The Ohio Department of Medicaid Next Generation Population Health and Quality Strategy

Submitted for CMS Review xx/xx/2022

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Executive Summary

As more than 90% of the 3.2million individuals served by the Ohio Department of Medicaid (ODM) are in managed care arrangements, this delivery model contributes significantly to achieving Medicaid's overall population health and quality goals. ODM is committed to implementing effective population health management strategies and processes. They become crucial tools that harness the innovation and technical capabilities of managed care entities to advance health outcomes for Ohioans.

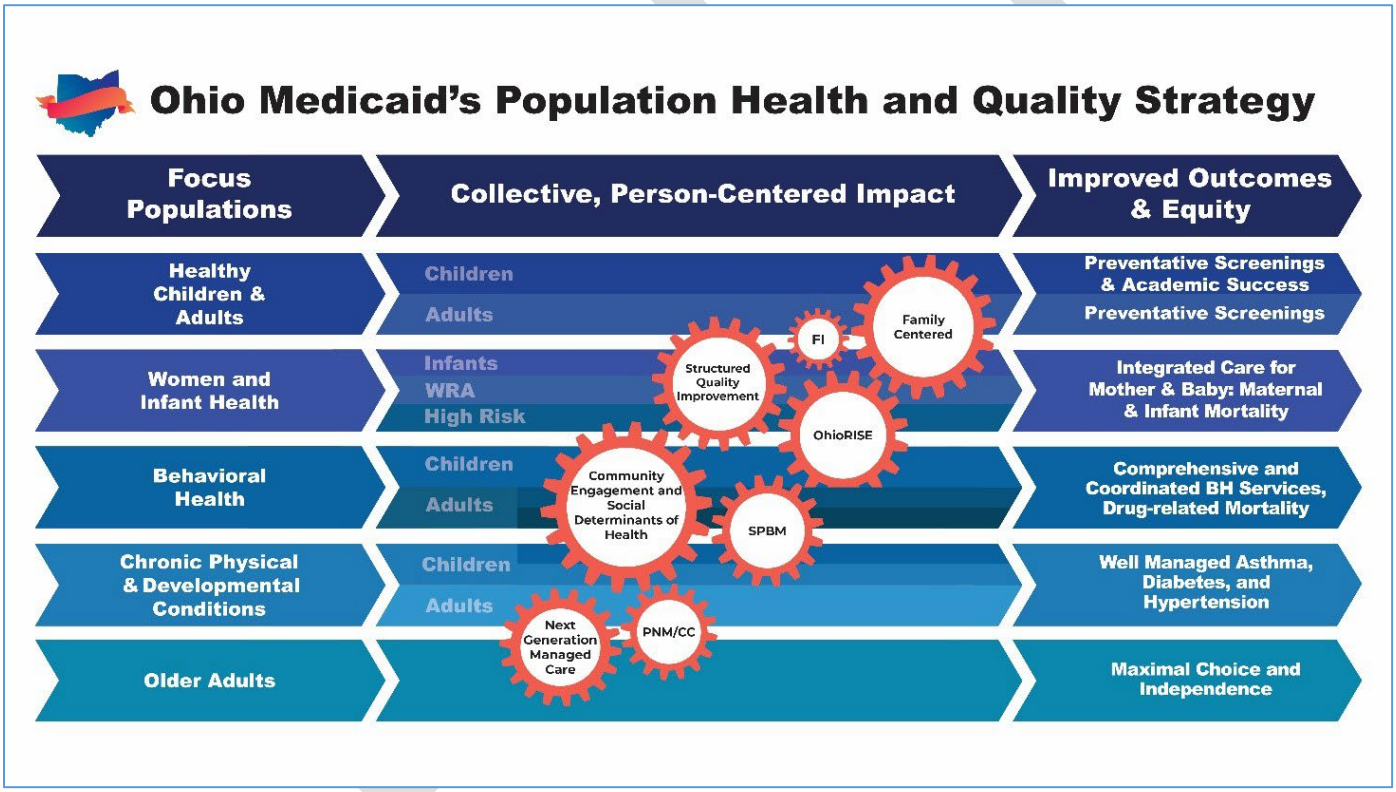
Ohio Medicaid leadership, at the urging of Governor Mike DeWine, has spent more than two years redesigning the state healthcare program, targeting our focus on the people who rely on Medicaid for their well-being. By putting the individual at the center of managed care, ODM is committed to dynamically pursuing the CMS and National Quality Strategy's aims of making care safer by reducing inappropriate care (e.g., hospital readmissions), engaging the person and family in their care, promoting prevention and treatment for leading causes of chronic disease and mortality, working with communities to enable healthy living, promoting member communication and care coordination, and making care affordable. We have concluded that a transformational shift in how managed care is implemented is necessary to meet these goals. Ohio's "next generation" of Medicaid managed care is focused on the individual rather than the business of managed care and is designed to leverage best practices in the context of family and community in multiple domains as depicted below.

Ohio's Medicaid managed care program advances many of these goals through ODM's population health approach, which hinges on the basic steps of understanding populations in the program, guarding against inadvertent coverage loss to maintain stability in efforts focused on health improvements, identifying those at risk for health and safety events so that greater reliability in best-evidenced care can be delivered across multiple care settings, all supported over the course of one's life in varied communities. This approach specifies significant member, provider, and community input to ensure collaboration in person-centered design in order to drive appropriate health service utilization including preventive care, address health inequities and disparate outcomes such as those observed in preterm birth and infant mortality, meet the complex physical and behavioral health needs of members, and employ ongoing monitoring to sustain health and well-being throughout the life course.

Using a population health management approach, ODM and its contracted managed care entities (MCE), in conjunction with providers, develop and harness actionable data to identify the needs of individuals in a timely manner; actively respond to those needs using population health strategies, such as quality improvement, community engagement, and care coordination; and transparently monitor and assess progress. Based on assessments of progress, approaches to population health are then refined to increase effectiveness and impact. The focus on transformative population health improvement is supported by more comprehensive and widespread value-based purchasing efforts emphasizing the outcome measures of quality.

ODM's population health approach is organized into five primary population streams to aid in the structure and development of effective population health management initiatives, as well as their monitoring and refinement. The population health streams are:

1) Healthy Individuals
2) Women and Infant Health (including women who are pregnant)
3) Behavioral Health
4) Chronic Physical and/or Developmental Conditions
5) Older Adults



To implement a comprehensive approach to the care of the Medicaid populations, ODM validated the need for two additional areas of payer specialization to better address gaps in the existing health delivery system: a plan focused on the complex behavioral health needs of multi-system youth, and a single Pharmacy Benefit Manager (SPBM) to bring greater transparency and accountability to Medicaid's prescription drug program.

In total, ODM's *Managed Care Population Health and Quality Strategy (Quality Strategy)* therefore describes the coordinated population health improvement efforts by Ohio's Medicaid contracted managed care entities

(MCEs), including Medicaid managed care organizations (MCO); the MyCare Ohio plans (MCOP); Ohio's Resilience through Integrated Systems and Excellence (OhioRISE) plan which is a prepaid inpatient health plan (PIHP) for youth with complex behavioral health and multi-system needs; and Ohio's single pharmacy benefit manager (SPBM) which is a prepaid ambulatory health plan (PAHP).

For population health and quality strategies to be effective, all the efforts must be aligned, deepening partnerships along both vertical and horizontal axes in the diagram below with shared measures, reporting and improvement efforts.

ODM recognizes that population health improvement is not possible without advancing opportunities for all individuals to achieve optimal health regardless of age, gender, race, religion, ethnicity, disability status, or geographic residence. Person-centered efforts to eliminate disparities in healthcare access, and health outcomes while improving the experience of healthcare are therefore woven throughout the *Quality Strategy*.

ODM's *Managed Care Population Health and Quality Strategy* is available online at: https://medicaid.ohio.gov/MEDICAID-101/-Quality-Strategy-and-Measures.

Contents

Section 1. Introduction

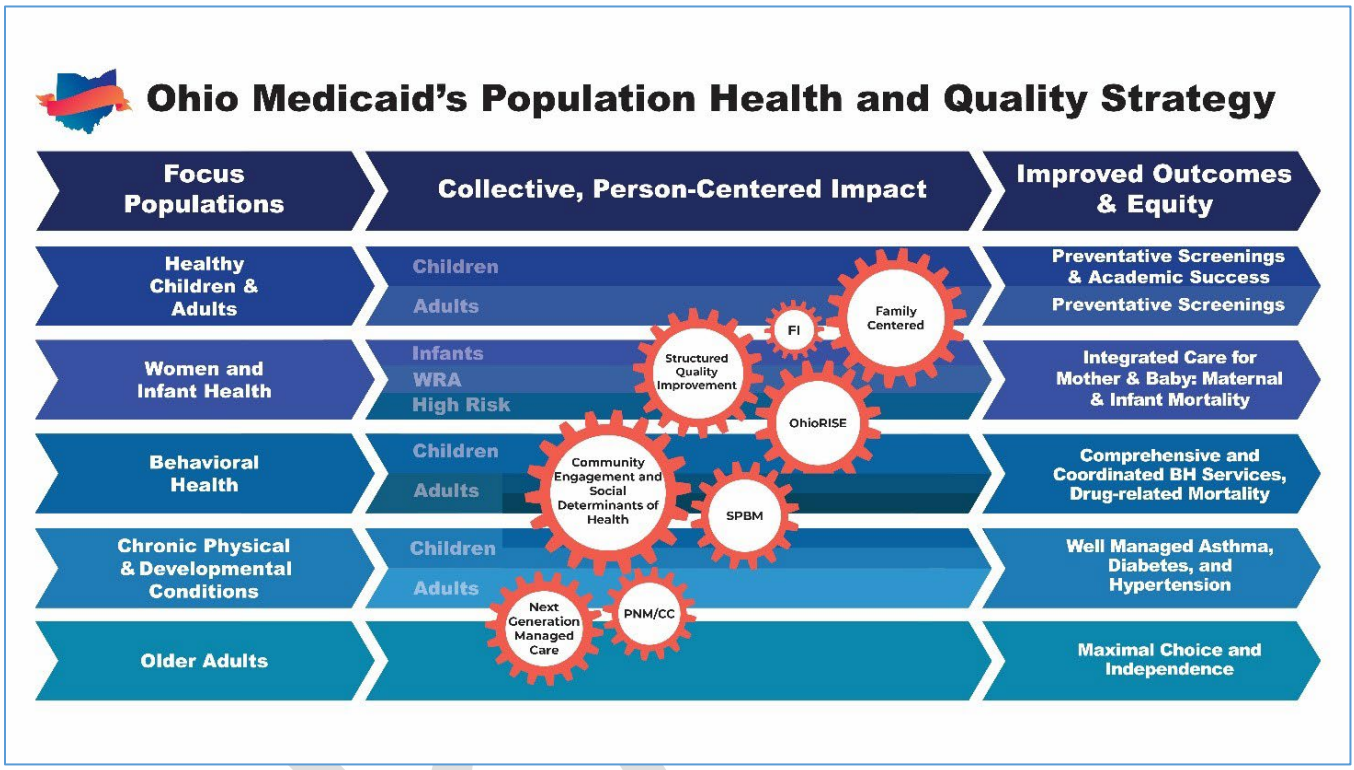
The Ohio Department of Medicaid is continually striving to improve healthcare access, the quality of the healthcare experience, and the health outcomes of the Medicaid population. ODM's core values drive this work.

