In accordance with 42 CFR 447.46 and this Agreement, except if the OhioRISE Plan and its network provider has established an alternative payment schedule mutually agreed upon and described in the provider contract, the OhioRISE Plan must:

1. Pay or deny 90% of all submitted clean claims within 21 calendar days of the date of receipt of the claim;

2. Pay or deny 99% of clean claims within 60 calendar days of the date of receipt of the claim; and

3. Pay or deny 100% of all claims within 90 calendar days of receipt of the claim.

b. Separate Measurement

i. The OhioRISE Plan must measure and comply with the prompt payment standards by the claim types specified below:

1. Care management entities (CME) claims for Tier 3 – Intensive Care Coordination and Tier 2 – Moderate Care Coordination; and

2. All other claim types (excluding MRSS and CME claims for Tier 3 – Intensive Care Coordination and Tier 2 – Moderate Care Coordination).

c. Application

i. The OhioRISE Plan must comply with the prompt pay requirement for both electronic and paper claims and for both network and out-of-network providers.

d. Reporting

i. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must submit quarterly prompt pay reports (Prompt Pay Report) to ODM.

7. Physician Incentive Plan Requirements

a. If the OhioRISE Plan operates a physician incentive plan, it must operate the plan in accordance with 42 CFR 438.3(i), 42 CFR 422.208, and 42 CFR 422.210.

b. In accordance with 42 CFR 422.208, if the OhioRISE Plan operates a physician incentive plan, no specific payment must be made directly or indirectly under the physician incentive plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

c. In accordance with 42 CFR 422.208, if the OhioRISE Plan's physician incentive plan places a physician or physician group at substantial financial risk for services that the physician or physician group does not furnish itself, the OhioRISE Plan must ensure all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection.

d. In accordance with 42 CFR 422.210, the OhioRISE Plan must provide assurance satisfactory to ODM that the requirements of 42 CFR 422.208 are met. In addition, the OhioRISE Plan must provide additional documentation and information about its physician incentive plans to ODM upon request.

e. In accordance with 42 CFR 428.10 and 42 CFR 422.210, and as specified by this Agreement, upon request by a member, and no later than 14 calendar days after the request, the OhioRISE Plan must provide the following information to the member:

i. Whether the OhioRISE Plan uses a physician incentive plan that affects the use of referral services;

ii. The type of incentive arrangement; and

iii. Whether stop-loss protection is provided.

f. Beginning with the rating period of January 1, 2026, in accordance with 42 CFR 438.3(i), the OhioRISE Plan's incentive payment contracts with network providers must include the following elements:

i. Have a defined performance period that can be tied to the applicable MLR reporting periods.

ii. Be signed and dated by all appropriate parties before the commencement of the applicable performance period.

iii. Include clearly defined, objectively measurable and well-documented clinical or quality improvement standards that the provider must meet to receive the incentive payment., and

iv. Specify a dollar amount or percentage of a verifiable dollar amount that can be clearly linked to successful completion of the metrics defined in the incentive payment contract, including date of payment.

The OhioRISE Plan must, on an annual basis, maintain a list of all incentive payment arrangements reported in the MLR numerator for each performance period. Upon request, the OhioRISE Plan must make this annual list and incentive payment contracts available to ODM.

8. Third Party Liability Requirements

a. The OhioRISE Plan must comply with OAC rule 5160-26-09.1 related to tort recovery, coordination of benefits, and reporting to ODM.

b. Pursuant to OAC rule 5160-26-09.1, the OhioRISE Plan must notify ODM of requests for information and provide ODM copies of information released pursuant to a tort action.

c. In performing its third party liability (TPL) responsibilities, the OhioRISE Plan must accept and use ODM's TPL information, as specified in Appendix K, Information Systems, Claims, and Data, of this Agreement.

d. If a member has third party insurance through a commercial payer (third-party payer), the OhioRISE Plan must help the member find a provider that is a network provider for both the OhioRISE Plan and the third-party payer or cover the coordination of benefits (COB) portion of the claim as if the provider were an OhioRISE Plan network provider. If the member uses an OhioRISE Plan network provider that is out-of-network with the third-party payer, the OhioRISE Plan must follow COB procedures outlined in OAC rule 5160-26-09.1 and pay the claim if there is a valid reason for non-payment by the third-party payer.

e. The OhioRISE Plan must coordinate with its coordination of benefits (COB)/third-party liability (TPL) vendor to ensure provider recoupments are not taken back by both the OhioRISE Plan and its COB/TPL vendor resulting in a loss for the provider.

f. The OhioRISE Plan must comply with coordination of benefits requirements for members who are Medicare enrolled as directed by ODM.

g. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must provide ODM with TPL information, including a change file based on reconciliation with ODM's data (Third-Party Liability Data File).

9. Submission of Cost Reports

a. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must submit annual and quarterly cost reports (Quarterly Cost Report and Annual Cost Report) using the cost report template provided by ODM. ODM may make modifications the cost report template that the OhioRISE Plan must use at any time.

b. The OhioRISE Plan must complete the cost reports in accordance with this Agreement and the cost report instructions provided by ODM.

c. The OhioRISE Plan must submit the cost reports in accordance with the timeframes specified by ODM in the cost report instructions.

d. The OhioRISE Plan must revise its cost reports in accordance with the observation log prepared by ODM's actuary and/or ODM instructions. The OhioRISE Plan must address and submit responses to all comments from either ODM or ODM's actuary within the timeframe specified by ODM.

10. Sharing Data with ODM's Actuary

a. Upon ODM's request, the OhioRISE Plan must share data with ODM's actuary. ODM represents and warrants that a Business Associate Agreement that complies with HIPAA and the Health Information Technology for Economic and Clinical Health Act ("HITECH") and the implementing federal regulations under both Acts, has been executed by ODM's actuary, is currently in effect, and will remain in effect for the term of this Agreement.

11. Notification of Regulatory Action

a. If the OhioRISE Plan is notified by ODI of proposed or implemented regulatory action, the OhioRISE Plan must report such notification and the nature of the action to ODM no later than one business day after receipt from ODI. Upon ODM's request, the OhioRISE Plan must provide any additional information as necessary to ensure continued satisfaction of the requirements of this Agreement. The OhioRISE Plan may request that information related to such actions be considered proprietary in accordance with Article VII of the Baseline Provider Agreement.

APPENDIX M – RATE METHODOLOGY

MILLIMAN REPORT

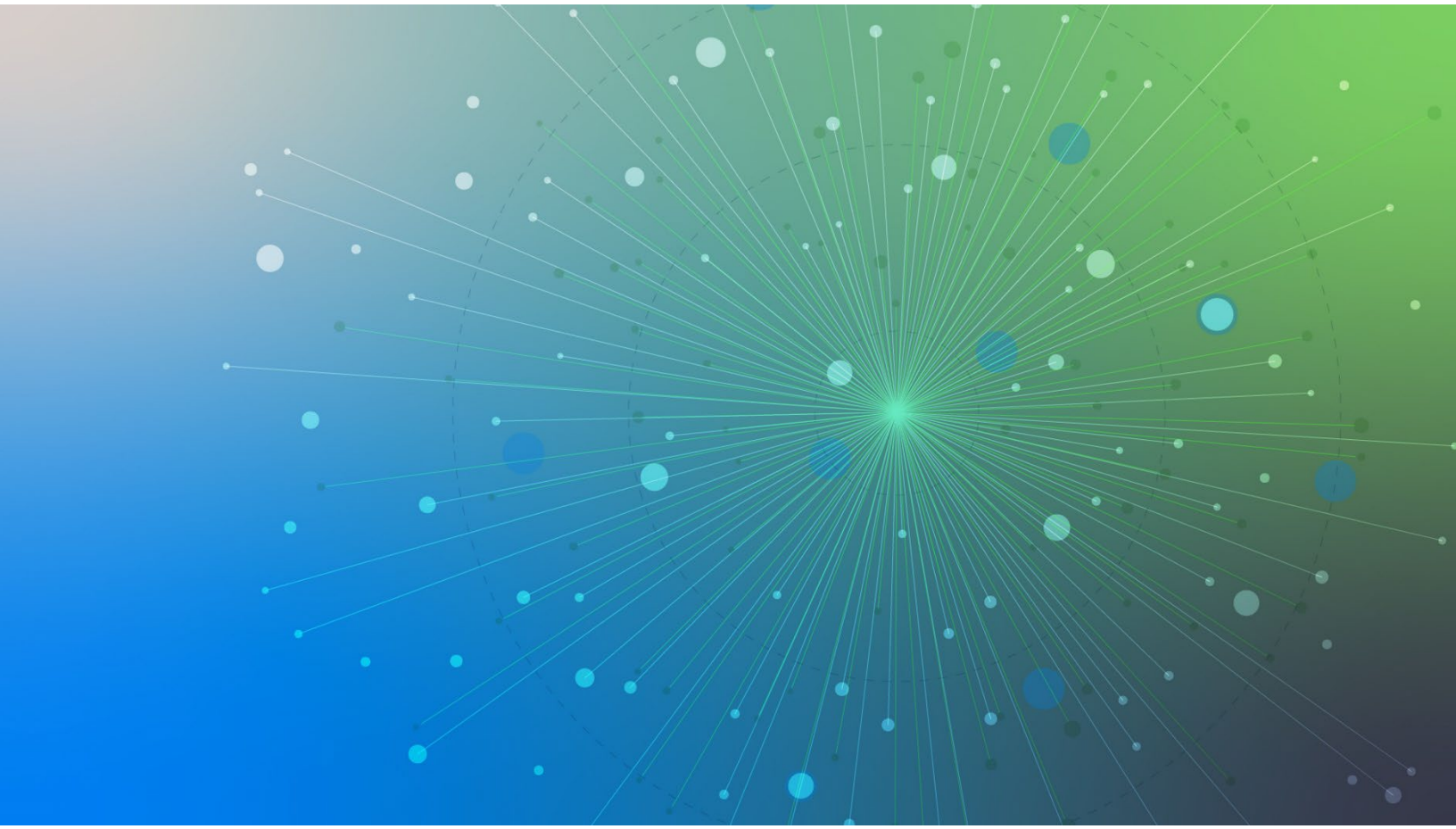
Calendar Year 2026 Provider Agreement Rate Certification

January 1, 2026 through December 31, 2026

Ohio Department of Medicaid

December 17, 2025

Jason A. Clarkson, FSA, MAAA
Mackenzie N. Egan, FSA, MAAA
Tyler J. Schulze, FSA, MAAA
Nolan R. Ginther, ASA, MAAA



Milliman

Milliman

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APPENDIX 1: CY 2026 RATE CHANGE SUMMARY

Introduction & Executive Summary

This document is an abridged version of the file titled "CY 2026 OhioRISE Capitation Rate Certification" dated December 12, 2025. Please refer to the certification report for a complete version of the OhioRISE CY 2026 capitation rate development documentation.

BACKGROUND

Milliman, Inc. (Milliman) has been retained by the Ohio Department of Medicaid (ODM) to provide actuarial and consulting services related to the development of capitation rates for the Ohio Resilience through Integrated Systems and Excellence (OhioRISE) program effective January 1, 2026 through December 31, 2026 (CY 2026).

This report provides documentation for the development of the actuarially sound capitation rates.

Section I. Medicaid managed care rates

1. GENERAL INFORMATION

The capitation rates provided under the certification are "actuarially sound" for purposes of 42 CFR 438.4(a), according to the following criteria:

- The capitation rates provide for all reasonable, appropriate, and attainable costs that are required under terms of the contract and for the operation of the MCO for the time period and population covered under the terms of the contract, and such capitation rates were developed in accordance with the requirements under 42 CFR 438.4(b).

To ensure compliance with generally accepted actuarial practices and regulatory requirements, we referred to published guidance from the American Academy of Actuaries (AAA), the Actuarial Standards Board (ASB), the Centers for Medicare and Medicaid Services (CMS), and federal regulations. Specifically, the following were referenced during the rate development:

- Actuarial standards of practice (ASOPs) applicable to Medicaid managed care rate setting which have been enacted as of the capitation rate certification date, including: ASOP 1 (Introductory Actuarial Standard of Practice); ASOP 5 (Incurred Health and Disability Claims); ASOP 12 (Risk Classification (for All Practice Areas)); ASOP 23 (Data Quality); ASOP 25 (Credibility Procedures); ASOP 41 (Actuarial Communications); ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies); ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification); and ASOP 56 (Modeling).
- Actuarial soundness and rate development requirements in Medicaid and CHIP Managed Care Final Rules.
- The 2025-2026 Medicaid Managed Care Rate Development Guide published by CMS.
- Throughout this document and consistent with the requirements under 42 CFR 438.4(a), the term "actuarially sound" will be defined as in ASOP 49:

  "Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes."[1]

[1] http://www.actuarialstandardsboard.org/asops/medicaid-managed-care-capitation-rate-development-and-certification/

A. Rate Development Standards

I. RATING PERIOD

The actuarial certification contained in the certification report is effective for the capitation rates attributable to a 12-month rating period from January 1, 2026 through December 31, 2026.

II. REQUIRED ELEMENTS

(a) Program information

(i) Managed Care program

The certified rates were developed for the State of Ohio's OhioRISE managed care program, which was first effective in July 2022.

Under this program, behavioral health services are provided through one Prepaid Inpatient Health Plan (PIHP) on a statewide basis. Aetna Better Health of Ohio is the contracted PIHP and is referred to as the "OhioRISE plan" in this report. The managed care population comprises children under 21 who have complex behavioral health needs. The program comprises members from all Medicaid aid categories, including low-income children and families, pregnant women, disabled, and those eligible for Medicaid as a result of Ohio's implementation of the ACA's Medicaid expansion. Dual-eligible (Medicare-Medicaid) members are not covered as part of the OhioRISE program. The program is limited to certain behavioral health services for enrolled members, a subset of which were previously covered under the Medicaid Managed Care (MMC) program.

(ii) Covered populations

ODM's OhioRISE program includes Medicaid beneficiaries in four distinct populations:

- Modified Adjusted Gross Income (MAGI): includes children, parents, and caretaker populations;
- Expansion (EXP or MAGI Expansion Adult): includes the population eligible for Medicaid under the ACA Medicaid expansion;
- Aged, Blind, and Disabled (ABD): limited to non-dual and non-institutional populations; and,
- Adoption and Foster Kids (AFK): includes the adoption and foster children population.

Additional criteria to be eligible for the OhioRISE program is as follows:

- Enrolled in Ohio Medicaid under either managed care or fee for service;
- Under the age of 21;
- Not enrolled in the MyCare Ohio program; and,
- Meet a functional needs threshold for behavioral health care, as identified by the Child and Adolescent Needs and Strengths (CANS) assessment.

OHIORISE ENROLLMENT RULES

Members enroll in the OhioRISE program through different pathways established through Ohio Administrative Code (OAC) rule.

- Ohio Administrative Code Rule 5160-59-02.1 outlines eligibility criteria for day one (July 1, 2022) enrollment in OhioRISE.
- Ohio Administrative Code Rule 5160-59-02 outlines eligibility criteria for ongoing enrollment in OhioRISE, which defines OhioRISE enrollment date as:
  - The submission date of the CANS assessment that determines the youth meets the criteria defined in the rule;

- The date of admission to an inpatient hospital with a primary diagnosis of mental illness or substance use disorder;
- Enrollment in the OhioRISE 1915(c) waiver as described in rule 5160-59-04 of the Administrative Code; and,
- The date the youth met criteria for IHBT as defined in the rule.

(iii) Eligibility criteria

Most Medicaid beneficiaries who meet the eligibility requirements for the OhioRISE program are required to enroll in managed care on a mandatory basis.

III. DIFFERENCES AMONG CAPITATION RATES

Any proposed differences among capitation rates according to covered populations are based on valid rate development standards and are not based on the rate of federal financial participation (FFP) associated with the covered populations.

IV. CROSS-SUBSIDIZATION OF RATE CELL PAYMENT

The capitation rates were developed at the rate cell level and neither cross-subsidized nor are cross-subsidized by payments from any other rate cell.