- **Innovation**. Continuously driving positive change to Ohio's healthcare landscape through creativity, curiosity and by challenging convention.
- **Collaboration**. Working together openly and inclusively to reach a mutual goal.
- **Stewardship**. Efficiently and conscientiously managing the public resources entrusted to us.
- **Accountability**. Establishing and using meaningful, measurable performance standards for all we do.
- **Integrity**. Honesty and transparency are intertwined in ODM's oversight of the healthcare methodologies and systems, with special attention to eliminating bias, thereby fostering trust between members and providers to strengthen care. We are committed to being honest and ethical in all we do.
- **Passion**. An unwavering belief that every Ohioan is entitled to quality, affordable, and person-centric healthcare is what drives Ohio Medicaid's leadership and workforce. We are committed to people and determined to succeed.

Commitment to these core values allows ODM to keep person-centered care at the forefront of its efforts. Without pursuing optimal health outcomes for all, population health cannot be achieved.

ODM's *Managed Care Population Health and Quality Strategy* (*Quality Strategy*) incorporates a population health management approach to improve healthcare quality, member and provider experience, and health outcomes while reducing cost. This includes the intelligent use of health data to identify individual and population needs in a timely manner; the use of population health approaches such as quality improvement, care management, and cross-system collaboration; supporting innovation and sustaining improvements through supportive payment practices; and capturing actionable, accurate and timely data for effective decision making. Delivering healthcare through a person-centered lens is integral to the success of each approach and is interwoven throughout the fabric of ODM's population health improvement efforts.

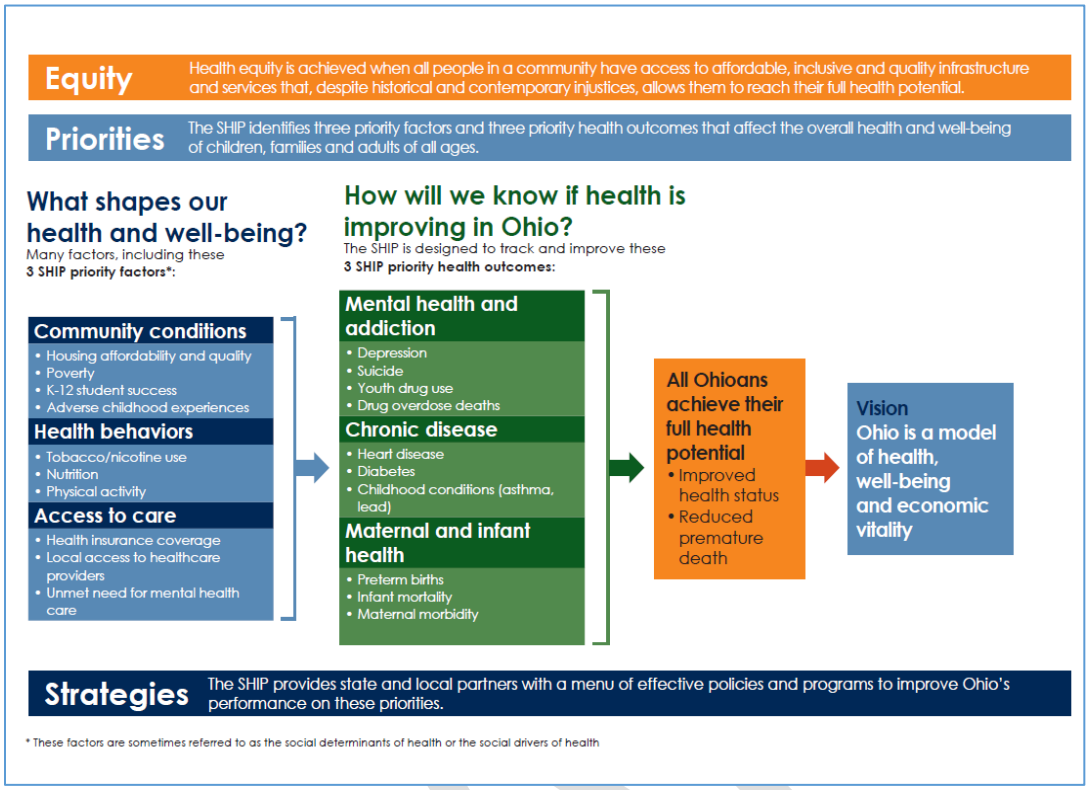
Figure 1. Population Health & Quality Strategy



ODM's contracted managed care entities (MCEs) include managed care organizations (MCOs), a prepaid inpatient health plan (PIHP) specially designed to serve children and adolescents with complex behavioral health needs, and a prepaid ambulatory health plan (PAHP) functioning as Ohio Medicaid's single pharmacy benefit manager. These MCEs are central to improving population health outcomes and are therefore required to participate in ODM's efforts to improve the health and quality of care for the Ohio Medicaid population.

Medicaid's collaborative partnerships with providers and provider associations, private insurers, other state agencies, academic medical centers, and state-level quality improvement (QI) collaboratives also contribute to the success of ODM's *Quality Strategy.* Each plays a role by ensuring coordinated planning and facilitating alignment across complementary initiatives. These partnerships are strengthened by the alignment of the *Quality Strategy* and the *State Health Improvement Plan* (Figure 3), supporting ODM's and the MCEs' work with other state agencies on improvement goals.

Figure 2. Ohio's 2020-2022 State Health Improvement Plan (SHIP)



A. Brief History of Ohio's Managed Care Program

1978 – The Ohio Medicaid managed care program was initiated as a waiver to improve access, quality, and continuity of care, while reducing the growth of Medicaid spending.

2005 – The Centers for Medicare and Medicaid Services (CMS) permitted Ohio to operate the program under the authority of a state plan amendment (SPA). In 2006, Ohio's Medicaid managed care program was expanded to all 88 Ohio counties.

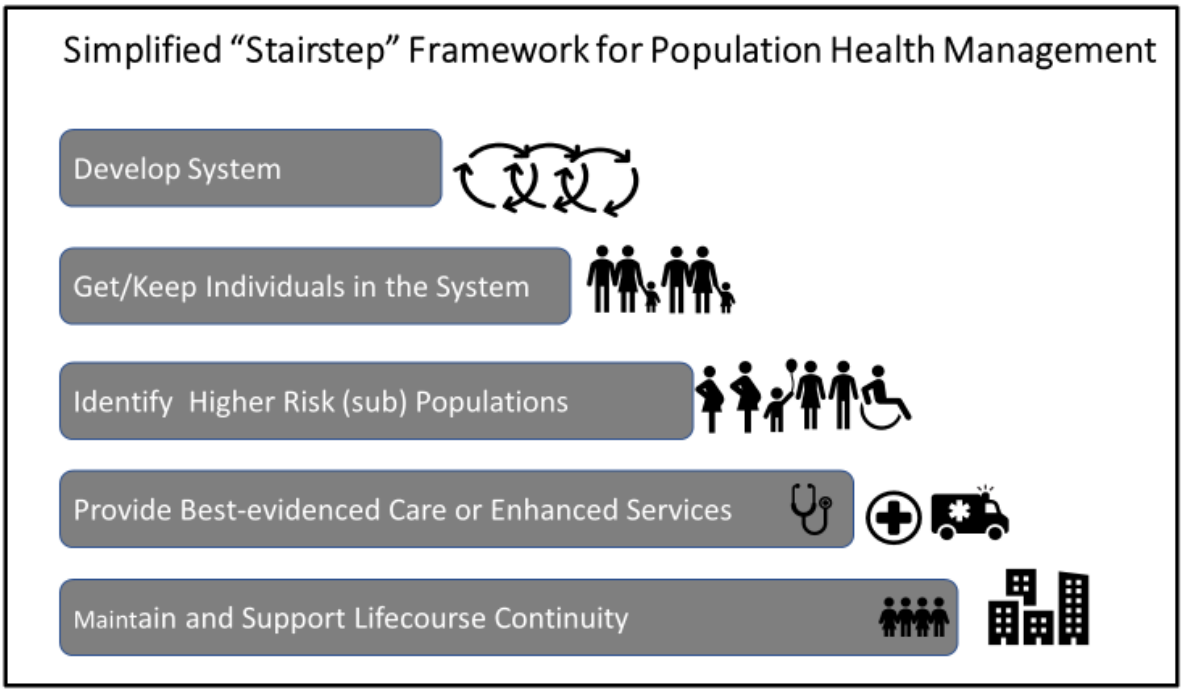
2012 – ODM made several changes to the program's administration, including: reducing the state's eight administrative service regions to three; combining coverage for the Covered Families and Children (CFC) and Aged, Blind, and Disabled (ABD) populations; covering a portion of children and youth with special healthcare needs (CYSHCN); requiring MCOs to meet higher standards on national performance measures to receive financial incentives; and requiring MCOs to develop provider incentives aimed at improving quality of care and health outcomes. These changes resulted in the release of a request for proposals for new managed care entities.

2013 – Five MCOs were selected and began providing services in all three regions. This first-generation redesign simplified program administration, encouraged market stability, and offered individuals more choice, allowing ODM to become more population health focused.

2014 – ODM began transforming its program to focus on population health. Many of the subsequent changes to the program reflect the five building blocks of this transformation: 1) building the system, 2) getting everyone in the system, 3) identifying risk, 4) providing personalized and enhanced services to

meet identified needs, and 5) maintaining and supporting the life course. Each of these building blocks is supported by a population health management framework that provides the resources and structure necessary to achieve population health.

Figure 3. Population Health Management Framework



Several delivery system changes were made in 2014 to build a system of coverage so that all Ohioans would have access to care.

- **January 2014** – ODM expanded Medicaid coverage to individuals making up to 138% of the federal poverty level (Group VIII), many of whom were childless adults living in poverty. Most of these individuals received their Medicaid coverage through an MCO. An evaluation of the Group VIII expansion found that enrollees reduced their medical debt, were more likely to report that their financial situation had improved, and had an easier time buying food, paying for housing, and continuing to work.[i,ii]
- **May 2014** – Ohioans dually eligible for both Medicaid and Medicare began enrolling in the MyCare Ohio program in 29 counties began enrolling in Ohio's integrated care delivery system to take advantage of benefits of both programs. This marked the first time that Medicaid recipients with a nursing facility-based level of care were eligible for the benefits of comprehensive care coordination. The 2018 evaluation of the MyCare program found that over 70% of members elected for a MyCare Ohio plan were satisfied with their care management experience. As illustrated by its receipt of a 2020 Pacesetter award from the Senior Care Action Network (SCAN) Foundation, Ohio is a national leader in transitioning people who need long term services and supports out of institutions and back into community settings. MyCare Ohio plans compare favorably to national benchmarks and the MyCare Ohio program has been successful in assisting Ohioans to live independently in their communities with supportive services.[iii] Between 2017 and 2020, Ohio's ranking in effective transitions improved from

number 31 to number 18 in the nation. During the same period, Ohio transitioned from 34th to 19th in the overall state scorecard rank.[iv]

2015 – ODM began transforming its quality improvement program to focus on more efficiently improving population health and monitoring performance.

- ODM received approval from CMS to introduce rapid cycle quality improvement methods, modeled after the Associates for Process Improvement's Model for Improvement, to MCO performance improvement projects. The new process, popularized by the Institutes for Healthcare Improvement (IHI), is used frequently by clinicians and healthcare systems to improve patient outcomes. The model uses a science-based approach to identify improvement opportunities, focus change efforts, quickly assess effectiveness, and monitor effectiveness over time. The use of this model has transformed ODM's approach to quality. This transformation has been achieved by focusing improvement efforts, encouraging timely action and learning, and transitioning from annual to weekly quality improvement data reports of progress towards quality improvement aims. These efforts resulted in improved preterm birth rates which continue to be sustained[v].
- ODM published the first Managed Care Report Card on ODM's website.[vi] The consumer-facing report card, which ranks MCO HEDIS and CAHPS quality performance, allowed individuals eligible for managed care to make informed health plan selections.

2016 – ODM began program changes to personalize care and provide enhanced services for high-risk individuals, families, and communities.

- ODM leveraged a Centers for Medicare and Medicaid Innovation (CMMI) funding opportunity to partner with clinicians and bring a population management approach to primary care. ODM began enrolling primary care practices into the Ohio Comprehensive Primary Care (Ohio CPC) program, a patient-centered medical home model using primary care-led, team-based care to comprehensively manage a person's health needs. Since its inception, the program has aimed to reward practices to improve the quality of care and lower costs by implementing core components of best care practices such as 24/7 care access, patient stratification, closed loop referrals and patient advisory councils.
- ODM released enhanced maternal care guidance that required MCOs to proactively use linked vital statistics and Medicaid claims data to identify and intervene with women at risk of poor birth outcomes and in need of enhanced maternal care. This included:
    - Geographically targeting birth outcome improvement efforts in areas of the state with the highest infant mortality rates (Ohio Equity Institute communities.
    - Integrating quality improvement science methods to more rapidly identify, implement, and spread successful interventions.
    - Leveraging technology (e.g., mobile messaging) to improve patient engagement.
    - Supporting state and community-based infant mortality reduction efforts.
    - Collaborative efforts (e.g., Ohio Perinatal Quality Collaborative, Ohio Collaborative for the Prevention of Infant Mortality).
    - MCO support of community-based initiatives include (e.g., CelebrateOne, Cradle Cincinnati, First Year Cleveland).

MCOs were expected to use these strategies, in conjunction with investing in and connecting women with Comprehensive Primary Care (CPC) practices, actively collaborating with community partners, and performing expedited outreach, to systematically address modifiable risk factors and obtain measurable improvements in birth outcomes.

- Ohio Medicaid MCOs began funding community-based initiatives chosen by the communities themselves. To encourage integration with the funded communities, ODM began requiring MCOs to employ community engagement coordinators to participate in these efforts.
- During 2016, ODM continued to refine its care management and quality improvement strategies to support population health more effectively. Care management was refined to emphasize a hands-on approach to addressing the needs of individuals in the program. ODM also maximized alignment with value-based purchasing efforts, elevated the role of healthcare providers in population health management, and established the framework necessary to effectively position the managed care program for service and population expansions.
- ODM incorporated more accountability for quality improvement infrastructure, leadership support, and capacity building into the MCO provider agreement and provided the MCOs and ODM staff with intensive quality improvement training in partnership with the James M. Anderson Center for Health System Excellence.

2017 – Ohio began mandatorily enrolling all eligible children in custodial care arrangements and children with medical handicaps into managed care. However, enrollment of individuals on developmental disability waivers remained voluntary.

It is important to note that in Ohio, the age, blind, and disabled (ABD) eligibility category does not directly correlate with the larger population of children that are disabled, including those with disabling behavioral health conditions. In fact, almost 85% of children and youth with special healthcare needs (based on claims analysis for conditions such as cerebral palsy, immunodeficiencies, cancer, and congenital defects) fall into the covered family and children (CFC) category.

2018 – Ohio moved to enrolling eligible individuals in managed care on the first day of their coverage by Ohio Medicaid.

ODM further emphasized the importance of population health by transitioning from an incentive-based pay for performance model to a quality withhold model in which performance measures were categorized into indices to underscore the necessity of managing whole conditions in a person-centered manner rather than focusing on a single performance measure at a particular point in a person's disease progression. With this more holistic framework, ODM used indices focused on conditions to evaluate an MCOs ability to improve outcomes. For example, the diabetes index is based on four diabetes measures. Plans must manage all aspects of their members' diabetes in order to score well on the diabetes index.

2019 – In response to increased awareness of the impact of underlying social factors on mental and physical health (e.g., stable food and housing), ODM and contracted MCOs developed a standardized health risk assessment (HRA) tool to be used in assessing all new members within 90 calendar days of enrollment. While assisting in the risk stratification and identification of potential care management needs, the HRA also allowed ODM to more strategically partner with communities to address member needs.

In 2019, ODM launched a Medicaid managed care procurement process with an explicit, bold vision for Ohio's Medicaid program – heightening the focus on people over the business of managed care. This is the first structural change since CMS' approval of Ohio's program in 2005.

The newly redesigned Ohio Medicaid managed care program is described in more detail below.

2020-Beginning July 1, 2020, use of the HRA was expanded to use with all members. The MCOs repeat the health risk assessment with members every three hundred sixty-five days.

During 2020, the COVID-19 pandemic necessitated converting quality withhold from a retrospective assessment of HEDIS measure improvement, requiring assessment of claims and electronic health record data to an assessment of the MCOs ability to collaboratively improve the safety and well-being of their members during the COVID pandemic.

During the latter half of the year, ODM and the Medicaid MCOs launched five initiatives to support Ohioans most susceptible to risks COVID-19. The efforts aimed to reduce the spread of COVID, address unintended consequences of COVID prevention protocols, protect those most susceptible to the virus, and leverage newly enacted telehealth expansions to extend access to care to small community and rural healthcare providers. They included:

- Restored Citizen Care Kits – a collaborative effort between ODM, the MCOs and the Ohio Department of Rehabilitation and Correction (ODRC) to provide essential personal protective equipment (PPE), and self-care supplies, cellphones, and flu immunizations to individuals returning to communities from Ohio's prisons. This effort also focused on improving post-release engagement of restored citizens with chronic health conditions.
- Childhood Immunizations – this effort deployed three strategies to close the gap in childhood immunizations: reducing administrative barriers to immunizations, supporting an immunization registry, and providing safe, convenient vaccination access to members.
- Nursing Facility and Assisted Living-this effort focused on supporting Ohio's Post-acute regional rapid response testing program, as well as embedding of care managers in high-risk nursing facilities to assist with infection prevention and control and related problem solving including perpetual preparedness, testing, and aftercare with telephonic and video-based technical assistance. This effort also included a friendly calls program in partnership with Area Agencies on Aging (AAAs) in which the MCOs collaborated to offer social support and connections to Medicaid members living in nursing and assisted living facilities who had been isolated through social distancing protocols of the pandemic.
- Provider support through telehealth expansion-this effort focused on reducing administrative burden, improving coding and billing, increasing knowledge of services that could be provided and billed as telehealth, and telehealth expansion into rural and small communities through grants and hands-on tech support and training.
- Transportation services expansions- efforts focused on increased safety of transportation services for drivers and passengers by retrofitting vehicles with a barrier between the driver and passenger, increased vendor safety information, provision of transportation to attain essential items such as groceries, and improved transportation as a component of discharge planning.