V. EFFECTIVE DATES

To the best of our knowledge, the effective dates of changes to the OhioRISE program are consistent with the assumptions used in the development of the certified CY 2026 capitation rates.

VI. MINIMUM MEDICAL LOSS RATIO

The capitation rates were developed such that the PIHP in the OhioRISE program is reasonably expected to achieve an MLR greater than 85%, which includes provisions for non-benefit costs that are appropriate and attainable. ODM's provider agreement indicates that ODM will perform MLR calculations for the OhioRISE program and, due to the risk corridor in effect, will not require remittance in the event the PIHP plan reports a MLR below 85%.

VII. COVID-19 PUBLIC HEALTH EMERGENCY

As part of the public health emergency (PHE) unwinding process, in February 2023 ODM began reviewing members' eligibility information for potential dis-enrollment, and the first set of members were dis-enrolled effective May 2023. Please see later sections for details on associated rate adjustments.

B. Appropriate Documentation

I. DOCUMENTATION OF REQUIRED ELEMENTS

This report contains appropriate documentation of all elements including data used, assumptions made, and methods for analyzing data and developing assumptions and adjustments.

II. COVID-19 PUBLIC HEALTH EMERGENCY AND RELATED UNWINDING

As part of the Consolidated Appropriations Act, 2023, continuous enrollment requirements were decoupled from the PHE on March 31, 2023, allowing eligibility reviews to begin prior to the expiration of the PHE. As such, the first disenrollments from the COVID-19 unwinding period began prior May 2023 and the unwinding period is estimated to have been completed prior to CY 2026.

(a) Available data and information

In developing rate assumptions related to the impact of COVID-19, our primary data source consisted of monthly enrollment experience through July 2025, plus claims experience through June 2025, to understand caseload and utilization patterns pre-, during- and post-PHE for the purpose of projecting future cost levels.

(b) Direct and indirect impacts in capitation rates

The base data used to develop the capitation rates consists of January 1, 2024 through December 31, 2024 (CY 2024) data, which inherently reflects some impact of COVID-19 on population acuity and service utilization. A later section provides descriptions of direct adjustments made to the rates to reflect projected acuity differences between the CY 2024 base data period and the CY 2026 rating period in instances where CY 2024 experience was impacted by COVID-19 and associated PHE unwinding. The impact of other COVID-19 related items that may contribute to differences between CY 2024 and CY 2026 service cost, such as the prevalence of telehealth utilization, COVID-19-related care, or systemic changes to healthcare utilization, are inherently encompassed in the CY 2024 base data and prospective utilization and cost per unit trend assumptions included in the rates.

(c) Non-risk arrangements

There are no non-risk arrangements in the OhioRISE program.

(d) Risk mitigation strategies

A risk corridor will be applied to the CY 2026 rating period.

2. DATA

This section provides information regarding the base data used to develop the capitation rates.

A. Appropriate Documentation

I. REQUESTED DATA

As the actuary contracted by ODM to provide consulting services and associated financial analyses for many aspects of the OhioRISE program (and not limited to capitation rate development), Milliman intakes and summarizes eligibility and expenditure data monthly using vendor files provided by ODM. As such, there is no separate data request from Milliman to the state specifically related to the base data for the capitation rate development. The remainder of this section details the base data and validation processes utilized in the CY 2026 capitation rate development.

II. DATA USED TO DEVELOP THE CAPITATION RATES

(a) Description of the data

(i) Types of data

The primary data sources used in the development of the OhioRISE rates are the following:

- Encounter data submitted by the managed care entities (MCEs);
- Eligibility data provided by ODM;
- Fee-for service (FFS) claims submitted by ODM;
- Annual cost report data submitted by the OhioRISE plan (CY 2024 cost report data);
- Re-priced inpatient and outpatient hospital claims experience provided by ODM;
- CY 2026 PIHP survey submitted by the OhioRISE plan;
- ODM fee schedules applicable to services affected by reimbursement changes due to legislative budget appropriations provided by ODM;
- Member-level enrollment data related to the PHE unwinding; and,
- July 2022 through June 2025 CANS assessment data provided by ODM.

(ii) Age of the data

The data serving as the base experience in the capitation rate development process reflects the CY 2024 incurred period.

The annual cost report and encounter data used in developing data quality adjustments as part of the base data process reflected claims incurred in CY 2024, paid through March 31, 2025. For the purposes of data adjustments, trend development, and analysis of emerging population enrollment patterns and claims experience, we reviewed cost report, encounter data, and CANS assessment data incurred through June 2025. Cost report data was provided by the OhioRISE plan, whereas encounter and CANS assessment data were provided by ODM.

To analyze inpatient and outpatient hospital reimbursement changes, ODM provided updated hospital encounter data for inpatient and outpatient hospital services that was re-priced to ODM's fee schedule in place at various points in time.

(iii) Data sources

The historical encounter data used for the rate certification is submitted by the OhioRISE plan on an ongoing basis. This data, along with historical FFS data, is stored in ODM's data warehouse. Medicaid enrollment, encounter and FFS data stored in ODM's data warehouse was provided to us for the purpose of developing the CY 2026 capitation rates.

We also received CY 2024 and Q2 2025 cost report data. The cost report data is contained in Microsoft Excel files that the OhioRISE plan submits to ODM.

(iv) Sub-capitation

The OhioRISE plan provided information related to sub-capitated services through their CY 2026 PIHP Survey submission. The OhioRISE plan indicated they do not have any sub-capitated arrangements that flow through encounters.

(b) Availability and quality of the data

(i) Steps taken to validate the data

The base experience used in the OhioRISE capitation rates relies on cost report and encounter data submitted to ODM by the OhioRISE plan, as well as FFS data. Managed care eligibility is maintained in MITS by ODM. The actuary, the PIHP, and ODM all play a role in validating the quality of encounter and cost report data used in the development of the capitation rates. The PIHP plays the initial role, collecting and summarizing data sent to the state. ODM's Bureau of Health Research and Quality Improvement, Data Analytics section focuses on encounter data quality and PIHP performance measurement, with measures focused on completeness, accuracy, and comparison between data sources. ODM's contract with the PIHP stipulates encounter data specific submission and quality standards. In addition, we perform independent analysis of encounter data and cost report data to evaluate the quality of the data being used in the rate development process. Below is a summary of measures specific to each quality area that are applied by either Milliman or ODM.

(A) Completeness

Encounter Data

ODM applies several measures to the encounter data submitted by the OhioRISE plan to evaluate the completeness of the data. A sample of measures focused on the completeness of the data include:

- Encounter data volume measures by population and service category;
- Incomplete rendering provider data;
- NPI provider number usage without Medicaid / reporting provider numbers;
- Percentage of encounters in the OhioRISE plan's fully adjudicated claims file not present in the ODM encounter data files; and,
- Percentage of encounters in the ODM encounter data files not present in the OhioRISE plan's fully adjudicated claims file.

We also summarize the encounter data to assess month to month completeness of the encounter data. These measures include:

- Encounter claims PMPM by high-level service categories;
- OhioRISE plan distribution of members by annual encounter-reported expenditures; and,
- OhioRISE plan distribution of members by monthly encounter-reported expenditures.

These measures are applied to identify any months where encounter data volume is unusually large or small, indicating a potential issue with the submitted encounter data. The CY 2024 encounter data used in the development of the rates was paid through March 31, 2025.

Cost Report Data

The OhioRISE plan submits quarterly and year-end annual cost report data to ODM. We reviewed the OhioRISE plan's quarterly and annual cost reports to identify large data variances, incomplete data, and other reporting issues. These issues are provided to the OhioRISE plan by ODM, and the cost reports are re-submitted to ODM as necessary.

The year-end cost report data must be certified by two officers of the OhioRISE plan and reconciled to the OhioRISE plan's audited NAIC financial statement information. The year-end annual cost report is completed by the OhioRISE plan using claims incurred and paid through March 31st of the following calendar year. The three months of claims run out limits the impact of the incurred but not paid (IBNP) estimate on the incurred expenditure estimates.

FFS Data

Similar to the process outlined for Encounter data, we relied upon FFS data provided by ODM for the purposes of OhioRISE capitation rate development. We summarized the FFS data to assess month to month completeness and to identify situations where the data may be incomplete

(B) Accuracy

Encounter Data

We review the accuracy of the encounter data by comparing expenditures to outside data sources including OhioRISE plan Cost Report and OhioRISE plan survey submissions. We also review the encounter data to ensure each claim is related to a covered individual and a covered service. We summarize the encounter data into an actuarial cost model format. Annual base period data summaries are created to ensure that the data for each service is consistent with prior historical periods. Stratification by rate cell facilitates this review, as it minimizes the impact of changes in population mix. This process identifies service category combinations that may have unreasonable reported data.

Cost Report Data

As stated in the Completeness section, the OhioRISE plan submits quarterly and annual cost report data to ODM. In terms of accuracy measures, the process of submitting both quarterly and annual reports identifies unreasonable or inconsistent values in the data among cost report submissions. In addition to utilization and cost metrics, financial measures such as MLR, underwriting margin, and administrative loss ratio are tracked across rate cells. These metrics enable us to quickly identify potential cost allocation issues. We also evaluate the cost report expenditures in relation to statutory financial statements for the OhioRISE plan to ensure expenditure differences are reasonable.

(C) Consistency of data across data sources

We performed a detailed review of the encounter data used in the development of CY 2026 capitation rates. Assessing the encounter data for consistency with the cost reports was a vital part of the rate development process. We reviewed utilization and cost metrics by rate cell and category of service for CY 2024 encounter data and CY 2024 cost report data. Composite PMPM expenditures in encounter data for the OhioRISE program were slightly less than composite PMPM expenditures in the cost report data (prior to any data quality adjustment). We also reviewed the consistency of other data sources used to inform assumptions in the rate setting process:

- **Eligibility.** Monthly enrollment in eligibility files received by ODM was reconciled with publicly available values on ODM's publicly available Enrollment and Expenditures Dashboard[2].
- **Re-priced inpatient claims experience.** To support our analysis of the impact of the All Patients Refined Diagnosis Related Groups (APR-DRG) and cost-to-charge ratio changes during the historical experience period and rate period, we received re-priced inpatient encounter records from ODM. The claims experience included the actual paid amount, along with claims re-priced to ODM's fee schedule. We confirmed the paid amount is consistent with the encounter experience we had previously received and confirmed the re-priced amounts are consistent with ODM's published inpatient hospital fee schedule.
- **Re-priced outpatient claims experience.** To support our analysis of the impact of Enhanced Ambulatory Patient Grouping System (EAPG) implementation, we received re-priced outpatient encounter records from ODM. The claims experience included the actual paid amount, along with claims re-priced to ODM's fee schedule. We confirmed the paid amount is consistent with the encounter experience we had previously received and confirmed the re-priced amounts are consistent with ODM's published outpatient hospital fee schedule.

(ii) Actuary's assessment

As required by Actuarial Standard of Practice (ASOP) No. 23, Data Quality, we disclose that Milliman has relied upon certain data and information provided by the Ohio Department of Medicaid and their vendors, primarily the MCEs participating in the MMC and OhioRISE programs. The values presented in the rate certification are dependent upon this reliance.

While there are areas for data improvement, as detailed in the Data concerns section below, we found the encounter data to be of appropriate quality for developing the CY 2026 capitation rates.

(iii) Data concerns

Through discussions with ODM and various data analyses, we were made aware of and confirmed encounter data quality concerns as well as other adjustments. The following list includes all adjustments that were considered in development of the base data:

- Apply missing encounter data adjustments as provided by the PIHP in the CY 2026 PIHP Survey. Add non-encounterable provider performance payments as provided in cost reports.
- Remove delegated admin from cost report sub-capitated expenditures, apply data quality adjustments to encounter data as warranted.
- Remove non-state plan services from cost report and encounter expenditures.
- State both cost report and encounter expenditures on a net basis.
- Reallocate negative cost report amounts and substitute adjusted cost report PMPM amounts.
- Remove monthly eligibility associated with members who have death dates prior to the start of the month.
- Remove monthly claims and eligibility associated with members that were incarcerated at the time.
- Remove monthly eligibility associated with member months that were duplicated in the vendor file eligibility information
- Apply data adjustments to the claims to reflect additional OhioRISE eligible claims that should have been paid by the OhioRISE program.

We have not identified any material concerns with the quality or availability of the cost report data, other than those listed above.

[2] https://data.ohio.gov/wps/portal/gov/data/projects/demographic-expenditure-dashboard

(c) Appropriate data

(i) Use of fee-for-service data

The OhioRISE population includes members and services previously served under FFS. As a result, FFS data for the services eligible to be covered under the OhioRISE program was used in the development of the OhioRISE capitation rates.

(ii) Use of managed care encounter data

Managed care encounter data was the primary data source used in the development of the capitation rates.

(d) Reliance on a data book

Development of the capitation rates did not rely on a data book or other summarized data source. We were provided with detailed claims data for all covered services and populations. We created data books summarizing CY 2024 encounter data and FFS data, which were shared with ODM and the OhioRISE plan.

III. DATA ADJUSTMENTS

Capitation rates were developed primarily from CY 2024 encounter data. Adjustments that were made to the base data are described in this section.

(a) Credibility adjustment

Due to data credibility considerations, the capitation amounts will not differ between the MAGI and Expansion rate cells and will be developed on a statewide basis with no regional variation.

(b) Completion adjustment

The base period encounter data reflects claims incurred during CY 2024 and paid through March 31, 2025. Completion factors were developed by summarizing the claims data and applying traditional actuarial techniques to develop estimates of incurred but not paid (IBNP) liability, using Milliman's Robust Time-Series Analysis System (RTS)[3].

First, we stratified the data by category of service in the population groupings. Claims for each of these population-service category stratifications were analyzed and formed into lag triangles by paid and incurred month. Claim completion factors were developed for each month of the base experience period, based on historical completion patterns. Completion factors developed using encounter data were compared to OhioRISE plan-reported IBNP liability estimates in the cost report for reasonableness.

The monthly completion factors were applied to unadjusted CY 2024 experience to estimate the remaining claims liability for the period.

(c) Errors found in the data

Through discussions with ODM and our independent review of the data, we were made aware of and confirmed data quality concerns and other adjustments.

(d) Program change adjustments

The subsections below include details related to the program and reimbursement changes that have occurred in the OhioRISE program.

Inpatient Reimbursement Changes. ODM updated its inpatient hospital base rates, hospital cost-to-charge ratios, and APR-DRG relative weights between the base period and the CY 2026 rating period. In addition, ODM continues to include an enhanced reimbursement methodology to ensure adequate and continued access to inpatient hospital services via the Cost Coverage Add-On (CCA).

[3] The Robust Time Series Reserve Analysis System (RTS) is a model designed to assist an actuary in performing an Incurred But Not Paid (IBNP) reserving analysis. The RTS is unique because it contains functionality that: provides reasonable best estimates in spite of contaminated data, provides reasonable margins for the total reserve, independently models shock claims, and provides forecasts of future cash flows. This methodology forecasts future claim runout using time series forecasting which employs the interrelationship between claim payments during the first three months of claim payments for each incurred month.

Outpatient Reimbursement Changes. ODM updated its outpatient hospital base rates, hospital cost-to-charge ratios, and EAPG relative weights between the base period and the CY 2026 rating period. In addition, ODM continues to include an enhanced reimbursement methodology to ensure adequate and continued access to outpatient hospital services via the CCA. We also considered the impact of reimbursement changes for outpatient facility services not paid based on EAPG, such as provider administered drugs.

In-State Psychiatric Residential Treatment Facilities (PRTF) Expansion. In-state PRTFs became available beginning November 2023 for youth with the most intense behavioral health needs. Previously, many of these members were being served out of state. Until sufficient in-state PRTFs are available, the OhioRISE plan will cover the costs of out-of-state (OOS) PRTF stays for members enrolled in OhioRISE. Per guidance from ODM, we continued to assume that the initial utilization of in-state facilities is in addition to out-of-state occupancy through the rating period, and projected utilization for each was developed independently.