2021- Having completed a series of strategic procurements designed to put the individual at the center of the program, the ODM introduced a redesign that began with the procurement of a prepaid inpatient

health plan (PIHP) to serve the needs of youth with complex behavioral health and multi-system needs enrolled in the OhioRISE (Resilience through Integrated Systems and Excellence) program; a single pharmacy benefit manager prepaid ambulatory health plan (PAHP); new regional managed care organizations with increased infrastructure, quality improvement, care coordination, and local community capacity.; a fiscal intermediary to streamline and simplify administrative tasks by serving as the single point of entry for all provider claims and prior authorization requests; and a statewide, centralized credentialing process preventing the need for providers of Medicaid services to undergo separate additional processes with each of ODM's contracted MCOs. During 2021, ODM focused on readiness review, training, and oversight activities that will lead to the successful launching and implementation of Ohio's Next Generation Medicaid Managed Care in 2022.

Quality withhold efforts continued to use continuous quality improvement methods for more rapid improvement of diabetes control and COVID-19 immunizations.

Figure 4. Timeline of ODM's Managed Care History

Key Administrative Actions		**Population Health & Quality Advancements**
Ohio MMC began as a waiver	**1978**	
Voluntary enrollment expanded to 29 counties in the mid-1980s	**mid-1980s**	
Mandatory MMC piloted in Montgomery County	**1989**	
Voluntary enrollment became available in six additional counties (late 1980s-early 1990s)	**1990s**	
Program for all-inclusive care for the elderly (PACE) expanded comprehensive managed care services to adults over age 55 meeting a nursing home level of care	**2002**	
Managed Care became mandatory statewide	**2006**	
	2010	Enhanced maternal care requirements integrated into MCO contracts
	2012	CMS' Adult Medicaid Quality Grant allowed ODM to focus on using science-based principles to guide improvement activities
Managed care redesign • MCO regions reduced from eight to three • New MCOs selected • Managed care expanded to children and youth with special healthcare needs (CYSHCN) through a 1915(b) waiver	**2013**	

		Expansion to the dual Medicaid-Medicare population through MyCare Ohio demonstration
		Medicaid coverage expansion to childless adults (Group VIII Expansion) in response to Affordable Care Act
	2014	Pre-release program to connect incarcerated individuals to MCO benefits in preparation of their release from prison
		Vital statistics files linked to Medicaid claims to identify high risk women based on previous preterm birth
	2015	First consumer-facing Managed Care Report Card comparing Medicaid Managed Care Organization performance in five key areas was posted to Medicaid.ohio.gov website
		Enhanced Maternal Care Guidance for MCOs released
		Integration of quality improvement principles into quality improvement projects (QIPs), including performance improvement projects (PIPs)
	2016	Transformation of care management strategy
		Launch of electronic Pregnancy Risk Assessment Form (PRAF 2.0), integrating pregnancy notification into Ohio's eligibility system to prevent coverage loss during pregnancy and postpartum, and facilitating referral to social services (e.g., the Special supplemental Nutrition
Special populations (foster children/children in custody, adopted children, breast and cervical cancer populations, bureau of children with medical handicaps), mandatorily enrolled in Managed Care. Managed care enrollment for individuals enrolled in a developmental disability waiver remained voluntary.	**2017**	Creation of maternal and infant health dashboards
		Began Provider Satisfaction Surveys to provide a 360-degree view of MCO performance
		Hypertension PIP includes Medicaid and MyCare plans in a focused effort to reduce disparities
		Managed Care Day 1 enrollment implementation for better coordination of care
	2018	Standardized health risk assessment (HRA)
		Quality Withhold (QW) incentive program replaces pay-for performance model
		Removal of prior authorization (PA) for Medication Assisted Therapy-MAT (1/2019)
	2019	Implementation of the ODM standardized health risk assessment (HRA) tool for MCO members (7/2019)
		Extensive engagement of stakeholders (member, provider, community) to inform managed care procurement (9/2019)

Competitive procurement process for single pharmacy benefit manager, regional managed care organizations, and the OhioRISE PIHP to serve multi-system youth with complex behavioral health needs and their families	**2020**	ODM and MCOs began using a unified preferred drug list (UPDL) Diabetes PIP collaborative begins (5/2020) QW based on MCO response to COVID-19 using science-based quality improvement methods (6/2020)
Next Generation managed care entities procured • Single Pharmacy Benefit Manager procured (01/2021) • OhioRISE procured (04/2021) • MCOs procured (04/2021) • OhioRISE plan procured (04/2021)	**2021**	QW collaborative QIPs to improve population health outcomes for older adults, healthy children, women and infants, and chronic conditions population streams
	2022	Next Generation Managed Care launch

B. Next Generation Managed Care – Delivery System Reforms

In 2019, ODM began reimagining the way the Ohio managed care program provides quality services to improve the health of the individual, their family, and community. The resulting design is built on insights gained from input from more than 1,100 comments from providers, stakeholders, members and community partners as well as lessons learned from quality improvement initiatives and identified gaps in previous models that have been oriented towards managing risk as the sole mechanism for controlling costs.

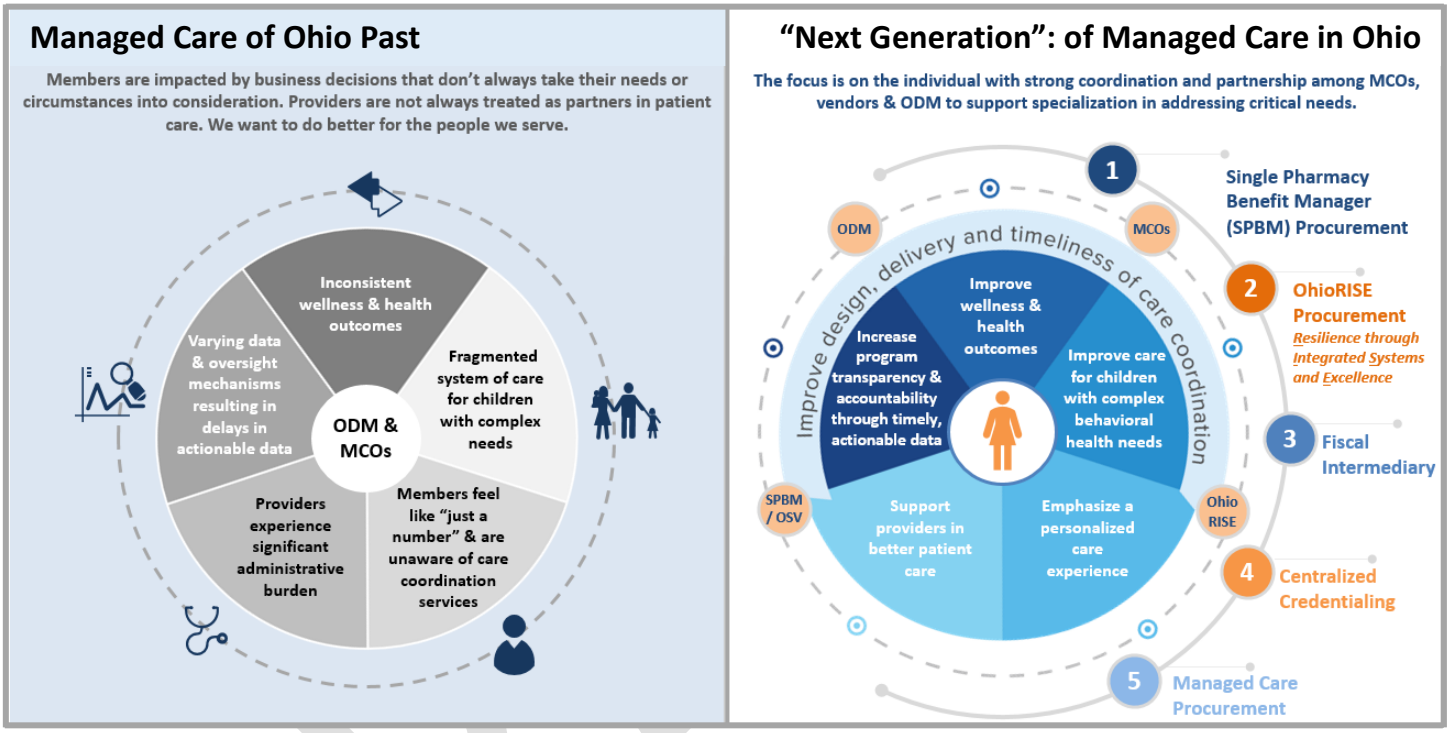
The newly redesigned Ohio Medicaid managed care program includes three types of managed care entities (MCE) to focus on more effectively serving individual and population needs: Managed Care Organizations; the OhioRISE prepaid inpatient health plan (PIHP), specifically designed to serve children and youth with complex behavioral health needs and involvement with multiple systems of care; and a statewide, a single pharmacy benefit manager (SPBM) prepaid ambulatory health plan (PAHP). The new design also includes administrative simplification using a Fiscal Intermediary (FI) to centralize claims payment and prior authorization, and a streamlining of provider enrollment through the Centralized Credentialing (CC) component of the Provider Network Module (PNM) of the ODM's Ohio Medicaid Enterprise System (OMES).

The next generation Ohio Medicaid program focuses on the individual and includes a strong cross-agency coordination and partnership among MCEs, vendors, sister state agencies and ODM to support specialization in addressing critical needs. ODM is working in collaboration with the Ohio Department of Job and Family Services (ODJFS), County Departments of Job and Family Services (CDJFS), Mental Health Addiction Services (MHAS), Department of Developmental Disabilities (DODD), Ohio Department of Aging and other state health and human services agencies to support a more seamless and personalized experience for individuals and providers.

The recent SPBM, OhioRISE, and MCO procurements highlight the evolving nature of Ohio's managed care program and quality strategy. This evolution is informed by a continual analysis of primary and secondary data, as well as feedback from members, clinicians, provider associations, and other stakeholders.

Reimagined managed care integrates quality throughout the program by taking a population health management approach to improving the health of more than three million Ohioans served. The foundation of this approach is focused on access to quality, person-centered health solutions designed to incorporate the context of family and community at all points along the continuum of care.

Figure 5. Next Generation Managed Care



The significant changes involved in reimagining managed care include moving to a regional managed care model to increase connectiveness to the communities of MCO members; implementation of OhioRISE, a specialized managed care program for youth with complex behavioral health and multi-system needs; and implementation of a single pharmacy benefit manager to improve management and administration of pharmacy benefits while increasing financial accountability and alignment with ODM's clinical and policy goals and improving transparency. These new structures, described in more detail below, shape the current quality strategy outlined within this document.

MCOs

In 2021, ODM announced the selection of seven MCOs to lead the department's evolution of managed care services. Members will continue to receive services with their current managed care plans until the transition in July 2022 and will not lose coverage. Members will have the opportunity to select a new plan during an MCO transition and open enrollment period.

ODM will conduct a thorough transition to support individuals and providers, including providing details about expected changes and assistance in navigating those changes. Transitions of care are discussed in more detail in Section 2: Population Health Management.

OhioRISE (Resilience through Integrated Systems and Excellence) Prepaid Inpatient Health Plan (PIHP)

In April 2021, ODM also selected a PIHP to serve the OhioRISE program by creating a seamless delivery system to improve the care of approximately 55,000 children ages 20 and under who have complex

behavioral health needs and need enhanced services. The tailored program serves members from all Medicaid aid categories, including low-income children and families, pregnant women, disabled, and those eligible for Medicaid based on Ohio's implementation of the Affordable Care Act's (ACA) Medicaid expansion. However, dual-eligible (Medicare-Medicaid members who receive coverage via the state's MyCare Ohio dual demonstration program) are not covered as part of OhioRISE.

The OhioRISE plan is responsible for developing and managing a full continuum of behavioral health network providers to include local services, community providers, and regional care management entities (CMEs) with demonstrated expertise necessary to effectively serve these populations. The program offers a "locus of accountability" by offering integrated care coordination (ICC) through regional CMEs and expanding access to critical services needed to assist families, state and local child-serving agencies, and other health providers in locating and using needed services.

OhioRISE employs a high-fidelity wraparound approach to improve service delivery and timeliness of care coordination. The wraparound approach has been proven to reduce unnecessary hospitalizations, decrease involvement with the juvenile justice and corrections systems, reduce out-of-home and out-of-state placements (residential care and foster care), increase school attendance and performance, and reduce custody relinquishment for children, youth, and families.

In designing the OhioRISE Program for MSY children and youth, ODM and partnering agencies noted the need to address unevenness in the availability of services needed by multi-system youth and their caregivers. With the procurement of the OhioRISE plan and contract implementation phases, ODM and its partner state agencies have continued to customize the structure and design of the OhioRISE program approach to focus on the needs of MSY children and youth.

Children and youth are eligible for the OhioRISE program if they meet a threshold score on the Child and Adolescent Needs and Strengths (CANS), a national, evidenced based tool developed for children's services to support clinical and service decision-making. The CANS will also be used to determine initial and ongoing level of need for the OhioRISE program and for determining initial and ongoing level of need for OhioRISE services.

Single Pharmacy Benefit Manager (SPBM) Prepaid Ambulatory Health Plan (PAHP)

In 2019, the Ohio General Assembly mandated, and Governor DeWine signed into law, the selection of a single pharmacy benefit manager (SPBM) in the state's fiscal year 2020-2021 biennial budget. Work to develop the contract requirements for a SPBM included a robust stakeholder engagement process, and CMS program certification. Today the pharmacy benefit is provided by Ohio Medicaid's six MCO, each of whom contract with one or more pharmacy benefit managers (PBM) to oversee prescription drug benefits. The current model requires healthcare providers to meeting unique, time-consuming processes required by each MCO to prescribe important, and sometimes life-sustaining, medications.

> "*Moving to a single pharmacy benefit manager that partners with Ohio Medicaid will improve management and administration of pharmacy benefits for our members participating through an MCO. Along with introducing a unified preferred drug list at the beginning of the year, the move to a single pharmacy benefit manager is another important step in providing quality care for our members, transparency in operations, and responsible stewardship of Ohio taxpayer dollars."* -Maureen Corcoran, ODM Director

In January 2021, Gainwell Technologies was chosen to operate ODM's SPBM. Once implemented, the SPBM will ease provider administrative burdens, reduce operational costs, and strengthen the state's fiscal oversight of this vital healthcare benefit. It is anticipated that the SPBM will assume responsibilities for fee-for-service (FFS) pharmacy benefits in the second year of the Contract.

Under the authority of a 1915(b) waiver as a prepaid ambulatory health plan (PAHP) as defined in 42 CFR 438.2, the SPBM operates under a non-risk contract with ODM to provide pharmacy benefit services to Medicaid individuals. Under this contract, providers are compensated using a transparent pass-through method of payment of ingredient cost and fees funded by ODM.

The SPBM also maintains a pharmacy claims system that integrates with the Ohio Medicaid Enterprise System (OMES), ODM's accounting system, ODM's enterprise data warehouse (EDW), and Medicaid contracted MCOs, pharmacies, and prescribers allowing for increased coordination of care.

These three managed care entities (MCOs, the OhioRISE PIHP, and the SPBM PAHP) come together to form the next generation Ohio Medicaid program. The future model is focused on the individual and includes strong cross-agency coordination and partnership among MCOs, vendors, sister state agencies, and ODM to support specialization in addressing critical needs. Additionally, ODM is working in collaboration with the Ohio Department of Job and Family Services (ODJFS), County Departments of Job and Family Services (CDJFS), the Ohio Department of Mental Health Addiction Services (MHAS), the Department of Developmental Disabilities (DODD), the Ohio Department of Aging, and other agencies to support a more seamless and personalized experience for individuals and their healthcare providers.

The next generation managed care program described above resulted in part from the ongoing evaluation and review of ODM's Managed Care Population Health and Quality Strategy.

C. ODM's Managed Care Population Health & Quality Strategy

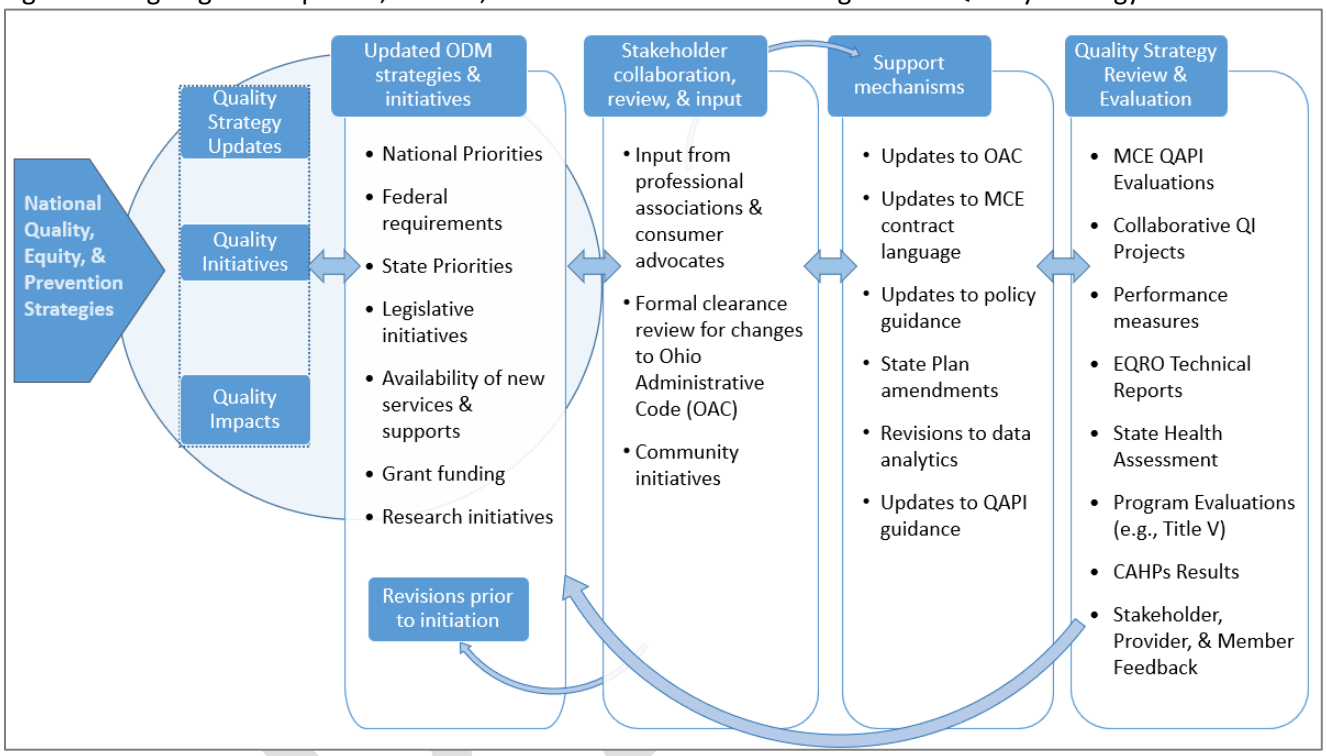
Initial Development and History

2003	Initial Quality Strategy one-page summary submitted to CMS for review
2008	Quality Strategy narrative submitted to CMS for review
2010	Quality Strategy update to account for deeming option submitted to CMS
2016	Updated Quality Strategy submitted to CMS for review
2018	Updated Ohio Quality Strategy submitted to CMS to review in response to Mega Rule changes
2020	Feedback on 2018 Ohio Quality received from CMS
2021	New CMS Quality Strategy guidance released by CMS
2022	Ohio Medicaid Quality Strategy updated to reflect programmatic changes resulting from ongoing review and evaluation of quality strategy, 2020 CMS feedback, 2021 CMS guidance, and contract changes

Ongoing Review and Evaluation

As illustrated by Figure 5 below, *ODM's Managed Care Population Health and Quality Strategy* is dynamic, with components that continually evolve and adapt to the constantly changing healthcare landscape and needs of Ohio's Medicaid insured population.

Figure 6. Ongoing Development, Review, and Refinement of the Managed Care Quality Strategy



Quality Strategy Evaluation Methodology

Updates to the strategy result from a continual assessment of managed care performance based on member, provider, and constituent feedback regarding the managed care experience (e.g., focus groups, requests for information, surveys such as the Consumer Assessment of Healthcare Providers and Systems-CAHPS, complaints and grievances); formal evaluation of performance metrics (e.g., HEDIS Aggregate Report) by population stream; the managed care entity's use of data to proactively identify and address potential needs (e.g., the enhanced maternal care file, linking vital statistics to claims); progress towards improvement project goals assessed via project specific QI meetings and PIP validation; and connections with community partners, clinical providers, and other stakeholders.