- For the out-of-state portion of the CY 2026 capitation rate development, we utilized encounter data pertaining to emerging out-of-state reimbursement and utilization rates, as well as information from the PIHP Survey to develop the cost estimates for CY 2026 experience.
- For the in-state portion of the CY 2026 capitation rate development, we utilized the per diem cost based on bed type and list and timing of PRTF bed availability as reported by the OhioRISE plan in their 2026 PIHP Survey, as well as occupancy rates from emerging encounter data to develop cost estimates for CY 2026. We additionally assumed that the occupancy rate of the in-state facilities aligns with the historical utilization.

PHE Unwinding Morbidity Adjustment. We evaluated the impact of population morbidity changes expected in CY 2026 not reflected in the CY 2024 base data used in the rate setting process. This included consideration for the resumption of member disenrollment following the Public Health Emergency (PHE). Due to the COVID-19 pandemic, the federal government declared a PHE beginning in March 2020. During the PHE, ODM received enhanced federal funding by meeting maintenance of eligibility (MOE) requirements. One aspect of the MOE required continuous Medicaid eligibility during the PHE, which decreased member movement out of managed care programs, including OhioRISE.

With the PHE ending effective May 11, 2023, managed care member dis-enrollment resumed with the first set of members having been dis-enrolled effective May 2023. We developed updated projected enrollment levels by rate cell and enrollment pathway to reflect projected changes in the OhioRISE population due to member redeterminations anticipated to occur prior to the CY 2026 rating period.

No CANS Disenrollment Morbidity Adjustment. We evaluated the impact of population morbidity changes expected in CY 2026 not reflected in the CY 2024 base data. This included consideration for members disenrolling as a result of the OhioRISE CANS disenrollment rule. Effective July 1, 2024, Section 5160-59-02 (OhioRISE: Eligibility and Enrollment) of the OAC was amended to indicate that OhioRISE individuals that meet the following criteria are subject to disenrollment:

- Two years have passed since the youth's enrollment in OhioRISE and the youth subsequently:
  - Has not had a Child and Adolescent Needs and Strengths (CANS) assessment meeting the eligibility criteria in paragraph (A)(4), (A)(5), or (A)(6)(a) of the rule in the last 2 years; and
  - Has not received intensive home-based treatment (IHBT) services in the last 365 days; and,
  - Has not experienced an inpatient hospital stay as described in paragraph (B) of the rule in the last 365 days.

Members that meet the criteria above are to be disenrolled on the last day of the following month, in which they meet the criteria, beginning August 31, 2024. We included an adjustment to reflect estimated CY 2026 acuity levels as a result of this rule change.

Duration / Pathway Adjustment. We evaluated the population mix of enrollment pathway and program duration expected in CY 2026 in comparison to the CY 2024 base period. Each member month was assigned to a cohort that describes the enrollment pathway of the member and month of duration enrolled in the OhioRISE program.

As the OhioRISE program has matured, there has been a shift in each of these categories that has a material impact on the population acuity in the rating period relative to the base period.

The enrollment pathway cohorts are defined as follows:

- Trigger – Enrollment in OhioRISE as a result of an inpatient trigger claim.
- CANS – Enrollment in OhioRISE as a result a qualifying CANS assessment.

Duration is defined as months since receiving initial OhioRISE eligibility and is split by the following cohorts:

- Months 0-2
- Months 3-5
- Months 6+

We developed updated projected enrollment levels by rate cell, enrollment pathway, and duration. The acuity adjustment portion of this adjustment accounts for the acuity associated with the expected mix of members by pathway and duration in the rating period. We developed this adjustment at the rate cell, enrollment pathway, duration and detailed category of service level. **Transitional Services and Supports (TSS).** TSS is used to support a youth and their family stabilize during a transition of care and is not intended to de-escalate crises and is available to youth on the OhioRISE 1915(c) waiver. We relied on ODM guidance and historical data from a similar service, state plan IHBT, to develop the projected TSS utilization rate and unit cost.

Quality Withhold Goals. For the CY 2026 rating period, ODM will administer a quality withhold arrangement for the OhioRISE program where return of withhold will be based in part on PIHP performance on two separate measures:

- Follow-up after emergency department visit for substance use; and,
- Follow-up after emergency department visit for mental health events.

In developing the CY 2026 capitation rates, we included additional benefit expense to reflect the estimated increase in needed follow-up visits for children with a substance use or mental health-related emergency department visit. Note that we expect withhold measures targeting some behavioral health services will result in additional benefit expense under the MMC program, rather than OhioRISE.

Program changes deemed immaterial to benefit expenses in the rate period

Adjustment factors were developed for policy and program changes estimated to materially affect the OhioRISE program during the rating period that are not fully reflected in the CY 2024 base period. Program adjustments were made in the rate development process to the extent a policy or reimbursement change is deemed to have a material cost impact to the OhioRISE plan. Program adjustments deemed immaterial include:

- **Mixed Services Protocol Adjustments.** Effective January 1, 2024, updates were made to the OhioRISE Mixed Services Protocol which identifies the responsible payer for services that may feasibly be covered either by MMC MCOs or the OhioRISE Plan. There were several updates to the Mixed Services Protocol occurring after January 1, 2024. We reviewed all updates to the Mixed Services Protocol and there were no impacts to payer responsibility, therefore we deemed this adjustment to be immaterial.
- **Expansion of Mental Health Peer Support Services.** Effective September 1, 2024, ODM expanded the coverage of peer support services to those with mental health (MH) needs. Peer support services were historically only available to individuals with substance use disorder (SUD) needs. We reviewed emerging experience for peer support services post-expansion; based on the utilization of this service, we determined this adjustment to be immaterial to the OhioRISE program.
- **OhioRISE 1915c Waiver Eligibility Rule Update.** An amendment to OAC rule 5160-59-04, effective June 23, 2025, clarifies that youth residing in an intermediate care facility for individuals with intellectual disabilities (ICF-IDD) must be disenrolled from the OhioRISE 1915c waiver after 90 consecutive days.

The previous rule required the OhioRISE plan to assess potential disenrollment after 90 days of residing in an institution and initiate disenrollment after 180 days. The previous rule still applies for institutions other than ICF-IDD. There were no instances in the CY 2024 base period where a member was residing in an ICF for longer than 90 days and was utilizing services under the 1915c waiver, therefore we determined this adjustment to be immaterial.

- **OhioRISE 1915c Provider Network Rule Update.** An amendment to OAC rule 5160-59-05 will allow CMEs to be a provider of OhioRISE waiver services. Based on a review of historical and emerging utilization for these services, we determined this adjustment to be immaterial.
- **Justice Involved Youth.** Effective October 1, 2025, juveniles in state correctional facilities who are within 30 days of their release date are eligible for enrollment in the OhioRISE program until their release date. Based on ODM's expectations for the number of members eligible to enroll and the impact to the types of services expected to be utilized, we determined this adjustment to be immaterial.
- **Non-Institutional Reimbursement Changes.** We reviewed other known fee schedule changes effective between the start of CY 2024 and the CY 2026 rating period, for services applicable to the OhioRISE program. Using fee schedules provided by ODM, as well as 5160-1-60 Appendix DD, we estimated the impact of these and other fee schedule changes and determined these to be immaterial.

We evaluated the composite impact of all of the immaterial items to assess whether an aggregate impact should be applied in the CY 2026 rate development process. The impact of immaterial program adjustments is immaterial on a composite basis, so no further adjustments were applied.

(e) Exclusion of payments or services from the data

The following adjustments were made to the base experience data to reflect non-state plan services, uncollected co-pays, pharmacy rebates, third party liability recoveries, and non-encounter claims payments.

Services excluded from initial base data summaries

Non-State Plan Services

We excluded all services included in the base data that do not reflect approved state plan services (nor are an approved in-lieu-of service).

Adjustments made to base data

Uncollected Co-pays

No adjustment was applied for uncollected co-pays as the OhioRISE program does not cover services subject to member co-pays

Third Party Liability/Fraud and Abuse

We reviewed third-party liability (TPL) and fraud recoveries based on data available in the cost reports and CY 2026 PIHP Survey. No adjustment was applied for claims recovered and not reflected in the baseline experience data.

Non-encounter Claims Payment

We reviewed non-claim payments made to providers for items such as plan directed shared savings payments, quality incentives, and other similar provider incentive payments based on data available in the cost reports and CY 2026 PIHP Survey. These adjustments were completed when developing the encounter data summaries.

Net Reinsurance

The PIHP provider agreement requires the PIHP contracted with ODM for the OhioRISE program to carry reinsurance for high-cost inpatient behavioral health claims. We adjusted inpatient behavioral health expenses as part of the base data development using the net cost of reinsurance (reinsurance premiums less reinsurance recoveries) as reported in the CY 2026 PIHP Survey.

3. PROJECTED BENEFIT COST AND TRENDS

This section provides information on the development of projected benefit costs in the capitation rates.

A. Rate Development Standards

I. FINAL CAPITATION RATE COMPLIANCE

The final capitation rates are in compliance with 42 CFR 438.4(b)(6) and are only based on services outlined in 42 CFR 438.3(c)(1)(ii) and 438.3(e). Non-state plan services provided by the OhioRISE plan have been excluded from the capitation rate development process. There are no approved in lieu of services.

II. BENEFIT COST TREND ASSUMPTIONS

Projected benefit cost trend assumptions are developed in accordance with generally accepted actuarial principles and practices. The primary data used to develop benefit cost trends is historical claims and enrollment from the covered populations.

III. IN LIEU OF SERVICES

The projected benefit costs do not include costs for in lieu-of services.

IV. ILOS COST PERCENTAGES

ODM has indicated that there are no ILOSs anticipated for CY 2026. As a result, there is no projected ILOS Cost Percentage for the OhioRISE program.

V. BENEFIT EXPENSES ASSOCIATED WITH MEMBERS RESIDING IN AN IMD

The 21 to 64-year-old population is not eligible to enroll in the OhioRISE program, and as a result, adult members residing in an IMD are not included in the rate certification.

B. Appropriate Documentation

I. PROJECTED BENEFIT COSTS

This section provides documentation of the methodology utilized to develop the benefit cost component of the capitation rates at the rate cell level.

II. DEVELOPMENT OF PROJECTED BENEFIT COSTS

(a) Description of the data, assumptions, and methodologies

This section of the report outlines the data, assumptions, and methodology used to project the benefit costs to the rating period. The baseline benefit costs were developed using the following steps:

Step 1: Create calendar year (CY) 2024 per member per month (PMPM) cost summaries

The capitation rates were developed from historical claims and enrollment data for the OhioRISE-enrolled populations. The foundation of the capitation rates consists of CY 2024 incurred encounter data that has been submitted by the OhioRISE plan and FFS claims provided by ODM during the period. In addition, we utilized the CY 2024 annual cost reports where appropriate, along with information provided by the OhioRISE plan via an additional survey of CY 2024 and emerging experience.

Step 2: Apply data quality adjustments

We applied data quality adjustments to the CY 2024 incurred encounter data submitted by the OhioRISE plan. This process included adjustments for known reporting discrepancies between the encounter data and what was reported in the CY 2026 PIHP survey, among other items. In situations where there are known discrepancies with OhioRISE plan encounter data, we applied adjustments using the CY 2024 cost report data.

Step 3: Apply historical and other adjustments to cost summaries

Utilization and cost per service rates from the CY 2024 experience period were adjusted for items such as incurred but not paid amounts, program adjustments, and fee schedule changes that occurred during CY 2024.

Step 4: Adjust for prospective program and policy changes and trend to the rating period

The CY 2024 data was adjusted for known policy and program changes that have occurred or are expected to be implemented between January 1, 2025 and December 31, 2026. In a previous section of this report, we documented these items and the adjustment factors for each rate cell. The adjusted PMPM values from the base experience period are trended forward to the midpoint of the contract period (July 1, 2026).

The resulting PMPMs from the application of these adjustments established the adjusted benefit expense by population rate cell for the rating period.

(b) Material changes to the data, assumptions, and methodologies

All material assumptions are documented in the rate certification report and the overall methodology utilized to develop the capitation rates is consistent with the prior rate-setting analysis.

(c) Overpayments to providers

As outlined in a previous section, we estimated TPL and fraud recoveries based on data available in the CY 2026 PIHP Survey. No additional adjustments were applied related to overpayments to providers.

III. PROJECTED BENEFIT COST TRENDS

This section discusses the data, assumptions, and methodologies used to develop the benefit cost trends, i.e., the annualized projected change in benefit costs from the CY 2024 encounter data to the CY 2026 rating period. We evaluated prospective trend rates using historical experience for the members and services projected to be covered through the OhioRISE program, as well as external data sources and actuarial judgement.

(a) Required elements

(i) Data

The primary data used to develop benefit cost trends is historical claims and encounters from the covered populations. Data used for trend development included cost and utilization experience from July 2022 through June 2025.

External data sources that were referenced for evaluating trend rates developed from ODM data include:

- *National Health Expenditure (NHE) projections* developed by the CMS office of the actuary[4], specifically those related to Medicaid. Please note that as these are expenditure projections, projected growth reflects not only unit cost and utilization, but also aggregate enrollment growth and enrollment mix changes such as aging. For trends used in the rate certification, we are displaying unit cost and utilization trends, so in general, our combined unit cost and utilization trends may differ from NHE trends.
- *Other sources*: We also reviewed internal sources that are not publicly available, such as historical experience from other programs and trends used by other Milliman actuaries.

(ii) Methodology

For internal ODM data, historical utilization and PMPM cost data was stratified by month, rate cell, and category of service. The data was adjusted for completion and normalized for historical population acuity changes. We used linear regression to project experience during the contract period. Contract period projections were compared to base period experience and emerging experience through June 2025 to determine an appropriate annualized trend. Additional details related to key aspects of the trend development process are outlined below.

[4] https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsprojected.html

(iii) Comparisons

Historical trends should not be used in a simple formulaic manner to determine future trends; actuarial judgment is also needed. We did not explicitly rely on the historical encounter and FFS data trend experience due to anomalies observed in the historical trend data. We referred to the sources listed in the prior section as well as considered changing practice patterns, the impact of reimbursement changes on utilization in the OhioRISE population and shifting population mix due to unwinding or post-unwinding dynamics and continued maturity of the OhioRISE program.

Note that explicit adjustments were made outside of trend to reflect all recent or planned changes in reimbursement from the base period to the rating period, as well as applicable program changes.

(b) Any other adjustments

(i) Impact of managed care

We did not adjust the trend rates to reflect a managed care impact on utilization or unit cost.

(ii) Trend changes other than utilization and cost

We did not adjust the benefit cost trend for changes other than utilization or unit cost.

IV. MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT SERVICE ADJUSTMENTS

We have reviewed ODM's final report regarding compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) as required by 42 CFR 438.3(c)(1)(ii). Results of the analysis indicate full compliance with MHPAEA for both quantitative and non-quantitative treatment limits with no remediation needed that would constitute a program adjustment. Based on the results, we have not made any rating adjustments to accommodate parity compliance.

V. IN LIEU OF SERVICES

The projected benefit costs do not include costs for in lieu-of services.

VI. RETROSPECTIVE ELIGIBILITY PERIODS

(a) Managed care plan responsibility

The PIHP is not responsible for retrospective eligibility periods.

(b) Claims treatment

Claims for retrospective eligibility periods are not reflected in the base data.

(c) Enrollment treatment

Enrollment is treated consistently with claims. We have not included retrospective eligibility in the base experience period.

(d) Adjustments

No explicit adjustment was applied for the CY 2026 OhioRISE capitation rates.

4. SPECIAL CONTRACT PROVISIONS RELATED TO PAYMENT

A. Incentive Arrangements

I. RATE DEVELOPMENT STANDARDS

There will be no incentive payments in the OhioRISE program during the rating period.

II. APPROPRIATE DOCUMENTATION

There will be no incentive payments in the OhioRISE program during the rating period.

B. Withhold Arrangements

I. RATE DEVELOPMENT STANDARDS

This section provides documentation of the withhold arrangement in the OhioRISE program.

II. APPROPRIATE DOCUMENTATION

(a) Description of the Withhold Arrangement

(i) Time period

ODM is utilizing a quality withhold arrangement for the OhioRISE program. The return of the withhold will be measured based on PIHP performance during the CY 2026 period.

(ii) Coverage

All enrollees, services, and providers that are part of the OhioRISE program are covered by the withhold arrangement.

(iii) Withhold purpose

The withhold measures are in place for the purpose of incentivizing the OhioRISE plan to test and learn how best to transform systems of care to improve the health outcomes of the population.

(iv) Description of total percentage withheld

For the CY 2026 rating period, ODM will establish a quality withhold of 1.5% of the capitation and will determine the return of the withhold based on review of the PIHP's performance relative to applicable benchmarks.

The capitation rates shown in the certification report are illustrated before offset for the withhold amount; however, the CY 2026 capitation rates documented in the certification report are actuarially sound while considering the amount of the withhold not expected to be earned.

(v) Estimate of percentage of withhold that is not reasonably achievable

Based on discussions with ODM, return of the CY 2026 quality withhold will be determined based on PIHP progress toward meeting goals for the pediatric population. This includes meeting targets for the following quality measures:

- Follow-up after emergency department visit for substance use; and,
- Follow-up after emergency department visit for mental health events.

Measure targets were set based on ODM's review of results in the OhioRISE program.

In addition, the PIHP must meet process milestones in the domain of behavioral health. These process milestones include a variety of components, such as developing interventions, implementing interventions, collaborating within communities, and assessing the impacts of interventions.

The capitation rates include projected benefit expense associated with achieving the milestones put forth by ODM for full withhold return.

(vi) Reasonableness of the withhold arrangement

Our review of the total withhold percentage of 1.5% of capitation revenue indicates that it is reasonable considering the PIHP's financial operating needs accounting for the size and characteristics of the population covered under the OhioRISE program. The magnitude of the withhold is reasonable and does not have a detrimental impact on the PIHP's financial operating needs and capital reserves. Our interpretation of financial operating needs and capital reserves relates to cash flow needs for the PIHP to pay claims and administer benefits for its covered population and months of claims reserve.

We evaluated the reasonableness of the withhold within this context by reviewing the PIHP's cash available to cover operating expenses, months of claims reserve, as well as the capitation rate payment mechanism utilized by ODM.

(b) Actuarial Soundness of Capitation Rates Considering Withhold

The rates are certified as actuarially sound after adjustment for the portion of the withhold that is not reasonably achievable. We estimate the full withhold return is reasonably achievable.

C. Risk Sharing Mechanisms

I. RATE DEVELOPMENT STANDARDS

This section provides documentation of the risk-sharing mechanisms in the OhioRISE program.

II. APPROPRIATE DOCUMENTATION

(a) Description of Risk-sharing Mechanism

(i) Rationale

There is material uncertainty in the OhioRISE program in CY 2026, due to the potential for differences between the base period and rating period population distributions, associated with:

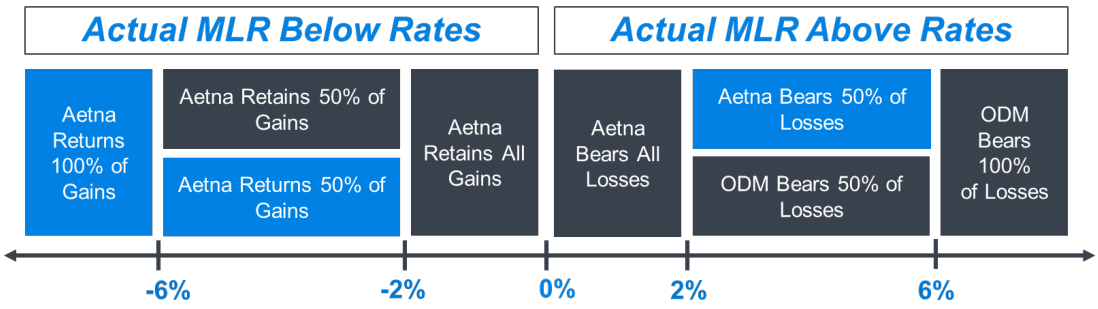
- Impacts related to the termination of the pause in redetermination associated with the COVID-19 public health emergency (PHE);
- Impacts related to the changes to the OhioRISE enrollment and eligibility rule resulting in member disenrollment from the OhioRISE program due to lack of a CANS assessment after 25 months;
- Member distribution among enrollment pathways; and,
- Member distribution related to duration of enrollment in the program.

As a result, ODM will implement a risk corridor as a risk mitigation mechanism where ODM and the OhioRISE plan would either retain or share in respective gains and losses within defined levels. The risk corridor will be a temporary arrangement that will be reevaluated for future rating periods.

(ii) Methodology

In recognition of the uncertainty outlined above, ODM will implement a 2-sided risk corridor based on medical loss ratios (MLR) for the OhioRISE program as a risk mitigation mechanism. Under this approach, the risk corridor is calculated based on the difference between the MLR assumed in the certified OhioRISE capitation rates and actual MLR results. The risk corridor arrangement will be specific to the CY 2026 rating period for the OhioRISE program.

The risk corridor parameters for the CY 2026 rating year are illustrated in the figure below.



The MLR difference for the OhioRISE plan will be calculated as actual MLR minus target MLR, according to the definitions provided below. The risk corridor financial responsibility parameters are defined as follows.

If the OhioRISE plan's actual MLR is greater than 2% of the target MLR, ODM will provide payment to the OhioRISE plan based on the sum of the following.

- For amounts between 2% and 6% of the MLR target: half of the MLR difference within this range, multiplied by net capitation revenue.
- For amounts greater than 6% of the MLR target: the amount of the MLR difference that exceeds 6%, multiplied by net capitation revenue.

If the OhioRISE plan's actual MLR is less than -2% of the target MLR, ODM will receive a recoupment from the OhioRISE plan based on the sum of the following.

- For amounts between -2% and -6% of the MLR target: half of the MLR difference within this range, multiplied by net capitation revenue.
- For amounts less than -6% of the MLR target: the amount of the MLR difference that is below -6%, multiplied by net capitation revenue.

The risk corridor settlement will be calculated for the OhioRISE plan across all capitation rate cells combined. Capitation premiums, medical expenses, and administrative expenses associated with healthcare quality improvement (HCQI) activities will be based on encounter data and financial reporting data submitted by the OhioRISE plan. ODM reserves the right to audit this information.

Actual MLR Calculation

For the purpose of risk corridor reporting, the actual MLR should be calculated consistent with 42 CFR § 438.8[5].

- The MLR numerator shall include medical incurred claims, expenses for HCQI activities, and expenses for fraud prevention activities.
  - Incurred claims will include appropriate accruals for items such as incurred but not paid amounts.
  - Incurred claims will include provider incentive, bonus, and provider withhold payments for the period.
  - Incurred claims will include State Directed Payments.
  - For all sub-contracted services, incurred claims will be defined as the amounts paid to providers.
  - Reported medical expenses for related entities will be reviewed to ensure the reimbursement structure is reasonable for the program.
- Incurred claims shall be offset by third party liability collections, fraud recoveries, reinsurance recoveries, and other exclusions of payments or services from the data.
  - **Note:** On May 15, 2019, a CMCS information bulletin provided additional guidance related to MLR requirements for third party vendors.[6]
- HCQI expenses will be defined consistent with CMS guidance. 45 CFR §158.150[7] outlines activities that improve health care quality and is referenced by 42 CFR §438.8(e)(3). These are generally outlined in 45 CFR §158.150(b)(2) as activities that:
  - Improve Health Outcomes
  - Prevent Hospital Readmissions
  - Improve Patient Safety / Reduce Medical Errors
  - Promote Health and Wellness
  - Health Insurance Technology and Meaningful Use

[5] Medical loss ratio (MLR) standards, https://www.law.cornell.edu/cfr/text/42/438.8
[6] Medical Loss Ratio (MLR) Requirements Related to Third Party Vendors, https://www.medicaid.gov/federal-policy-guidance/downloads/cib051519.pdf
[7] Activities that improve health care quality, https://www.law.cornell.edu/cfr/text/45/158.150

- 42 CFR §438.358[8] outlines activities related to external quality review (EQR). In general, activities associated with satisfying the EQR requirements are considered activities that improve health care quality.
  - **Note:** 45 CFR §158.150(c) provides a listing of activities explicitly excluded from being defined as quality improving activities.
- The MLR denominator shall include premium revenue less applicable fees and taxes.
  - Premium revenue shall include PIHP reported quality withhold revenue, if applicable.
  - Premium revenue shall include revenue related to State Directed Payments.
  - Taxes excluded from the denominator shall include the Health Insuring Corporation (HIC) Tax.

Target MLR Calculation

The target MLR will be calculated consistent with 42 CFR §438.8.

- The target MLR numerator shall include medical expenses along with expenses for HCQI activities.
  - Medical expenses will be calculated as the amounts included in the CY 2026 per member per month (PMPM) capitation rates, multiplied by actual observed member months, plus expenses for state directed payments incorporated via separate payment term.
  - HCQI will be defined as the Care Management expenses included in the CY 2026 capitation rates.
  - The target MLR denominator will be calculated based on capitation rates net of the HIC Tax. The denominator will also include revenue received by the OhioRISE plan for state directed payments incorporated via separate payment term. The denominator of the target MLR calculation will be referred to as net capitation revenue.
- The target MLR will be greater than 85%.
- Consistent with CMS guidance, the following non-benefit expenses will be excluded from risk corridor calculations:
  - PIHP administrative expenses including MRSS admin described in a later section; and
  - Delegated administrative expenses.

(iii) Effect on capitation rate development

The presence of the CY 2026 risk corridor has no effect on the development of the capitation rates.

(iv) Accordance with generally accepted actuarial principles

The CY 2026 risk corridor was developed in accordance with generally accepted actuarial principles and practices.

(v) Consistency with pricing assumptions

The CY 2026 risk corridor is consistent with pricing assumptions used in capitation rate development.

(vi) Remittance/payment

The CY 2026 risk corridor will not result in a remittance/payment if calculated based on pricing assumptions used in capitation rate development and experience conforms exactly to the assumptions that underlie the capitation rates.

(b) Medical Loss Ratio

There are no minimum MLR remittance requirements for the OhioRISE program, and as a result there are no financial consequences.

[8] Activities related to external quality review, https://www.law.cornell.edu/cfr/text/42/438.358

(c) Reinsurance Requirements and Effect on Capitation Rates

The PIHP provider agreement requires the OhioRISE plan to carry reinsurance for high-cost inpatient-related behavioral health claims. We have adjusted inpatient behavioral health expenses in the historical period by the net cost of reinsurance (reinsurance premiums less reinsurance recoveries) as reported in the CY 2024 annual cost report data.

D. State Directed Payments

I. RATE DEVELOPMENT STANDARDS

Consistent with guidance in 42 CFR §438.6(c), the January to December 2026 rates reflect consideration of the following state directed payments:

- Hospital Additional Payment (HAP);
- University of Cincinnati Health Hospital (UCHth-HAP) hospital payments;
- University of Toledo Medical Center (UTMC-HAP) hospital payments
- Cincinnati Children's Hospital (CCH-H) hospital payments;
- Firelands Health System (FHS) hospital payments;
- MetroHealth System (MHS) hospital payments;
- Premier Health (PH-H) hospital payments;
- University Hospital (UH-H) hospital payments;
- Rural Hospital Pilot Program (RHPP) hospital payments;
- Kettering Health (KH) hospital payments; and,
- Mobile Response and Stabilization Services (MRSS) Firehouse Model.

(a) Description of managed care plan requirement

ODM requires that MCEs provide enhanced reimbursement to hospitals for inpatient and outpatient facility services as part of the HAP, UCHth-HAP, UTMC-HAP, CCH-H, FHS, MHS, PH-H, UH-H, RHPP, and KH directed payment arrangements submitted via 438.6(c) preprints. These state directed payments are administered via separate payment terms. Separate payment term amounts will be allocated to rate cell based on utilization during the rating period.

ODM requires that the OhioRISE plan adhere to a value-based payment purchasing model population-based payment based upon the attribution of a covered population of enrollees to eligible MRSS providers as part of the MRSS directed payment arrangement submitted via 438.6(c) preprint. The PIHP is responsible for allocating PMPM payments to these providers attributable to the rating period.

(b) Prior written approval

At the time of writing, ODM has not yet received approval for all directed payment preprints. We have received and reviewed the submitted (or most recent draft) preprints provided by ODM and the state directed payment arrangements reflected in these certified rates are consistent with those preprints.

(c) Accordance with standards

The contract arrangements that direct the OhioRISE plan expenditures were developed in accordance with guidance in 42 CFR §438.4, the standards in §438.5, §438.7, §438.8, and generally accepted actuarial principles and practices.

(d) How payment arrangement is reflected in managed care rates

All state directed payments included in the certification are reflected via a separate payment term.

(e) Directed payments not documented in the certification

We acknowledge the state may not use *de minimis* flexibility for changes to state directed payments and must submit a rate amendment for updates to state directed payments not included in the certification.

II. APPROPRIATE DOCUMENTATION

(a) Additional state directed payments

There are no additional directed payment arrangements.

(b) Other reimbursement rate requirements

There are no requirements regarding reimbursement rates the plans must pay to providers unless specified in the certification as a directed payment, pass-through payment, or authorized under applicable law, regulation, or waiver.

E. Pass-through Payments

I. RATE DEVELOPMENT STANDARDS

There are no pass-through payments reflected in the CY 2026 capitation rates.

II. APPROPRIATE DOCUMENTATION

There are no pass-through payments reflected in the CY 2026 capitation rates.

5. PROJECTED NON-BENEFIT COSTS

A. Rate Development Standards

I. OVERVIEW

In accordance with 42 CFR §438.5(e), the non-benefit component of the capitation rate includes reasonable, appropriate and attainable expenses related to PIHP operation of the OhioRISE program.

The remainder of this section provides documentation of the data, assumptions and methodology that we utilized to develop the non-benefit cost component of the capitation rate.

II. PMPM VERSUS PERCENTAGE

The non-benefit cost was developed as a percentage of the capitation rate.

B. Appropriate Documentation

I. DEVELOPMENT OF NON-BENEFIT COSTS

(a) Description of the data, assumptions, and methodologies

Data

The primary data sources used in the development of the CY 2026 non-benefit costs are listed below:

- The OhioRISE plan's cost reports for CY 2024 and Q2 2025, which includes experience through June 2025;
- CY 2026 PIHP Survey completed by the OhioRISE plan; and
- Average costs from the financial statements of Medicaid health plans nationally, as summarized by Palmer, Pettit, and McCulla. These reports date from 2012 through 2025, analyzing financial results from 2011 through 2024.[9]

[9] The 2025 report analyzing administrative costs for 2024 can be found at: https://www.milliman.com/en/insight/medicaid-managed-care-financial-results-2024

Assumptions and methodology

In developing the administrative costs, we reviewed historical administrative expenses for the OhioRISE program along with national Medicaid health plan administrative expenses. We considered the size of participating health plans and the resulting economies of scale that could be achieved, along with the benefits covered and the demographics of the OhioRISE population.

Historical reported administrative expenses were reconciled between the available data sources for the purpose of evaluating the quality of the data provided. CY 2024 and Q2 2025 cost report administrative expenses were analyzed for reasonableness and completeness of the data provided. This data formed the baseline for projected CY 2026 administrative expense amounts.

(b) Material changes

In addition to data sources used for the prior rating period, the non-benefit expenses reflected in the CY 2026 OhioRISE capitation rates were additionally informed by plan-reported experience from the CY 2024 and Q2 2025 cost reports.