Other sources of information that are used to inform ODM's *Quality Strategy* include ad hoc data analysis, reviews of quarterly performance metrics; the Ohio Pregnancy Assessment Survey (OPAS), the Ohio Medicaid Assessment Survey (OMAS), the COVID-19 OMAS extension survey to assess the impact of COVID-19 over time; program evaluations (e.g., Group VIII, community-based improvement efforts); reports from other state agencies (the *State Health Assessment,* annual infant mortality reports and ODH's Title V *Maternal and Child Health Needs Assessment)*; collaboration and direct feedback from sibling state agencies, as well as from consumers and their families as part of ODM's managed care redesign; MCO evaluations of their own Quality Assessment and Performance Improvement (QAPI) programs; and ODM and External Quality Review Organization (EQRO) evaluation of progress on quality and performance improvement projects during monthly quality improvement oversight calls.

The integration of these multiple sources of information, along with the *Annual EQRO Technical Report*, allows ODM to identify health disparities and opportunities for improvement within each population stream.

The Role of the EQRO

In accordance with Title 42 Code of Federal Regulations (CFR) §438.364, ODM's External Quality Review Organization produces an annual *EQRO Technical Report* which evaluates the quality, timeliness, and accessibility of care furnished to members of Ohio's Medicaid program by the MCOs.

The 2020 Annual EQRO Technical Report, authored by Island Peer Review Organization (IPRO), summarizes the EQRO's evaluation of the effectiveness of *ODM's Medicaid Managed Care Population Health and Quality Strategy* by assessing performance improvement projects (PIPs), comprehensive administrative reviews, performance measures, network adequacy validations, encounter data validations (EDV), the provider satisfaction survey, and producing the annual MCO report card.

Each of the sections of the report include information on data collection and analysis methodologies, comparative findings, a discussion of the findings, and, where applicable, the MCOs' performance strengths and opportunities for improvement. As mandated by 42 CFR § 438.364, the data included in this report make it possible to benchmark performance statewide and nationally. This data also assists ODM in its collaborations with other state agencies to address common health issues—particularly those that are prevalent, chronic, and preventable.

A copy of the most recent EQRO Technical Report is publicly available on ODM's website at: https://medicaid.ohio.gov/wps/portal/gov/medicaid/about-us/qs/odm-quality-reports/external-quality-review-tech-report.

Formal updates to the quality strategy are submitted to CMS every three years or when a significant change is made to the program.

Significant change in this context means a change in benefit design or content, population coverage, or structure of the ODM delivery system.

The significant changes involved in reimagining managed care include moving to a regional managed care model to increase connectiveness to the communities of MCO members; implementation of OhioRISE, a specialized managed care program for youth with complex behavioral health and multi-system needs; and procurement of a single pharmacy benefit manager to improve management and administration of managed care recipients' pharmacy benefits while increasing financial accountability and alignment with ODM's clinical and policy goals and improving transparency. These new structures shape the current quality strategy outlined within this document.

As required by 42 CFR 438.340, the ODM Managed Care Quality Strategy is made available on ODM's public website (https://medicaid.ohio.gov/MEDICAID-101/-Quality-Strategy-and-Measures#1930258-odm-managed-care-quality-strategy).

Prior to submitting the *ODM Managed Care Population Health and Quality Strategy* to CMS, ODM reviews the strategy with its medical care advisory committee (MCAC), provides opportunities for input via formal in-person meetings and webinars, and otherwise makes the strategy available for public comment.

Ohio does not have any officially recognized tribal entities and therefore ODM was unable to consult with these organizations to inform the Quality Strategy (https://www.ncsl.org/research/state-tribal-institute/list-of-federal-and-state-recognized-tribes.aspx).

The ongoing nature of review and modification shown in *Figure 5* allows ODM's population health and quality strategy to remain relevant, align with CE and MCOP contractual requirements, and quickly incorporate relevant feedback needed to respond to the needs of individuals and families served by Medicaid in the context of an ever-evolving healthcare landscape.

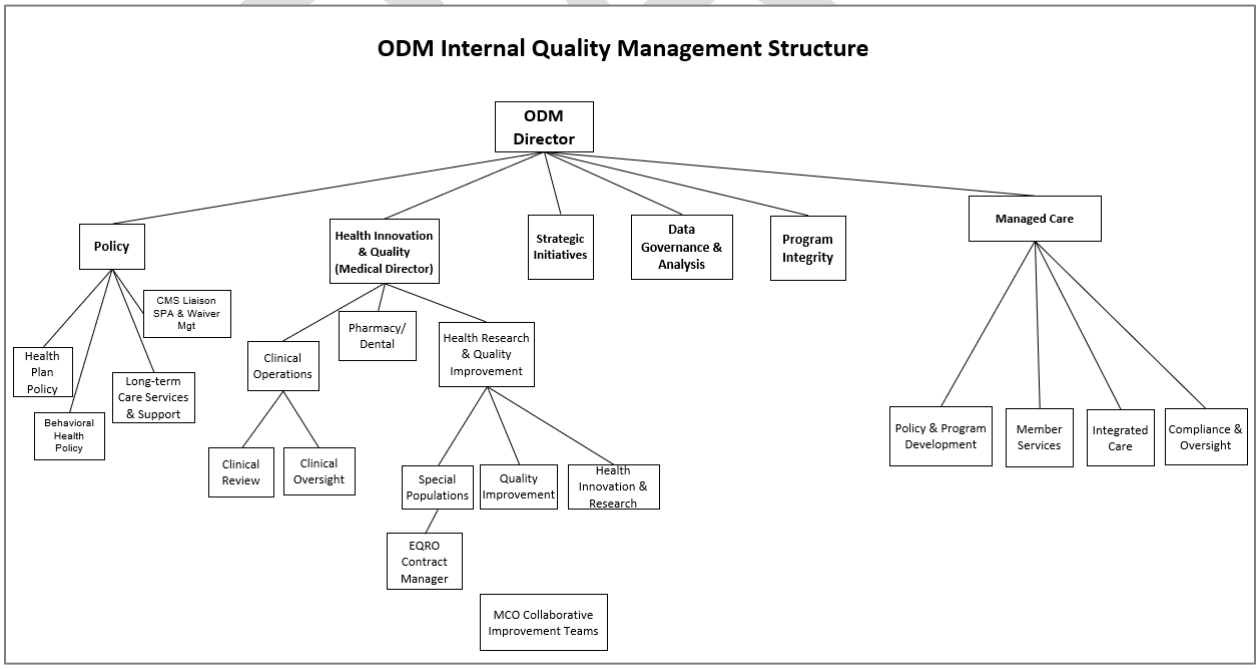
Quality Management Structure

Internal Quality Management Structure

Although the core team of ODM's internal quality management structure is located within the Office of Health Innovation and Quality under the direction of ODM's medical director, quality performance is integral to every aspect of the Ohio Department of Medicaid. This enables each area within Medicaid to play a role in the continual improvement of Medicaid services and supports and is key to the design and evaluation of the quality program in the sharing of expertise, insights, and data for decision making.

As part of ODM's oversight of the next generation of managed care, a cross-agency Quality Strategy Committee is being created. This committee will oversee the drafting of ODM's next Population Health and Quality strategy and assist in monitoring MCE progress through the attendance of Quality Improvement meetings, and review of the Population Health Management Strategy and QAPI submissions.

Figure 7. ODM's Managed Care Program's Quality Structure



External Quality Management Structure

Several of Medicaid's external partners contribute to the structure and success of ODM's managed care program. Each of these is described below and shown in *Figure 8*.

External Quality Review Organization (EQRO): Ohio contracts with an independent EQRO, Island Peer Review Organization, to conduct annual reviews of the quality, accessibility, and timeliness of services provided to Medicaid individuals by managed care entities. In accordance with 42 CFR 438.364, ODM's External Quality Review Organization produces an annual *EQRO Technical Report* which summarizes the quality, timeliness, and accessibility of care furnished to members of Ohio's Medicaid program by the MCEs in key performance areas, including member satisfaction.

The information included in the *Annual EQRO Technical Report* and the *HEDIS Annual Report* depicts the healthcare landscape for the state's Medicaid population. These reports, along with *ODM's Managed Care Population Health & Quality Strategy*, and *the State Health Improvement Plan*, assist ODM in its collaborations with other state agencies to address common health issues—particularly those that are prevalent, chronic, and preventable. ODM uses the data and information within these sources, along with information from MCE improvement projects, and input from stakeholders to measure progress toward goals and objectives of its population health and quality strategy, identify areas where targeted quality improvement interventions could be beneficial, and determine if new or revised goals are needed.

Information and recommendations generated by the EQRO assist ODM in determining needed changes to its population health and quality strategy and associated guidance, monitoring, and implementation mechanisms.

Managed Care Entities (MCE): ODM's quality management strategy is informed through MCE performance metric reporting, MCE quality improvement activities, MCE Family Advisory council input, monitoring of access and utilization, sharing of individual enrollee concerns and grievances, and the annual Quality Assessment and Performance Improvement (QAPI) program reports.

Additional Stakeholders: ODM takes great pride in obtaining the perspective of stakeholders to inform ODM's efforts to improve the member's healthcare experience and health outcomes. Ohio's Managed Care Population Health Quality Strategy is influenced by input from ODM's MCAC, family and community partners (e.g., Ohio Family and Children First), provider associations (e.g., Ohio Chapter of the American Academy of Pediatrics, the Ohio Hospital Association, the Association of Health Plans), the Ohio Commission on Minority Health, legislative committees (e.g., Joint Medicaid Oversight Committee), state quality collaborative organizations (e.g., Ohio Perinatal Quality Collaborative), Ohio's academic medical centers, and national organizations (e.g., NCQA).