(c) Other material adjustments

There are no other material adjustments applicable to the non-benefit cost component of the capitation rate.

II. NON-BENEFIT COSTS, BY COST CATEGORY

Administrative expenses have not been developed from the ground up (based on individual components). However, individual components were reviewed within the OhioRISE cost reports and financial statement data, in part to determine a distribution between administrative expenses and care management activities.

The CY 2026 non-benefit cost allowance is determined and applied as a percentage of the capitation rates before fees and taxes.

In addition, the CY 2026 capitation rates include amounts for the following non-benefit expenses:

Statewide MRSS Program: For CY 2026 the OhioRISE plan is required to contract with the state-identified Single Funding Source Manager (SFSM) for the MRSS state directed payment. The Single Funding Source Manager will collect the MRSS separate payment term amount from the OhioRISE plan on a monthly basis. The contract will be an administrative services subcontract directly between the OhioRISE plan and the Single Funding Source Manager. For the CY 2026 capitation rates, we included additional administrative expenses associated with this arrangement in the capitation rates. The MRSS Admin expense represents the delegation of administrative services from the OhioRISE plan to the Single Funding Source Manager (SFSM). ODM expects the OhioRISE plan to delegate this additional administrative expense to the SFSM.

Fees and Taxes are loaded to the capitation rates after the application of non-benefit expenses. This includes the HIC tax. The HIC tax will remain at 1% of total capitation.

6. RISK ADJUSTMENT

This section provides information on the risk adjustment included in the contract.

A. Rate Development Standards

I. OVERVIEW

The composite capitation rates for the OhioRISE program will not be risk adjusted as there is only one PIHP contracted for the program.

7. ACUITY ADJUSTMENTS

A. Rate Development Standards

This section provides documentation of the acuity adjustments in the OhioRISE program.

B. Appropriate Documentation

There will be no acuity adjustments in the OhioRISE program for the CY 2026 capitation rate period.

Limitations and Data Reliance

The information contained in this report has been prepared for the Ohio Department of Medicaid (ODM) to provide documentation of the development of the certified capitation rates for the OhioRISE program for the period of January 1, 2026 through December 31, 2026 (CY 2026). The data and information presented may not be appropriate for any other purpose.

The information contained in this report, including the appendices, has been prepared for ODM and their consultants and advisors. It is our understanding that the information contained in this report may be shared with the prepaid inpatient health plan (PIHP) participating in the OhioRISE program and the Centers for Medicare and Medicaid Services (CMS). Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this report to third parties. Likewise, third parties are instructed that they are to place no reliance upon this report prepared for ODM by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this report must rely upon their own experts in drawing conclusions about the capitation rates, assumptions, and trends.

Milliman has developed certain models to estimate the values included in this report. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOPs). The models rely on data and information as input to the models. We have relied upon certain data and information provided by ODM, MCOs participating in the MMC program, and the OhioRISE plan for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete. The models, including all input, calculations, and output may not be appropriate for any other purpose.

It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

We acknowledge the unique nature of the COVID-19 Public Health Emergency and the resumption of redeterminations and terminations of coverage occurred between the base period and the rating period. The assumptions documented in the certification report reflect information known to us at the time of this report. We acknowledge that the resumption of redeterminations and enrollment unwinding period could have a material impact on utilization, acuity, Medicaid enrollment, service delivery, and other factors related to the capitation rates illustrated in the rate certification.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses contained herein.

Appendix 1: CY 2026 Rate Change Summary

Ohio Department of Medicaid
OhioRISE Program
Capitation Rates Effective January 1, 2026
Rate Change Summary

Rate Cell	Average Monthly Enrollment	CY 2026 Capitation Rate	Amended September 2025 Capitation Rate	% Change
MAGI/Expansion	44,802	$ 1,340.87	$ 1,403.30	(4.4%)
ABD	10,957	$ 2,048.68	$ 2,079.70	(1.5%)
AFK	7,924	$ 2,561.71	$ 2,644.92	(3.1%)
Composite	**63,683**	**$ 1,614.56**	**$ 1,674.17**	**(3.6%)**

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APPENDIX N – COMPLIANCE ACTIONS

1. General Requirements

a. Pursuant to OAC rule 5160-26-10 and 42 CFR 438 Subpart I, ODM may impose the compliance actions described in this appendix against the OhioRISE Plan if ODM finds that the OhioRISE Plan has failed to comply with the terms of this Agreement or any other federal or state requirements. Compliance actions include but are not limited to the administrative actions and sanctions described in this appendix. The compliance actions are not exclusive, meaning that ODM's imposition of any particular compliance action does not preclude ODM from taking additional compliance actions available under this Agreement or state and federal law.

b. The requirements within this appendix do not limit ODM's authority to investigate fraud, waste, and abuse; to conduct audits; or to pursue legal remedies arising from those investigations and audits.

c. ODM, at its sole discretion, will determine and impose the most appropriate compliance action based on considerations that include the severity of the noncompliance, whether or not there is a pattern of repeated noncompliance, and the number of eligible individuals and members affected. ODM will consider evidence provided by the OhioRISE Plan that the noncompliance was beyond its control and could not have reasonably been foreseen (e.g., a construction crew severs a phone line, a lightning strike disables a computer system) as a mitigating factor in determining a compliance action. ODM will not consider OhioRISE Plan subcontractor noncompliance to be beyond the OhioRISE Plan's control unless the noncompliance was beyond the subcontractor's control.

d. The OhioRISE Plan must take immediate action to correct noncompliance identified by the OhioRISE Plan or ODM. The OhioRISE Plan's responsibility to correct noncompliance is not dependent upon ODM's identification of noncompliance or compliance actions therefrom.

e. The OhioRISE Plan must report to ODM upon becoming aware of any noncompliance that could impair a member's ability to obtain correct information regarding services, impair member rights, affect the ability of the OhioRISE Plan to deliver covered services, or affect a member's ability to access covered services.

f. The OhioRISE Plan is singularly responsible for fully complying with all terms in this Agreement. The OhioRISE Plan is precluded from using ODM technical assistance to help the OhioRISE Plan achieve compliance with this Agreement as a defense for OhioRISE Plan noncompliance.

g. ODM will issue notices of compliance actions in writing to the OhioRISE Plan contact identified in the Baseline Provider Agreement.

2. Administrative Actions

a. Notice of Noncompliance

i. ODM may issue a written Notice of Noncompliance to the OhioRISE Plan when ODM identifies OhioRISE Plan noncompliance and does not require any other compliance action (e.g., OhioRISE Plan developed corrective action plan, directed corrective action plan).

ii. The OhioRISE Plan must take immediate action to correct the identified noncompliance and notify ODM of the action taken to address noncompliance.

b. Corrective Action Plans

i. General

1. If ODM determines that the OhioRISE Plan is not in compliance with one or more requirements in this Agreement, including those requirements established by a transition plan in accordance with Appendix O, Plan Termination and Non-Renewal, ODM may issue a Notice of Compliance Action, identifying the deficiency or deficiencies and the required OhioRISE Plan follow-up for each. The OhioRISE Plan follow-up may come in the form of an OhioRISE Plan-developed Corrective Action Plan (CAP) or a Directed CAP. ODM will also issue a Notice of Compliance Action when ODM determines that sanctions are necessary.

2. A CAP is a structured activity, process, or quality improvement initiative implemented by the OhioRISE Plan to address noncompliance. The OhioRISE Plan must submit all CAPs as specified by ODM. The OhioRISE Plan's CAP must, at a minimum, identify:

a. The root cause or causes of a deficiency;

b. The goals, objectives, methodologies, and actions/tasks to be taken to achieve compliance; and

c. The staff responsible to carry out the CAP within the established timelines.

3. A CAP will remain in effect until the OhioRISE Plan has provided evidence to ODM's satisfaction that the OhioRISE Plan has fulfilled the requirements of the CAP to achieve and sustain compliance. Failure of the OhioRISE Plan to achieve compliance within the timeframes established within the CAP, or to sustain compliance thereafter, may result in an escalation of compliance actions as provided in this appendix.

ii. OhioRISE Plan-Developed CAP

1. When directed by ODM, the OhioRISE Plan must submit a proposed CAP as specified in the Notice of Compliance Action for any instance of noncompliance with this Agreement or any federal or state requirement. The OhioRISE Plan's proposed CAP is subject to ODM approval.

iii. Directed CAP

1. When directed by ODM in a Notice of Compliance Action, the OhioRISE Plan must comply with an ODM-developed or "directed" CAP when ODM has determined the specific action that the OhioRISE Plan must implement.

2. ODM may also issue a directed CAP if the OhioRISE Plan fails to submit a CAP.

3. Sanctions

a. Pre-Determined Financial Sanctions

i. In addition to other compliance actions available to ODM, ODM may impose the following pre-determined financial sanctions in accordance with Table N.1 below.

Table N.1. Pre-Determined Financial Sanctions

	Noncompliance	Financial Sanction
1.	Failure to demonstrate readiness within the timeframe established by ODM as part of the OhioRISE Plan's readiness review as specified in Appendix A, General Requirements.	• $1,000 per calendar day for each readiness requirement until the OhioRISE Plan demonstrates readiness to ODM's satisfaction
2.	Failure to comply with staffing requirements as specified in Appendix A, General Requirements.	• $500 per calendar day per position
3.	Failure to have appropriate OhioRISE Plan staff members attend meetings as requested by ODM as specified in Appendix A, General Requirements.	• Corrective Action Plan (CAP)
4.	Failure to meet monthly call center metrics for member services or provider services call center as specified in Appendix A, General Requirements.	• $5,000 per month, per metric
5.	Failure to secure protected health information as defined by Health Insurance Portability and Accountability Act (HIPAA) as specified in Appendix A, General Requirements.	• $500 per member, per occurrence AND • Costs associated with credit monitoring or identity theft, safeguard services, as determined necessary by ODM
6.	Failure to forward a grievance, appeal, or request for state hearing received in error by the OhioRISE Plan to the appropriate ODM-contracted managed care entity, as required by Appendix A, General Requirements.	• $500 per member, per occurrence
7.	Failure to resolve at least 98% of expedited appeals within required timelines, as specified in Appendix A, General Requirements.	• $5,000 per month
8.	Failure to resolve at least 95% of standard appeals within required timelines, as specified in Appendix A, General Requirements.	• $5,000 per month
9.	Failure to resolve at least 98% of access-related member grievances, and 95% non-access-related member grievances within required timelines, as specified in Appendix A, General Requirements.	• $5,000 per month

	Noncompliance	Financial Sanction
10.	Failure to continue services during a pending appeal or state hearing as specified in Appendix A, General Requirements.	• Cost of services that should have been continued as determined by ODM AND • $250 for each calendar day the service should have been continued
11.	Failure to authorize services after receiving a reversal of OhioRISE Plan decision resulting from an appeal or state hearing as specified in Appendix A, General Requirements.	• Cost of services that should have been authorized as determined by ODM AND • $250 for each calendar day the service should have been authorized
12.	Failure to ensure appropriate OhioRISE Plan representatives attend state hearings as scheduled as specified in Appendix A, General Requirements.	• $1,000 per occurrence
13.	Failure to provide necessary witnesses or evidentiary materials for state hearings as specified in Appendix A, General Requirements.	• $500 per occurrence
14.	Failure to meet member safeguard requirements as specified in Appendix A, General Requirements, placing a member at risk for a negative health outcome or jeopardizing the member's health, safety, or welfare.	• $50,000 per occurrence
15.	Failure to comply with OhioRISE 1915(c) waiver operational reporting requirements, as specified in Appendix A, General Requirements.	• $100 per reporting requirement per calendar day, unless the OhioRISE Plan requests and is granted an extension by ODM.
16.	Failure to meet FDR notification requirements as specified in Appendix A, General Requirements.	• $25,000 per occurrence
17.	Failure to comply with HealthTrack complaint requirements and outreach providers within the required timeline.	• $50 per business day
18.	Failure to comply with timeframes for at least 98% of expedited service authorization requests, as specified in Appendix B, Coverage and Services.	• $5,000 per month
19.	Failure to comply with timeframes for at least 95% of standard service authorization requests, as specified in Appendix B, Coverage and Services.	• $5,000 per month
20.	Failure to follow ODM or ODM-approved clinical coverage policies as specified in Appendix B, Coverage and Services.	• $1,000 per occurrence, per member

	Noncompliance	Financial Sanction
21.	Failure to submit clinical coverage policies and any subsequent proposed changes to ODM for review and prior approval prior to implementation as specified in Appendix B, Coverage and Services.	• $5,000 per occurrence AND • $500 for each calendar day the policy or policy change is in effect before being submitted to ODM
22.	Failure to notify network and out-of-network providers of changes to clinical coverage policies at least 30 calendar days prior to implementation as specified in Appendix B, Coverage and Services.	• $5,000 per occurrence AND • $500 for each calendar day of the OhioRISE Plan's noncompliance with the 30-calendar day prior notification requirement
23.	Failure to provide feedback to a care management entity (CME) on the development of a child and family-centered care plan within the timeframes specified in Appendix B, Coverage and Services.	• $500 per calendar day, per member
24.	Failure to provide a timely and content-compliant Notice of Action as required by OAC rule 5160-26-08.4 and Appendix B, Coverage and Services.	• $250 per calendar day, per person
25.	Failure to authorize and provide timely access to covered services as specified in Appendix B, Coverage and Services.	• $250 per calendar day, per member, per service
26.	Failure to authorize and provide medically necessary early and periodic screening, diagnosis, and treatment (EPSDT) services as specified in Appendix B, Coverage and Services.	• $750 per occurrence AND • Cost of services not provided, as determined by ODM
27.	Failure to comply with the PRTF Service Authorizations specified in Appendix B, Coverage and Services.	• $500 per calendar day, per member
28.	Failure to cooperate with ODM's external quality review organization (EQRO) as specified in Appendix C, Population Health and Quality.	• $2,500 per occurrence
29.	Failure to actively participate in quality improvement projects or performance improvement projects facilitated by ODM or the EQRO as specified in Appendix C, Population Health and Quality.	• $2,500 per occurrence

	Noncompliance	Financial Sanction
30.	Failure to comply with transition of care requirements for members transitioning to the OhioRISE Plan from fee-for-service (FFS) or an ODM contracted MCO, as specified in Appendix D, Care Coordination.	• $100 per calendar day, per member AND • The value of the services the OhioRISE Plan failed to cover during the applicable transition of care period, as determined by ODM
31.	Failure to complete a required assessment (e.g., health risk assessment, Child and Adolescent Needs and Strengths [CANS] assessment), develop a child and family-centered care plan, submit timely MSY Program funding applications, or authorize or initiate all services specified in the care plan for a member within specified timelines as specified in Appendix D, Care Coordination.	• $500 per member, per calendar day, per service AND • Cost of services not provided, as determined by ODM
32.	Failure to comply with transition of care requirements for members transitioning between health care settings, as specified in Appendix D, Care Coordination.	• $100 per calendar day, per member AND • The value of the services the OhioRISE Plan failed to cover during the applicable transition of care period, as determined by ODM
33.	Failure to comply with transition of care requirements for members transitioning from the OhioRISE Plan to an MCO due to improved assessment score or a member's request for disenrollment, as specified in Appendix D, Care Coordination.	• $100 per calendar day, per member AND • The value of the services the OhioRISE Plan failed to cover during the applicable transition of care period, as determined by ODM
34.	Failure to comply with transition of care requirements for members transitioning from one CME to another CME, as specified in Appendix D, Care Coordination.	• $100 per calendar day, per member AND • The value of the services the OhioRISE Plan failed to cover during the applicable transition of care period, as determined by ODM

	Noncompliance	Financial Sanction
35.	Failure to obtain ODM's approval prior to using member, provider, and marketing materials that require ODM's approval prior to distribution as specified in Appendix E, Member, Provider, and Marketing Materials.	• $250 for every calendar day the unapproved materials are used
36.	Failure to comply with the timeframes for providing member materials as specified in Appendix E, Member, Provider, and Marketing Materials.	• $500 per occurrence
37.	Failure to include and distribute ODM-approved new member materials, as specified in Appendix E, Member, Provider, and Marketing Materials.	• $500 per occurrence
38.	Failure to notify ODM and impacted members of provider termination of network provider within required timeframes as specified in Appendix F, Provider Network.	• $250 per calendar day, per member, for ODM notification • $100 per calendar day, per member, for member notification
39.	Failure to provide timely notification to ODM of network changes that impact 250 or more members or reduce the OhioRISE Plan's network by 10% or more as specified in Appendix F, Provider Network.	• $2,500 per occurrence
40.	Failure to meet minimum provider capacity standards as specified in Appendix F, Provider Network. Provider capacity is measured on a quarterly basis.	• $500 for each category (e.g., Medication Assisted Treatment [MAT], hospitals), for each county, per quarter
41.	Failure to meet access (time and distance) requirements as specified in Appendix F, Provider Network. Access compliance is measured on a quarterly basis.	• $500 per county, per provider type, per quarter
42.	Failure to meet provider network information performance standards, as specified in Appendix F, Provider Network.	• $25,000 for each performance standard not met
43.	Failure to comply with requirements related to utilizing PMF required data elements as specified in Appendix F, Provider Network.	• $5,000 for each calendar day of the OhioRISE Plan’s noncompliance with daily reconciliation of the PNM system generated PMF
44.	Failure to respond to information or witness requests within specified timeframe as specified in Appendix G, Program Integrity.	• $500 per calendar day per request
45.	Payment to a terminated or suspended provider as specified in Appendix G, Program Integrity.	• Twice the amount of the payment made to the terminated or suspended provider

	Noncompliance	Financial Sanction
46.	Failure to report credible allegation of fraud, waste, or abuse as specified in Appendix G, Program Integrity.	• $250 per occurrence
47.	Failure to follow deconfliction processes as specified in Appendix G, Program Integrity.	• CAP for first and non-consecutive noncompliance • $250 per occurrence for the second and subsequent occurrence(s) • ODM may impose additional sanctions as may be determined by ODM
48.	Failure to report recoveries as specified in Appendix G, Program Integrity.	• Twice the amount of recovery that was not reported
49.	Failure to adjust claims/encounters to reflect recovery as specified in Appendix G, Program Integrity.	• Twice the amount of the value of the adjustment
50.	Failure to meet quality measure requirements in Table I.1 of Appendix I, Quality Measures.	• For the first instance of noncompliance, 0.25% of the amount calculated based upon the OhioRISE Plan's capitation for the greater of the 12 months prior to the month in which the compliance action is issues, or the 12 months of the measurement year, for each established minimum performance standard (MPS), under each quality measure • For consecutive instances of noncompliance, 0.5% of the amount calculated based upon the OhioRISE Plan's capitation for the greater of the 12 months prior to the month in which the compliance action is issues, or the 12 months of the measurement year, for each established MPS, under each quality measure
51.	Failure to submit self-reported, audited HEDIS data as specified in Appendix I, Quality Measures.	• $300,000 per occurrence
52.	Failure to submit data for measures designated as "reporting only" with self-reported, audited HEDIS data, as specified in Appendix I, Quality Measures.	• $300,000 per occurrence •

	Noncompliance	Financial Sanction
53.	Failure to submit the Annual Submission of Final HEDIS Audit Report as specified in Appendix I, Quality Measures.	• $300,000 per occurrence •
54.	Failure to administer a Consumer Assessment of Healthcare Providers and Systems CAHPS ECHO survey and submit the survey data to ODM, as specified in Appendix I, Quality Measures	• $300,000 per occurrence AND • The OhioRISE Plan will be considered non-compliant with the standards for the CAHPS ECHO performance measure in Appendix I, Quality Measures, for the corresponding contract period
55.	Failure to include guidance in policy or operational manuals with CMEs related to measure outcomes in Table I.1, as specified in Appendix I, Quality Measures.	• CAP
56.	Failure to meet requirements to adjudicate claims to final status, notify out-of-network providers of procedures for claims submissions when requested, and/or notify network and out-of-network providers of the status of submitted claims as specified in Appendix K, Information Systems, Claims, and Data.	• $10,000 per calendar day for the period of noncompliance
57.	Failure to meet the encounter data volume standards for every service category in all quarters of the measurement period for each of the following populations: aged, blind, and disabled children and Covered Families and Children (CFC) children members, as specified in the most current version of the Methodology for Encounter Data Quality Measures document referenced in Appendix K, Information Systems, Claims, and Data.	• CAP for first and non-consecutive noncompliance • 2% of the amount calculated based upon the OhioRISE Plan's capitation for second consecutive noncompliance within five reporting periods • 3% of the amount calculated based upon the OhioRISE Plan's capitation for the third consecutive noncompliance within five reporting periods

	Noncompliance	Financial Sanction
58.	Failure to meet the requirements for rejected encounters as specified in the most current version of the Methodology for Encounter Data Quality Measures document referenced in Appendix K, Information Systems, Claims, and Data.	• CAP for first and non-consecutive noncompliance • 2% of the amount calculated based upon the OhioRISE Plan's capitation for second consecutive noncompliance within five reporting periods • 3% of the amount calculated based upon the OhioRISE Plan's capitation for the third consecutive noncompliance within five reporting periods
59.	Failure to meet acceptance rate requirement as specified in the the most current version of the Methodology for Encounter Data Quality Measures document referenced in Appendix K, Information Systems, Claims, and Data.	• CAP for first and non-consecutive noncompliance • 2% of the amount calculated based upon the OhioRISE Plan's capitation for second consecutive noncompliance within five reporting periods • 3% of the amount calculated based upon the OhioRISE Plan's capitation for the third consecutive noncompliance within five reporting periods
60.	Failure to meet payment accuracy measures for encounter data accuracy studies as specified in the most current version of the Methodology for Encounter Data Quality Measures document referenced in Appendix K, Information Systems, Claims, and Data.	• CAP for first-time noncompliance • 1% of the amount calculated based upon the OhioRISE Plan's capitation for all subsequent noncompliance
61.	Failure to meet the minimum record submittal rate for encounter data accuracy studies as specified in the most current version of the Methodology for Encounter Data Quality Measures document referenced in Appendix K, Information Systems, Claims, and Data.	• $5,000

	Noncompliance	Financial Sanction
62.	Failure to meet standards for rendering provider data for all quarters of the measurement period as specified in the most current version of the Methodology for Encounter Data Quality Measures document referenced in Appendix K, Information Systems, Claims, and Data.	• CAP for first and non-consecutive noncompliance • 2% of the amount calculated based upon the OhioRISE Plan's capitation for second consecutive noncompliance within five reporting periods • 3% of the amount calculated based upon the OhioRISE Plan's capitation for the third consecutive noncompliance within five reporting periods
63.	Failure to meet standards for National Provider Identifier (NPI) provider number usage as specified in the most current version of the Methodology for Encounter Data Quality Measures document referenced in Appendix K, Information Systems, Claims, and Data.	• CAP for first and non-consecutive noncompliance • 2% of the amount calculated based upon the OhioRISE Plan's capitation for second consecutive noncompliance within five reporting periods • 3% of the amount calculated based upon the OhioRISE Plan's capitation for the third consecutive noncompliance within five reporting periods
64.	Failure to meet encounter submission requirements as specified in the most current version of the Methodology for Encounter Data Quality Measures document referenced in Appendix K, Information Systems, Claims, and Data.	• 1% of the amount calculated for first measurement period of noncompliance • 2% of the amount calculated for subsequent noncompliance
65.	Failure to meet encounter timeliness standards as specified in Appendix K, Information Systems, Claims, and Data, and the most current version of the Methodology for Encounter Data Quality Measures document referenced in Appendix K, Information Systems, Claims, and Data.	• 1% of the amount calculated based upon the OhioRISE Plan's capitation for first measurement period of noncompliance • 2% of the amount calculated based upon the OhioRISE Plan's capitation for subsequent noncompliance

	Noncompliance	Financial Sanction
66.	Failure to comply with claims payment systemic error (CPSE) policies and activities to correct CPSEs as specified in Appendix K, Information Systems, Claims, and Data.	• CAP for first and non-consecutive noncompliance • $2,500 per occurrence for second consecutive noncompliance within five reporting periods
67.	Failure to comply with timeframes when implementing ODM rate changes, as specified in Appendix K, Information Systems, Claims, and Data	• $10,000 per calendar day for the period of noncompliance
68.	Failure to comply with any of the following reinsurance requirements as specified in Appendix L, Payment and Financial Performance: Failure to maintain reinsurance coverage as required; Failure to obtain approval from ODM for deductibles in excess of $100,000; or Failure to obtain approval from ODM when reinsurance covers less than 80% of inpatient costs in excess of the deductible incurred by one member for one year.	The lesser of: • 10% of the difference between the estimated amount the OhioRISE Plan would have paid in premiums for the reinsurance policy if it had been in compliance, and what the OhioRISE Plan actually paid while it was out of compliance OR • $25,000
69.	Failure to comply with prompt pay requirements as specified in Appendix L, Payment and Financial Performance.	• For the first instance of noncompliance, 0.04% of the amount calculated based upon the OhioRISE Plan's capitation for each claim type and timeframe separately • For the second instance of noncompliance, 0.08% of the amount calculated based upon the OhioRISE Plan's capitation for each claim type and timeframe separately • For additional violations during a rolling 12-month period, 1% of the amount calculated based upon the OhioRISE Plan's capitation for each claim type and timeframe separately

	Noncompliance	Financial Sanction
70.	Failure to comply with the TPL provider recoupments requirements as specified in Appendix L, Payment and Financial Performance.	• $250 for each violation • ODM may impose additional sanctions may be assessed as determined by ODM
71.	Failure to submit a proposed Transition Plan within 10 business days of receiving notice from ODM in accordance with Appendix O, OhioRISE Plan Termination and Non-Renewal.	• $5,000 per calendar day • ODM may impose additional financial sanctions if the OhioRISE Plan fails to revise the proposed Transition Plan as necessary to obtain ODM approval
72.	Failure to submit a deliverable or respond to ODM's requests within the required timeframe under this Agreement.	• $100 per deliverable or request, per calendar day
73.	Failure to complete or comply with a CAP as described in this appendix.	• $500 for each calendar day the CAP is not completed, implemented, or complied with as determined by ODM
74.	Failure to notify the inpatient behavioral facility that the OhioRISE Plan is responsible for coverage of the stay within one business day of being notified by the MCO.	• $250 per occurrence

b. Pre-Determined Non-Financial Sanctions

i. In addition to other compliance actions available to ODM, ODM may impose the following pre-determined non-financial sanctions in accordance with Table N.2 below.

Table N.2. Pre-Determined Non-Financial Sanctions

	Noncompliance	Non-Financial Sanction
1.	Failure to maintain an acceptable status with the National Committee for Quality Assurance (NCQA) as specified in Appendix A, General Requirements.	• If the OhioRISE Plan receives a Provisional status, the OhioRISE Plan must complete a second review within 12 months of the original review decision. If the new results are in a Provisional or Denied status, ODM will consider this a material breach of this Agreement and may terminate this Agreement. • If the OhioRISE Plan receives a Denied status, ODM will consider this a

	Noncompliance	Non-Financial Sanction
		material breach of this Agreement and may terminate this Agreement.
2.	Failure to comply with OhioRISE 1915(c) waiver care coordination and operational requirements as specified in Appendix A, General Requirements and Appendix C, Population Health and Quality.	• CAP for first and non-consecutive compliance. • $2,500 for each failure to comply with the CAP, as determined by ODM.
3.	Failure to comply with OhioRISE 1915(c) waiver performance standards, as specified in Appendix I, Quality Measures	• A CAP for each waiver performance measure for which the OhioRISE Plan falls below the 86% threshold.
4.	Failure to submit quarterly Financial Statements to ODM as specified in Appendix L, Payment and Financial Performance.	• ODM may require the OhioRISE Plan to complete a CAP. • To the extent that the OhioRISE Plan does not demonstrate compliance with the CAP, the OhioRISE Plan will be subject to the financial sanction in Table N.1.
5.	Failure to submit annual Financial Statements to ODM as specified in Appendix L, Payment and Financial Performance.	• ODM may require the OhioRISE Plan to complete a CAP. • To the extent that the OhioRISE Plan does not demonstrate compliance with the CAP, the OhioRISE Plan will be subject to the financial sanction in Table N.1.
6.	Failure to meet financial performance requirements as specified in Appendix L, Payment and Financial Performance.	• ODM may require the OhioRISE Plan to complete a CAP. • To the extent that the OhioRISE Plan does not demonstrate compliance with the CAP, the OhioRISE Plan will be subject to the financial sanction in Table N.1.
7.	Failure to notify ODM within one business day after the receipt of a proposed or implemented regulatory action by Ohio Department of Insurance (ODI) as Appendix L, Payment and Financial Performance.	• OhioRISE Plan failure to comply with this requirement may result in an immediate new enrollment freeze.

c. Financial Sanctions

i. General

1. ODM may impose financial sanctions for noncompliance that does not fall into pre-determined sanctions. The amount of the financial sanction may vary depending upon the OhioRISE Plan's noncompliance, repeated violations, failure to meet the requirements in a CAP, and the impact of the noncompliance to members.

ii. Level 1 Sanctions

1. ODM may impose a Level 1 sanction up to a maximum of $15,000 per occurrence of OhioRISE Plan failure to comply with a term of this Agreement and federal and state requirements that does not result in a member being unable to receive a medically necessary service or in a poor health outcome for the member. Examples may include:

    a. Failure to ensure that staff performing care coordination functions are operating within their professional scope of practice or that they are complying with the state's licensure/credentialing requirements;

    b. Failure to update the CFCP in a timely manner when the needs of a member change;

    c. Failure to coordinate care for a member across providers, specialists, and team members, as appropriate;

    d. Failure to adhere to a documented communication plan, including the contact schedule for in-person visits and telephone calls;

    e. Failure to make reasonable attempts to obtain a discharge/transition plan from an inpatient facility; and

    f. Failure to notify providers of claim reprocessing or payment recovery within the timeframe specified in Appendix K, Information Systems, Claims, and Data.

iii. Level 2 Sanctions

1. ODM may impose a Level 2 sanction up to a maximum of $25,000 per occurrence of the OhioRISE Plan's failure to comply with a term of this Agreement and/or state and federal requirements.

2. Level 2 sanctions include but are not limited to the following types of OhioRISE Plan's noncompliance:

    a. Noncompliance that is associated with a poor health outcome for the member;

b. Failure to provide medically necessary services that the OhioRISE Plan must provide under the terms of this Agreement to its enrolled members, such as:

i. Failure to assist a member in accessing needed services in a timely manner after receiving a request from the member;

ii. Failure to meet requirements related to discharge planning;

iii. Failure to provide services specified in the member's discharge plan;

iv. Failure to ensure staff performing care coordination functions are appropriately responding to a member's care coordination needs; and

v. Failure to complete a care gap analysis that identifies gaps between recommended care and care received by a member.

c. Misrepresentation or falsification of information furnished to an eligible individual, member, or provider; and

d. Failure to comply with physician incentive plan requirements.

iv. Level 3 Sanctions

1. ODM may impose a Level 3 sanction up to a maximum of $100,000 per occurrence of the OhioRISE Plan's failure to comply with a term of this Agreement and/or state and federal requirements.