Other state agencies, including the Ohio Department of Aging, the Ohio Department of Mental Health and Addiction Services, the Ohio Department of Health, the Ohio Department of Job and Family Services, and the Ohio Department of Developmental Disabilities assist ODM with the administration of various programs. Individuals in the Medicaid program enrolled with an MCO may receive services delivered in coordination with one or more of these agencies or their local counterparts.

Most importantly, however, ODM's efforts are informed by the perspective of the member themselves and the clinical providers who members trust with their care. ODM's next generation of managed care specifically requires that MCEs incorporate the perspective of members and providers into the design of policies and initiatives to increase their likelihood of addressing the root cause inhibiting member health and the effectiveness of their initiatives.

Figure 8. ODM's External Quality Partners

EQRO External Quality Review Organization	MMCs & MCOPs Medicaid & MyCare Ohio Program Managed Care Plans	Additional Quality Partners
➢ Assesses compliance with federal Medicaid managed care regulations & state requirements ➢ Crosswalks NCQA standards with CFR requirements (deeming) ➢ Validates managed care plan provider network submissions & performance measurement ➢ Reviews information systems ➢ Conducts consumer & provider surveys ➢ Validates encounter data ➢ Validates Performance Improvement Projects (PIPs) ➢ Compiles the external quality review technical report ➢ Creates MCP scorecard & dashboard	➢ Use data and scientific principles to proactively identify and stratify members to strategically address needs ➢ Implement and maintain the infrastructure (e.g., leadership, staffing, data and information systems) necessary to support population health strategies ➢ Strategically employ and evaluate the following approaches across the care continuum (prevention and wellness to multiple chronic conditions) to further inform and refine the population health management approach. o Quality Improvement (including, adequate infrastructure, training, data, and metrics to support QAPI program emphasizing rapid cycle, continuous quality improvement methods) o Care Coordination o Specialized Services and Special Populations (e.g., members with special health care needs) o Health Equity and Health-related Social Needs o Community Reinvestment o Optimized Delivery System (e.g., ensuring access to specialists, and promoting internal and external best practices) o Utilization Management	• Provider Associations (American Academy of Pediatrics Ohio Chapter; Ohio Association of Health • State agencies [i.e. Department of Mental health and Addiction Services, Department of Health] • Ohio Commission on Minority Health • Legislative Committees [e.g Joint Medicaid Oversight Committee] • Academic Medical Centers, including six medical schools Ohio Leverages the academic expertise through the Medicaid Technological Assistance and Policy Program (MEDTAPP). • National Organizations (NCQA, NMDN, NASHP, CHCS) • The Medical Care Advisory Committee (MCAC) consists of Medicaid consumers, advocates, service providers, & public agencies working together & sharing their experience & knowledge with ODM to maximize the quality of care available to low-income Ohioans. The MCAC advises the Ohio Medicaid. The Committee also provides input on Medicaid initiatives, including the Quality Strategy. • Voice of the customer (e.g., Voices for Children. Provider Associations)

D. Managed Care Program Goals and Objectives

Ohio Department of Medicaid's (ODM's) mission is to improve population health by pursuing the priorities of best evidence-based care, engaging the person and family in care, promoting communication and coordination, promoting prevention and treatment, working with communities to enable healthy living, and making quality care affordable.

ODM has designed the Ohio Medicaid managed care program to achieve these priorities by focusing on the following goals which must be achieved within the context of family and community while keeping the individual at the forefront of all efforts.

Each of these goals requires specific strategies, which are discussed in more detail below. The objectives, measures, and performance targets for each goal are provided also.

Goal 1. Improved Wellness and Health Outcomes

Strategies & Initiatives

Population health management requires an emphasis on access to care and early identification of risk to improve health outcomes and promote wellness. ODM's population health framework recognizes the necessity of early, and ongoing, connection to primary care as key to improving the health and wellness of the population served by its managed care program. This focus is also reflected in the identification of healthy adults and healthy children population streams. Specific strategies for improving health and wellness span the life course and include:

- Collaboration with other state agencies (e.g., the Ohio Department of Health (ODH), the Ohio Department of Mental Health and Addiction Services, the Ohio Department of Education (ODE).
- Proactive use of data to inform population health approaches, including the identification of patterns (e.g., grievance and complaints data), analysis of linked vital statistics-claims data (e.g., enhanced maternal care file), use of clinical data (e.g., EHR and HIE data), early identification of pregnancy to assist in maintenance of Medicaid eligibility and connection to care (e.g. Report of Pregnancy) as well as incorporating the perspectives of members, providers, families and communities (e.g., interviews of mothers on medicaid-IMOM residing in high infant mortality areas).
- Collaborations with academic medical centers to improve chronic conditions (e.g., Hypertension, Diabetes).
- Regular assessment of population needs and access to care through standardized health risk assessments (e.g., MCO Health Risk Assessments, Child and Adolescent Needs and Strengths [CANS], Pregnancy Risk Assessment Forms [PRAFs]).
- Use of geo-analysis to assess Ohio Medicaid provider network adequacy.
- The development and maintenance of a standardized pregnancy risk assessment and referral platform providing referrals to the Women, Infants, and Children program, smoking cessation programs, home visiting, and other services designed to improve birth outcomes.
- Connections to health information exchanges within Ohio to connect clinical and claims information to close gaps in care and referrals to health-related social services.
- Collaborative MCO improvement efforts focused on improving wellness and health outcomes.
- Development of the OhioRISE program to improve outcomes for children involved in multiple systems of care.

Objectives, Measures, and Performance Targets

Objectives, quality measures and performance targets for this goal can be found in the tables below. An asterisk (*) next to the measure indicates a key measure for monitoring progress towards the elimination of disparities and the ultimate goal of health equity. Given that Ohio Medicaid recently procured new health plans, many of the performance targets will be designated as informational, or "reporting only" until sufficient data is available to set minimum performance standards (MSP). Further, the COVID-19 pandemic has made it difficult to use previous years' data to set performance targets.

An MPS is traditionally based on the historical performance of ODM's contracted MCEs, with the initial intent of sequentially raising minimal performance every yea. However, due to the COVID-19 pandemic, this methodology has been replaced for MY 2022 by an approach that compares MCE performance to outliers and national benchmarks. Methodology for this approach can be found on the Medicaid website under Managed Care Program File Specifications and Methodologies | Medicaid (ohio.gov). For July 2022 onward, baseline data needs to be reset to reflect procurement of three new MCOs, as well as the transition to a regional managed care approach that provides an opportunity for improved connection to providers and members.

Population Stream	Required Stratification	Performance Measure	Measurement Steward	Performance Target SFY 2023 (MY 2022)	Performance Target SFY 2024 (MY 2023)	Performance Target SFY 2025 (MY 2024)
Objective 1.1. Improve Access to Care						
Connections to Primary and Preventive Care						
Women and Infant Health		Connect Women who Deliver with Primary Care Post Discharge	ODM	Reporting Only	Reporting Only	Reporting Only
Healthy Adults	Race	Adults' Access to Preventive/Ambulatory Health Services – Total	NCQA/HEDIS	MPSO	MPS	MPS
Improved Timeliness of Care						
Healthy Children		Connect Infant to Primary Care: Two Visits within Three Months Post Discharge	ODM	Reporting Only	Reporting Only	Reporting Only
Healthy Children	Race	Well-Child Visits in the First 30 Months of Life Well-Child Visits in the First 15 Months of Life, Six or More Well-Child Visits*	NCQA/HEDIS	MPSO	MPS	MPS
Healthy Children	Race	Well-Child Visits in the First 30 Months of Life - Well-Child Visits for Age 15 Months–30 Months, Two or More Visits*	NCQA/HEDIS	MPSO	MPS	MPS
Healthy Children	Race	Child and Adolescent Well-Care Visits*	NCQA/HEDIS	3-11 years MPSO	3-11 years MPS	3-11 years MPS
				12-17 years MPSO	12-17 years MPS	12-17 years MPS
				18-21 years MPSO	18-21 years MPS	18-21 years MPS
				Total Reporting Only	Total MPS	Total MPS
Healthy Children	Race	Annual Dental Visit	NCQA/HEDIS	MPSO	MPS	MPS

Population Stream	Required Stratification	Performance Measure	Measurement Steward	Performance Target SFY 2023 (MY 2022)	Performance Target SFY 2024 (MY 2023)	Performance Target SFY 2025 (MY 2024)
Behavioral Health-Children	OhioRISE plan Population	Timely Access to Services: Rate of timely access to services per 1,000 eligible beneficiaries by Mobile Response and Stabilization Services (MRSS), Intensive Care Coordination (ICC) and Intensive Home-Based Treatment (IHBT) service types for each quarter of the SFY and annual aggregate Methodology: # of children with a claim for service X within defined timeframe/# of eligible beneficiaries with a claim for service X * 1,000	ODM Source: Shadow billing within the case rate or provider report	Reporting Only	Reporting Only	Reporting Only (Quarterly) MPS TBD (Annual)
Women and Infant Health	Race	Prenatal and Postpartum Care – Timeliness of Prenatal Care	NCQA/HEDIS	MPSO	MPS	MPS
Women and Infant Health	Race	Prenatal and Postpartum Care – Postpartum Care	NCQA/HEDIS	MPSO	MPS	MPS
Objective 1.2 Improve Screening to Identify Health and Health-Related Needs						
Healthy Children	Race	Developmental Screen First Three Years	Oregon University	Reporting Only	Reporting Only	Reporting Only
Healthy Children		Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Percentile Documentation	NCQA/HEDIS	MPSO	MPS	MPS
Healthy Children		Screening for Depression (Ages 12 – 17)	CMS	Reporting Only	Reporting Only	MPS
Healthy Children		Tobacco Use: Screening and Cessation Intervention (Ages 12-17)	AMA-PCPI	Reporting Only	Reporting Only	Reporting Only
Healthy Children	Race, OhioRISE	Kindergarten Readiness	ODM	MCO: Reporting Only OhioRISE: Reporting Only	MCO: Reporting Only OhioRISE: Reporting Only	MCO: MPS OhioRISE: Reporting Only
Healthy Children	Race, OhioRISE	Chronic Absenteeism	ODM	Reporting Only OhioRISE: Reporting Only	Reporting Only OhioRISE: Reporting Only	MPS OhioRISE: Reporting Only
Healthy Children	Race, OhioRISE	3rd Grade Reading	ODM	Reporting Only	Reporting Only	MPS