2. Level 3 sanctions include but are not limited to the following types of OhioRISE Plan noncompliance:

a. Discrimination among members on the basis of their health status or need for health care services (this includes any practice that would reasonably be expected to encourage termination or discourage selection of members or eligible individuals whose medical condition indicates probable need for substantial future medical services); and

b. Misrepresentation or falsification of information provided to ODM or Centers for Medicare and Medicaid Services (CMS).

v. Financial Sanction Calculation

1. ODM will evaluate OhioRISE Plan noncompliance and, in its sole discretion, determine the appropriate level and amount of the financial sanction to impose. ODM will consider relevant information regarding noncompliance, as well as the following aggravating and mitigating factors:

a. The extent, severity, duration, and impact of noncompliance;

b. Whether the noncompliance poses or results in a quality of care or safety concern;

c. Whether noncompliance was intentional;

d. Whether the OhioRISE Plan promptly identified, reported, and remediated the noncompliance;

e. OhioRISE Plan enrollment size relative to the amount of the financial sanction;

f. Financial implications to providers; and

g. Financial harm and risk to the State.

d. Compounded Financial Sanctions

i. ODM will compound pre-determined and financial sanctions if the OhioRISE Plan fails to achieve compliance within the timeframe established by ODM or maintain compliance for the same requirement for a six-month timeframe after demonstrating compliance.

ii. ODM will calculate compounded financial sanctions as follows:

1. For each subsequent measurement period (e.g., daily, monthly, quarterly), ODM will assess two times the amount of the pre-determined or financial sanction, or the maximum amount for Level 1 financial sanctions, whichever is less, if:

a. The OhioRISE Plan fails to demonstrate compliance within the timeframe identified in the Notice of Compliance Action; or

b. The OhioRISE Plan fails to comply with the same requirement throughout a six-month timeframe after demonstrating compliance.

e. Collection of Pre-Determined and Financial Sanctions

i. ODM will directly deduct pre-determined and financial sanctions imposed against the OhioRISE Plan from the net capitation paid to the OhioRISE Plan. ODM will specify on the invoice the date ODM will deduct the funds.

ii. If ODM requests an Electronic Funds Transfer (EFT) from the OhioRISE Plan, the OhioRISE Plan must pay the pre-determined and financial sanction to ODM within 30 calendar days of the date of the invoice or as otherwise directed in writing by ODM. Pursuant to ORC section 131.02, ODM will certify to the Attorney General's (AG's) Office payments owed by the OhioRISE Plan to the State that are not received within 45 calendar days. The AG's Office will impose the appropriate collection fee for OhioRISE Plan payments certified to the AG's Office.

iii. For pre-determined and financial sanctions calculated in accordance with this appendix, ODM will use the OhioRISE Plan's average monthly net capitation, disregarding the financial sanctions for the 12 months prior to the month in which ODM issues the compliance action to the OhioRISE Plan.

f. Temporary Management

i. Pursuant to OAC 5160-26-10 and 42 CFR 438.706, ODM may impose temporary management when the OhioRISE Plan has repeatedly failed to comply with the requirements in this Agreement.

ii. The OhioRISE Plan must bear all costs incurred from the appointment of temporary management.

iii. ODM's imposition of temporary management against the OhioRISE Plan will not be delayed to provide the OhioRISE Plan with an opportunity to request reconsideration. Temporary management will remain in place until ODM determines that the noncompliance will not reoccur.

g. Termination

i. In accordance with 42 CFR 438.708, ODM may terminate this Agreement if ODM determines that the OhioRISE Plan has failed to carry out the substantive terms of this Agreement or failed to meet the applicable requirements in Sections 1932, 1903(m) or 1905(t) of the Social Security Act.

ii. ODM may terminate or amend this Agreement if at any time ODM determines that continuation of this Agreement is not in the best interest of members or the state of Ohio, pursuant to OAC rule 5160-26-10.

iii. Nothing in this appendix precludes ODM from terminating this Agreement pursuant to Article VIII of the Baseline Provider Agreement.

4. Request for Reconsideration

a. Other than as specified below, pursuant to OAC rule 5160-26-10, the OhioRISE Plan may seek reconsideration of any compliance action in this appendix imposed by ODM.

i. The OhioRISE Plan may not seek reconsideration of a compliance action by ODM that results in the imposition of a Notice of Noncompliance, CAP, or directed CAP, as defined in this appendix.

b. The OhioRISE Plan may only seek reconsideration of a CAP when a CAP is required for the first violation in a series of progressive compliance actions.

c. The OhioRISE Plan must submit a request for reconsideration on the form required by ODM, in accordance with the following procedure:

i. The OhioRISE Plan must submit a request for reconsideration to ODM no later than 30days fromthe date appearing on the Notice of Compliance Action sent to the OhioRISE Plan.

ii. The OhioRISE Plan's request for reconsideration must explain in detail why ODM should not impose the specified compliance action. At a minimum, the OhioRISE Plan's reconsideration request must include a statement of the proposed compliance action being contested, the basis for the OhioRISE Plan's request, and any supporting

documentation. In considering the OhioRISE Plan's request for reconsideration, ODM will review only the written material submitted by the OhioRISE Plan.

iii. ODM will take reasonable steps to issue a final written decision or request additional information within ten business days after receiving the OhioRISE Plan's request for reconsideration. If ODM requires additional time, ODM will notify the OhioRISE Plan in writing.

iv. If ODM approves the OhioRISE Plan's reconsideration request in whole, ODM will rescind the associated compliance actions.

v. If ODM approves the OhioRISE Plan's reconsideration request in part, ODM at its sole discretion may rescind or reduce the associated compliance actions.

vi. If ODM denies the OhioRISE Plan's reconsideration request in whole, ODM will take the compliance actions outlined in the original notification of noncompliance.

APPENDIX O – PLAN TERMINATION AND NON-RENEWALS

1. General Requirements

a. This Agreement may be terminated or not renewed as specified in Article VIII of the Baseline Provider Agreement.

i. OhioRISE Plan-Initiated Terminations and Non-Renewal

1. When initiated by the OhioRISE Plan, the OhioRISE Plan must provide ODM written notice of the termination or non-renewal of this Agreement as required in Article VIII of the Baseline Provider Agreement.

ii. ODM-Initiated Terminations for Cause Under OAC Rule 5160-26-10

1. If ODM initiates the proposed termination, non-renewal, or amendment of this Agreement pursuant to OAC rule 5160-26-10 by issuing a proposed adjudication order pursuant to ORC section 5164.38, and the OhioRISE Plan submits a valid appeal of that proposed action pursuant to ORC Chapter 119, this Agreement will be extended through the issuance of an adjudication order of the OhioRISE Plan's appeal under ORC Chapter 119.

2. Pursuant to OAC rule 5160-26-10, ODM may notify the OhioRISE Plan's members of the proposed action and inform the members of their right to immediately terminate their enrollment with the OhioRISE Plan without cause. If ODM has proposed the termination, non-renewal, denial, or amendment of this Agreement and access to medically necessary covered services is jeopardized, ODM may propose to terminate the enrollment of all of the OhioRISE Plan's members. The OhioRISE Plan may request reconsideration of a proposed enrollment termination of members as follows:

a. ODM will notify the OhioRISE Plan of the proposed enrollment termination via certified or overnight mail to the OhioRISE Plan. The OhioRISE Plan will have three business days from the date of receipt to request reconsideration.

b. The OhioRISE Plan must submit reconsideration requests to ODM's Director by mail. ODM must receive the request by 3:00 pm Eastern Time on the third business day following the OhioRISE Plan's receipt of the ODM notification of termination.

c. The OhioRISE Plan's request must explain in detail why the proposed enrollment termination is not justified. ODM will not consider justification other than what is submitted in writing by the OhioRISE Plan.

d. The ODM Director will issue a final decision or a request for additional information within five business days of receipt of the OhioRISE Plan's request for reconsideration. ODM will notify the OhioRISE Plan in

writing if the Director requires additional time in rendering the final reconsideration decision.

e. The proposed OhioRISE Plan enrollment termination will not occur while the reconsideration is under review and pending the Director's decision. If the Director denies the reconsideration, the OhioRISE Plan enrollment termination will proceed at the first possible effective date.

iii. Termination due to ODM OhioRISE Program Procurement Process

1. In the event this Agreement terminates as a result of ODM's procurement of the OhioRISE Program pursuant to ORC section 5167.10, the OhioRISE Plan has no right to appeal under the authorities in ORC Chapter 119 pursuant to ORC section 5164.38. This requirement applies whether the OhioRISE Plan is or is not selected as a result of the ODM procurement.

iv. Termination or Modification of this Agreement due to Lack of Funding

1. In the event this Agreement terminates or is modified due to a lack of available funding, the OhioRISE Plan has no right to appeal under the authorities in ORC Chapter 119 pursuant to ORC section 5164.38.

b. If for any reason this Agreement is terminated or not renewed, the OhioRISE Plan must comply with the transition requirements as described in this appendix.

c. The OhioRISE Plan will continue to be subject to compliance actions as specified in Appendix N, Compliance Actions, of this Agreement until ODM approves the OhioRISE Plan's final report as specified by ODM documenting that the OhioRISE Plan has fulfilled all outstanding obligations.

2. Transition Requirements

a. Upon notice of the termination/non-renewal of this Agreement the OhioRISE Plan must comply with the following transition requirements:

i. Member Care Responsibilities.

1. The OhioRISE Plan must comply with all duties and obligations, including all responsibilities related to member care.

ii. Transition Plan

1. The OhioRISE Plan must submit a proposed Transition Plan within ten business days of the notice of termination/non-renewal of this Agreement for ODM approval. The OhioRISE Plan must revise the proposed Transition Plan as necessary to obtain ODM's approval. The OhioRISE Plan's proposed Transition Plan must include the following:

a. The OhioRISE Plan's agreement to comply with all duties and obligations incurred prior to the effective date of this Agreement termination/non-renewal, including the performance of ongoing functions, and the submission of all reports and deliverables;

b. The identification of the OhioRISE Plan's Transition Coordinator, the OhioRISE Plan's single point of contact responsible for coordinating the OhioRISE Plan's transition activities;

c. The proposed submission timeframes for all outstanding reports and deliverables as identified by ODM;

d. If applicable, the member outreach workflow identifying the approach and timing of outreach to members impacted by the termination/non-renewal of this Agreement;

e. The OhioRISE Plan's proposed communication plan, including the OhioRISE Plan's written notifications and proposed timeline to notify all subcontractors, providers, and members impacted by the termination/non-renewal of this Agreement. The OhioRISE Plan's proposed communication plan must include the following standardized notifications:

    i. Provider Notification

        1. If applicable, the OhioRISE Plan must notify contracted providers impacted by the termination/non-renewal of this Agreement at least 55 calendar days prior to the effective date of the termination/non-renewal of this Agreement. The provider notification language and process must be approved by ODM prior to distribution.

    ii. Member Notification

        1. If applicable, unless otherwise notified by ODM, the OhioRISE Plan must notify its members impacted by the termination/non-renewal of this Agreement at least 45 calendar days in advance of the effective date of termination/non-renewal. A member outreach workflow identifying the approach and timing of outreach to the members impacted must be included. The member notification language and process must be approved by ODM prior to distribution.

    iii. MCO Notification

        1. The OhioRISE Plan must notify each member's MCO at least 55 calendar days prior to the effective date of the termination/non-renewal of this Agreement. The MCO notification must be approved by ODM prior to distribution.

    iv. Prior Authorization Redirection Notification

1. If applicable, the OhioRISE Plan must create two notices to assist members and providers with prior authorization requests received or approved during the last month of enrollment. The first notice is for prior authorization requests for services to be provided after the effective date of termination/non-renewal; this notice will direct members and providers to contact their MCO or other entity as directed by ODM. The second notice is for prior authorization requests for services to be provided before and after the effective date of termination/non-renewal. The OhioRISE Plan must use ODM model language to create the notices and receive approval by ODM prior to distribution. The notices must be mailed to the provider and copied to the member for all requests received during the last month of OhioRISE Plan membership.

f. The OhioRISE Plan's member transition of care plan, including the transition of care narrative, timeline, and member services workflow to support an efficient and seamless transition of members from coverage under this Agreement to coverage under ODM's designee. The transition of care plan must identify at-risk populations and prioritize those members. The member transition plan must include a review of prior authorized services and a plan to continue authorization of those services, excluding prescribed drugs, for 90 calendar days after the effective date of the termination/non-renewal of this provider agreement.

2. Transition Plan Updates

a. The OhioRISE Plan must report Transition Plan updates to ODM detailing OhioRISE Plan progress toward completing OhioRISE Plan obligations under this Agreement and the Transition Plan on a monthly basis, on the fifth day of the month following the month reported.

iii. Fulfill Existing Duties and Obligations

1. During the term of this Agreement and after termination/non-renewal of this Agreement, the OhioRISE Plan must fulfill all duties and obligations as required under OAC Chapters 5160-29 and 5160-59 and any provider agreements related to the provision of services for the Medicaid population during periods of time when the OhioRISE Plan was under contract with ODM. OhioRISE Plan duties and obligations include the performance of ongoing functions and the submission of all outstanding reports and deliverables as identified in the Transition Plan. Specific examples of functions and reporting include but are not limited to the following:

a. Member Grievances and Appeals, Provider Complaints, and State Hearings

i. The OhioRISE Plan must resolve all provider complaints and member grievances and appeals related to the OhioRISE Plan's decisions and responsibilities exercised under this Agreement. The OhioRISE Plan must also participate in state hearings related thereto. The OhioRISE Plan must provide a monthly report of:

1. Member complaint, grievance, appeal, and state hearing information; and

2. Provider complaint information, as outlined in the OhioRISE Plan's ODM-approved Transition Plan.

b. Claims Payment

i. The OhioRISE Plan must pay all outstanding obligations for services and benefits rendered to members during the period of time when the OhioRISE Plan was under contract with ODM in accordance with the requirements in this Agreement and OAC rule 5160-26-09.1. This includes without limitation, the payment of funds owed as a result of the concurrent risk analysis process as well as the reporting, data integration, and payment requirements related to quality improvement strategies and value-based initiatives initiated by the OhioRISE Plan under this Agreement.

c. Encounter and Claims Data

i. As directed by ODM, the OhioRISE Plan must provide encounter data, cost report data, and claims aging reports, including incurred but not reported amounts, related to time periods through the final date of service every 30 calendar days as part of the monthly Transition Plan reporting requirement. The OhioRISE Plan must continue encounter reporting until all services rendered prior to the termination/non-renewal of this Agreement have reached adjudicated status and data validation of the information has been completed to the satisfaction of ODM.

d. Population Health and Performance Data

i. After the termination date of this Agreement for any reason, the OhioRISE Plan must continue to provide population health, care coordination, and quality data files as specified in Appendix C, Population Health and Quality, Appendix D, Care Coordination; and Appendix I, Quality Measures, for all periods prior to the termination of this Agreement. In addition, the OhioRISE Plan must continue to provide all data files required to determine the status of any Quality Withhold and other

incentive programs that may have been in operation under this Agreement after this Agreement is terminated.

e. Financial Reports

i. i. The OhioRISE Plan must provide financial reports as outlined in the OhioRISE Plan's ODM-approved Transition Plan, including:

1. Audited financial statements, inclusive of a balance sheet;

2. Reinsurance audit activities on prior contract years; and

3. Finalization of any open or pending reconciliations.

iv. Cooperation

1. The OhioRISE Plan must fully cooperate with ODM, ODM's designee(s), ODM vendors, and all other entities as directed by ODM to support a seamless transition of members and administrative responsibilities under this Agreement to the satisfaction of ODM. The OhioRISE Plan must participate in any meetings, workgroups, or other activities as requested by ODM to support the transition, both before and after the date of termination of this Agreement for any reason, as determined necessary by ODM. The OhioRISE Plan must promptly respond to ODM requests related to the transition, including but not limited to ODM programmatic requests, ODM data requests, and ODM information technology requests and meet all deliverable timelines required by ODM.

2. ODM will offset all additional costs and expenses incurred by ODM as a result of the OhioRISE Plan's failure to cooperate and/or promptly respond as set forth in this section by deducting the additional costs and expenses from the monetary assurance.

v. Maintenance of Financial Requirements and Insurance

1. The OhioRISE Plan must comply with financial and insurance requirements until ODM provides the OhioRISE Plan written notice that all continuing OhioRISE Plan obligations under this Agreement have been fulfilled.

vi. Refundable Monetary Assurance

1. The OhioRISE Plan must submit a refundable monetary assurance within ten business days of receiving upon the invoice. This monetary assurance will be held by ODM and must be in an amount of 10% of the capitation amount paid by ODM subject to termination/non-renewal in the month the termination/non-renewal notice is issued.

2. The OhioRISE Plan must remit the monetary assurance in the specified amounts via separate electronic fund transfers payable to Treasurer of State, state of Ohio (ODM). The OhioRISE Plan must contact its Contract Administrator to

verify the correct amounts required for the monetary assurance and obtain an invoice number prior to submitting the monetary assurance. Information from the invoices must be included with each electronic fund transfer to ensure monies are deposited in the appropriate ODM fund account. In addition, the OhioRISE Plan must send copies of the electronic fund transfer bank confirmations and copies of the invoices to its Contract Administrator.

3. If the monetary assurance is not received as specified above, ODM will withhold the OhioRISE Plan's next month's capitation payment until such time that ODM receives documentation that the monetary assurance is received by the Treasurer of State. This transaction will be created as an accounts receivable and will show up on the remittance advice.

4. Upon ODM's approval of the OhioRISE Plan's final report as specified by ODM, ODM will refund the monetary assurance to the OhioRISE Plan, less any costs and expenses as set forth above.

vii. Quality Withhold

1. Unreturned funds from the quality withhold program of this Agreement set forth in Appendix J, Quality Withholds, will be retained by ODM.

viii. Final Accounting of Amounts Outstanding

1. The OhioRISE Plan must submit to ODM a final accounting list of any outstanding monies owed by ODM no later than six months after the termination/non-renewal date. ODM's payment will be limited to only those amounts properly owed by ODM. Failure by the OhioRISE Plan to submit a list of outstanding items, or to include all outstanding items on that list, within the timeframe will be deemed a forfeiture of any additional compensation due to the OhioRISE Plan.

ix. Member Transitions

1. The OhioRISE Plan must conduct all member transition activities in accordance with the ODM-approved Transition Plan and in accordance with ODM requirements. When transitioning members to ODM or ODM-designees (MCOs, SPBM), the OhioRISE Plan is responsible for notifying ODM and/or ODM designees of pertinent information related to the special needs of transitioning members. The OhioRISE Plan must transfer member data to ODM and/or ODM's designees- within the time period and in a file format as specified by ODM.

x. Data Files

1. If applicable, in order to assist members with transition and continuity of care, the OhioRISE Plan must create data files to share with each receiving ODM designee. The OhioRISE Plan must provide the data files in a consistent format specified by ODM and may include information on the following: care management, prior authorizations, inpatient facility stays, and prescribers. The timeline for the OhioRISE Plan providing these files will be at the discretion of

ODM. At termination, the OhioRISE Plan will be responsible for all costs associated with data sharing and for ensuring the accuracy and data quality of the files.

xi. Program Integrity Activities

1. The OhioRISE Plan must continue program integrity activities for two years from the end of this Agreement. Program integrity activities include requesting deconfliction and abiding by the ODM response, promptly submitting fraud referrals, conducting post-payment reviews and audits, and continuing to identify overpayments and recoupment. The OhioRISE Plan shall submit to ODM quarterly inventory reports on all of these activities. Each quarterly inventory report submitted, and any subsequent revision to an inventory report, must be certified as accurate by the OhioRISE Plan CFO.

    a. Overpayment Recovery. The OhioRISE Plan may recover overpayments made to providers if the overpayment is identified and the provider is notified within two years of the date the OhioRISE Plan improperly paid the provider, within six months of the MFCU returning a fraud referral to the OhioRISE Plan, or if ODM recovers the payment to the provider from the OhioRISE Plan, whichever is later.

    b. ODM Audits. The OhioRISE Plan must allow ODM to audit capitation payments made to the OhioRISE Plan and payments made to providers by the OhioRISE Plan, as well as recover overpayments under the time limits in ORC section 5164.57.

    c. Cooperation with Law Enforcement and Record Retention. The OhioRISE Plan must continue to cooperate with law enforcement and federal audits for ten years following the termination of this Agreement. The OhioRISE Plan must retain records for ten years and allow auditing and inspection of those records for ten years.

xii. OhioRISE Plan Release

1. ODM will release the OhioRISE Plan from its responsibilities under the Transition Plan upon ODM's approval of the OhioRISE Plan's final report documenting that the OhioRISE Plan has fulfilled all outstanding obligations. Following ODM release, the OhioRISE Plan will retain ongoing responsibility for providing data to support audits related to the Medicaid population served by the OhioRISE Plan during the term of this Agreement.

APPENDIX P — CHART OF DELIVERABLES

1. General

a. The OhioRISE Plan must submit all deliverables required by this Agreement and as requested by ODM. Deliverables include but are not limited to policies, procedures, plans, member and provider notices, member materials, notifications to ODM, data, and reports.

b. The OhioRISE Plan must submit each deliverable as specified by ODM, including but not limited to the format and timeframe for submission. Format means the content, form, and manner of submission.

c. ODM may, at its discretion, change the format or timeframe for submission of a deliverable or deliverables.

d. ODM may, at its discretion, require the OhioRISE Plan to submit additional deliverables in the format and timeframe specified by ODM.

e. If this Agreement or ODM otherwise requires ODM prior review or approval of a deliverable, the OhioRISE Plan must receive written notice of review or approval from ODM prior to the deliverable taking effect.

f. Unless otherwise specified by ODM, deliverables must be submitted to the email address provided by ODM.

g. Unless otherwise specified by this Agreement or ODM, deliverables are due by 3:00 pm Eastern Time on the due date indicated. If the due date falls on a weekend or a state holiday, the due date is 3:00 pm Eastern Time on the next business day.

h. The OhioRISE Plan must review all deliverables prior to submission to ODM and ensure the OhioRISE Plan submits timely, accurate, and complete deliverables to ODM.

i. The OhioRISE Plan's failure to submit timely, accurate, and complete deliverables to ODM is subject to compliance actions as specified in Appendix N, Compliance Actions.

j. If ODM requests a revision to a deliverable, the OhioRISE Plan must make the changes and resubmit the deliverable in the format and timeframe specified by ODM. ODM will determine the OhioRISE Plan's compliance with the requirement to submit timely, accurate, and complete deliverables based on the original submission.

k. The OhioRISE Plan must review the content of deliverables to determine whether performance as documented in the deliverable complies with this Agreement. If the OhioRISE Plan identifies deficient performance, the OhioRISE Plan, in the submission of the deliverable, must include written documentation to ODM that identifies the area or areas of deficiency, and the steps taken by the OhioRISE Plan to bring performance into compliance with this Agreement. The OhioRISE Plan's self-identification of a deficiency does not impact ODM's ability to take a compliance action under Appendix N, Compliance Actions; however, ODM may consider the OhioRISE Plan's self-identification when determining the appropriate compliance action.

2. Ad Hoc Deliverables

a. The OhioRISE Plan must submit notifications and other ad hoc deliverables (deliverables that are not scheduled, but the OhioRISE Plan must submit to ODM under specific circumstances) to ODM as specified in this Agreement or as otherwise directed by ODM.

b. Unless otherwise specified by this Agreement or ODM, the OhioRISE Plan must submit all notifications and other ad hoc deliverables to ODM in writing.

3. Scheduled Deliverables

a. The Chart of Scheduled Deliverables in Section 4 below summarizes the scheduled deliverables specified in this Agreement, including the applicable reference to this Agreement, the deliverable name, the frequency of the deliverable, the due date, and the name of any applicable reporting guidance document.

b. The Chart of Scheduled Deliverables is presented here for convenience only and does not limit the OhioRISE Plan's responsibility to provide all deliverables required by ODM in the format and frequency specified by ODM.

4. Chart of Scheduled Deliverables

#	Provider Agreement Appendix	Deliverable Name	Frequency	Due Date
1.	Appendix A	Protected Health Information (PHI) Breach Report	Annual	• January 31 for the year ending the previous December
2.	Appendix A	Member Services Call Center Report	Monthly	• 15th of the month
3.	Appendix A	Member and Family Advisory Council Report	Quarterly	• January 30 for the quarter ending December 31 • April 30 for the quarter ending March 31 • July 30 for the quarter ending June 30 • October 30 for the quarter ending September 30
4.	Appendix A	Monthly Appeal and Grievance Activity Report	Monthly	• 15th of the month
5.	Appendix A	Monthly Grievance and Appeal System Report	Monthly	• 5th of the month

#	Provider Agreement Appendix	Deliverable Name	Frequency	Due Date
6.	Appendix A	Provider Call Center Report	Monthly	• 15th of the month
7.	Appendix A	Provider Claim Dispute Resolution Report	Monthly	• 15th of the month
8.	Appendix A	Provider Advisory Council Activity Report	Semi Annual	• January 15 for the 6-month period ending December 31 • July 15 for the 6-month period ending June 30
9.	Appendix A	OhioRISE Plan Organizational and Functional Chart	Annual and Upon Key Staff Changes	• January 15
10.	Appendix A	OhioRISE Plan Staff Training Plan	Annual	• September 30
11.	Appendix A	FDR Oversight Report	Annual	• January 15
12.	Appendix A	Waiver Restrictive Intervention, Restraint and/or Seclusion report	Quarterly	• January 15 • April 15 • July 15 • October 15
13.	Appendix A	Waiver Monthly Enrollment Report	Monthly Annually	• 15th of the month • July 15th for the previous waiver year (state fiscal year)
14.	Appendix A	Waiver Cost Cap Report	Quarterly	• January 15 • April 15 • July 15 • October 15
15.	Appendix A	Member Requests for Waiver Services and Access to Care	Quarterly	• January 15 • April 15 • July 15 • October 15
16.	Appendix A	Waiver Enrollment and Disenrollment Statistics	Monthly and Annually	• 15th of the month • July 15th for the previous waiver year (state fiscal year)
17.	Appendix A	Accreditation Reports	Varies	• Within 30 calendar days, or as soon as practicable, of receiving accreditation

#	Provider Agreement Appendix	Deliverable Name	Frequency	Due Date
18.	Appendix A	Provider Claim Inquiry Report	Monthly	• 15th of the month
19.	Appendix B	Mental Health Parity and Addiction Equity Act (MHPAEA) Compliance Assessment Tool and Attestation of Compliance	Annual	• December 31
20.	Appendix B	CMS Annual Drug Utilization Review (DUR) Survey	Annual	• April 30
21.	Appendix B	Medication Therapy Management (MTM) Program Utilization and Financial Metric Report	Quarterly	• February 1 (Annual and Quarterly template) • May 1 (Quarterly) • August 1 (Quarterly) • November 1 (Quarterly)
22.	Appendix B	PRTF Annual Report	Annually	• January 15th
23.	Appendix B	PRTF Quarterly Report	Quarterly	• January 31 • April 30 • July 31 • October 31
24.	Appendix C	Community Reinvestment Evaluation	Annually	• March 31
25.	Appendix C	Community Reinvestment Plan	Annually	• October 15
26.	Appendix C	Evidence of QI Training Completion	Within 1 month of completion	• Varies
27.	Appendix C	QAPI Evaluation	Annual	• July 15
28.	Appendix C	QI Template	At least weekly	• At least 2 business days prior to the QI meeting
29.	Appendix D	Care Coordination Program Description	Annual	• July 31
30.	Appendix D	OhioRISE CME Oversight Report Definitions	Monthly	• 15th of the month
31.	Appendix D	Monthly Member Assignment Report	Monthly	• 15th of the month
32.	Appendix D	Health Risk Assessment Submission File	Quarterly	• January 31 • April 30 • July 31 • October 31

#	Provider Agreement Appendix	Deliverable Name	Frequency	Due Date
33.	Appendix D	Out of Home Placement Report	Quarterly	• January 31 • April 30 • July 31 • October 31
34.	Appendix D	Care Coordination Activity Report	Monthly	• 15th of the month
35.	Appendix D	Transition of Care Report	Monthly	• 15th of the month
36.	Appendix D	PRTF Transition Report	Monthly	• 15th of the month
37.	Appendix F	Change in Circumstance	Monthly	• 5th of the month
38.	Appendix F	Network Development and Management Plan	Annual	• January 15
39.	Appendix F	Time and Distance Reports	Quarterly	• January 30 for the quarter ending December 31 • April 30 for the quarter ending March 31 • July 30 for the quarter ending June 30 • October 30 for the quarter ending September 30
40.	Appendix F	Telehealth Report	Annual	• January 15
41.	Appendix F	Provider Visit Report	Monthly	• 15th of the month
42.	Appendix F	Lead Source Report	Monthly	• 15th of the month
43.	Appendix F	CANS Timely Completion Report	Quarterly	• January 31 • April 30 • July 31 • October 31

#	Provider Agreement Appendix	Deliverable Name	Frequency	Due Date
44.	Appendix F	The Non-Medicaid Youth Flat File	Monthly	• 20th of the month
45.	Appendix G	Compliance Plan	Annual	• January 15
46.	Appendix G	Fraud, Waste, and Abuse Plan	Annual	• January 15
47.	Appendix G	Fraud, Waste, and Abuse Report	Annual	• February 26
48.	Appendix G	Fraud, Waste, and Abuse Inventory Report	Quarterly	• January 31 • April 30 • July 31 • October 31
49.	Appendix H	APM Strategy	Triennial	• September 1
50.	Appendix H	Value-Based Payment Progress Report	Annual	• July 15 •
51.	Appendix H	APM Data Set	Quarterly	• May 15, for January 1–March 31, and October 1-December 31 • August 15, for April 1–June 30 • November 15, for July 1-September 30
52.	Appendix I	Waiver Service Claims Audit Report	Quarterly/Annually	• January 31 • April 30 • July 31 (Both) • October 31
53.	Appendix I	Number of LOC Evaluations (initial and redetermination)	Quarterly/Annually	• January 31 • April 30 • July 31 (Both) • October 31
54.	Appendix I	Waiver Service Providers with an Active Medicaid Provider agreement Report	Monthly	15th of the month
55.	Appendix I	Self-Reported, Audited HEDIS Results and HEDIS IDSS Data Certification Letter	Annual	• Mid-June
56.	Appendix I	HEDIS Final Audit Report (FAR)	Annual	• Mid-July
57.	Appendix I	CAHPS Member Experience Survey Data	Annual	• June 15
58.	Appendix J	QW Innovation Fund Expenditure Report	Quarterly	• Jan 15 • May 15 • August 15 • Nov 15

#	Provider Agreement Appendix	Deliverable Name	Frequency	Due Date
59.	Appendix K	Summary of BC-DR Plan Test Results	Annual	• Within 30 days of receiving results
60.	Appendix K	System Audit Results	Annual	• Within 2 weeks of receiving results
61.	Appendix K	CPSE Report	Monthly	• 15th of the month
62.	Appendix K	Network Provider HIE Participation Report	Annual	• June 30
63.	Appendix K	EHR and HIE Provider Support Plan	Annual	• January 15
64.	Appendix K	MCE Non-Claims Reporting	Quarterly	• March 15 • May 15 • August 15 • November 15
65.	Appendix L	NAIC Annual Financial Statement	Annual	• March 1
66.	Appendix L	NAIC Quarterly Financial Statements	Quarterly	• May 15 • August 15 • November 15
67.	Appendix L	Annual Audit Report	Annual	• June 1
68.	Appendix L	NAIC/Cost Report Reconciliation	Annual	• April 30
69.	Appendix L	HIC Tax Report	Quarterly	• March 15 • May 15 • August 15 • November 15
70.	Appendix L	MLR Reporting Tool and Documentation	Annual	• For each MLR reporting year
71.	Appendix L	Prompt Pay Report	Quarterly	• 15th of the first month of the calendar quarter
72.	Appendix L	Third Party Liability Data Files	Weekly	• No later than 6:00 pm Eastern Time Thursday
73.	Appendix L	Annual Cost Report	Annual	• April 30
74.	Appendix L	Quarterly Cost Report	Quarterly	• January 31 • May30 • July 31 • October 31