Population Stream	Required Stratification	Performance Measure	Measurement Steward	Performance Target SFY 2023 (MY 2022)	Performance Target SFY 2024 (MY 2023)	Performance Target SFY 2025 (MY 2024)
				OhioRISE: Reporting Only	OhioRISE: Reporting Only	OhioRISE: Reporting Only
Healthy Children	Race, OhioRISE	Graduation Rate	ODM	Reporting Only OhioRISE: Reporting Only	Reporting Only OhioRISE: Reporting Only	MPS OhioRISE: Reporting Only
Healthy Children		Contraceptive Care: All Women (Ages 15 – 20)	US Office of Population Affairs (OPA)	Reporting Only	Reporting Only	Reporting Only
Healthy Children		Contraceptive Care: Postpartum Women (Ages 15 – 20)	US OPA	Reporting Only	Reporting Only	Reporting Only
Women and Infant Health		Contraceptive Care – All Women (Ages 21 – 44)	US OPA	Reporting Only	Reporting Only	Reporting Only
Women and Infant Health		Contraceptive Care – Postpartum Women (Ages 21 – 44)	US OPA	Reporting Only	Reporting Only	Reporting Only
Women and Infant Health		Chlamydia Screening in Women, Total	NCQA/HEDIS	MPSO	MPS	MPS
Women and Infant Health		Breast Cancer Screening	NCQA/HEDIS	MPSO	MPS	MPS
Women and Infant Health		Cervical Cancer Screening	NCQA/HEDIS	MPSO	MPS	MPS
Healthy Adults		Tobacco Use: Screening and Cessation, Ages 18 and Older	AMA-PCPI	>12%	>12%	>12%
Objective 1.3 Improve Appropriate Service Utilization						
Healthy Adults		Ambulatory Care-Emergency Department (ED) Visits	NCQA/HEDIS	MPSO	MPS	MPS
Healthy Adults		Inpatient Utilization – General Hospital/Acute Care	NCQA/HEDIS	Reporting Only	Reporting Only	Reporting Only
Women and Infant Health		C-Section	ODM	Reporting Only	Reporting Only	Reporting Only

Population Stream	Required Stratification	Performance Measure	Measurement Steward	Performance Target SFY 2023 (MY 2022)	Performance Target SFY 2024 (MY 2023)	Performance Target SFY 2025 (MY 2024)
Behavioral Health-Children	OhioRISE Plan Population Only	Awaiting Discharge: Rate of children in Behavioral Health Inpatient or PRTF who could be discharged medically but are awaiting discharge per 1,000 eligible beneficiaries by service type for each quarter of the MY and annual Methodology: # of enrolled children awaiting discharge from Behavioral Health Inpatient or PRTF/# of eligible beneficiaries in Behavioral Health Inpatient or PRTF * 1,000	Steward: ODM Source: Daily report from Behavioral Health Inpatient/ PRTF facilities Or possibly Auth Reported by: OhioRISE Plan	Reporting Only	Reporting Only	Reporting Only (Quarterly) MPS TBD (Annual)
Behavioral Health-Children	OhioRISE Plan Population Only	Length of Time Awaiting Discharge: Average LOS per utilizer in Behavioral Health inpatient or PRTF who could be discharged but are awaiting placements (stuck youth) by service type for each quarter of the MY and annual aggregate Methodology: Sum of LOS for enrolled children awaiting placement in Behavioral Health inpatient or PRTF/# of enrolled children in Behavioral Health Inpatient or PRTF awaiting placement	Steward: ODM Source: Daily report from Behavioral Health Inpatient/ PRTF facilities Or possibly Auth Reported by: OhioRISE Plan	Reporting Only	Reporting Only	Reporting Only (Quarterly) MPS TBD (Annual)
Behavioral Health-Children	OhioRISE Plan Population Only	Emergency Department (ED) Utilization: Rate of children with a claim for an ED encounter for Behavioral Health related issue per 1,000 eligible beneficiaries for each quarter of the MY and annual	Steward: ODM Source: Claims Reported by ODM	Reporting Only	Reporting Only	Reporting Only (Quarterly) MPS TBD (Annual)
Objective 1.4 Improve Appropriate Medication Use						
Women and Infant Health		Progesterone Usage	ODM	Reporting Only	Reporting Only	Reporting Only
Healthy Adults		Antibiotic Utilization	NCQA	Reporting Only	Reporting Only	Reporting Only

Population Stream	Required Stratification	Performance Measure	Measurement Steward	Performance Target SFY 2023 (MY 2022)	Performance Target SFY 2024 (MY 2023)	Performance Target SFY 2025 (MY 2024)
Behavioral Health-Children	OhioRISE Population	Antidepressant Medication management-Effective Acute Phase Treatment, Effective Continuation Phase Treatment	NCQA/HEDIS	Acute Phase MCO: Ages 17 and Younger Reporting Only OhioRISE: Ages 17 and Younger, Ages 18-20, Total (13-20) N/A	Acute Phase MCO: Ages 17 and Younger MPS OhioRISE: Ages 17 and Younger, Ages 18-20, Total (13-20) Reporting Only	Acute Phase MCO: Ages 17 and Younger MPS OhioRISE: Age-17 and younger, Ages 18-20, MPS TBD Total (13-20) Reporting Only
				Continuation Phase MCO: Ages 17 and younger Reporting Only OhioRISE: Ages 17 and Younger, Ages 18-20, Total (13-20) N/A	Continuation Phase MCO: Ages 17 and younger MPS OhioRISE: Ages 17 and Younger, Ages 18-20, Total (13-20) Reporting Only	Continuation Phase MCO: Ages 17 and younger MPS OhioRISE: Age-17 and younger, Ages 18-20, MPS TBD Total (13-20) Reporting Only
Behavioral Health--Children	Race, OhioRISE Plan Population	Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication – Initiation	NCQA/HEDIS	MCO: MPSO OhioRISE: NA	MCO: MPS OhioRISE: Reporting Only	MCO: MPS OhioRISE: MPS TBD
Behavioral Health--Children	Race	Follow-up Care for Children Prescribed ADHD Medication –Continuation and Maintenance Phase	NCQA/HEDIS	MCO: MPSO OhioRISE: N/A	MCO: MPS OhioRISE: Reporting Only	MCO: MPS OhioRISE: MPS TBD

Population Stream	Required Stratification	Performance Measure	Measurement Steward	Performance Target SFY 2023 (MY 2022)	Performance Target SFY 2024 (MY 2023)	Performance Target SFY 2025 (MY 2024)
Behavioral Health-Children	OhioRISE Plan Population Only	Antipsychotic Medications: Rate of children on any antipsychotic medication stratified by with and without a claim for Medicaid Behavioral Health service per 1,000 eligible beneficiaries for each quarter of the MY and annual Methodology A: # of enrolled children on antipsychotic medication with a claim for Medicaid Behavioral Health services/# of eligible beneficiaries with a claim for Medicaid Behavioral Health services * 1,000 Methodology B: # of enrolled children on antipsychotic medication without a claim for Medicaid Behavioral Health services/# of eligible beneficiaries without a claim for Medicaid Behavioral Health services *1,000	Steward: ODM Source: SPBM/Claims Reported by ODM	Reporting Only	Reporting Only	Reporting Only (Quarterly) MPS TBD (Annual)
Behavioral Health-Children	OhioRISE Plan Population Only	Antipsychotic Medications: Rate of children on 4 or more antipsychotics per 1,000 eligible beneficiaries stratified by age for each quarter of the MY and annual Methodology: # of enrolled children on 4 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	Reporting Only	Reporting Only (Quarterly) MPS TBD (Annual)
Behavioral Health--Adult		Antidepressant Medication Management-Effective	NCQA/HEDIS	Acute Phase MPSO	Acute Phase MPS	Acute Phase MPS

Population Stream	Required Stratification	Performance Measure	Measurement Steward	Performance Target SFY 2023 (MY 2022)	Performance Target SFY 2024 (MY 2023)	Performance Target SFY 2025 (MY 2024)
		Acute Phase Treatment, Effective Continuation Treatment—Ages 19 and older		Continuation Phase MPSO	Continuation Phase MPS	Continuation Phase MPS
Women and Infant Health		Progesterone Usage	ODM	Reporting Only	Reporting Only	Reporting Only
Chronic Physical & Developmental Conditions		Statin Therapy for Patients with Diabetes, Received Statin Therapy	NCQA/HEDIS	MPSO	MPS	MPS
Chronic Physical & Developmental Conditions	Race	Statin Therapy for Patients with Cardiovascular Disease, Received Statin Therapy, Total	NCQA/HEDIS	MPSO Requirement	MPS	MPS
Chronic Physical & Developmental Conditions		Pharmacotherapy Management of COPD Exacerbation	NCQA/HEDIS	Dispensed Systemic Corticosteroid Within 14 calendar days: Reporting Only	Dispensed Systemic Corticosteroid Within 14 calendar days: Reporting Only	Dispensed Systemic Corticosteroid Within 14 calendar days: Reporting Only
				Dispensed a Systemic Bronchodilator within 30 calendar days: Reporting Only	Dispensed a Systemic Bronchodilator within 30 calendar days: Reporting Only	Dispensed a Systemic Bronchodilator within 30 calendar days: Reporting Only
Chronic Physical & Developmental Conditions		HIV Viral Load Suppression	HRSA	Reporting Only	Reporting Only	Reporting Only
Objective 1.5 Optimize Outcomes and Quality of Life						
Women and Infant Health	Race	Preterm Births (PTB)	NCQA	Reporting Only	Reporting Only	Reporting Only
Women and Infant Health	Race	Percentage of Live Births Weighing Less Than 2,500 Grams	CHIPRA	≤ 9.2%	≤ 9.2%	≤ 9.2%
Healthy Children	Race	Kindergarten Readiness	ODM	Reporting Only	Reporting Only	MPS
Healthy Children	Race	Chronic Absenteeism	ODM	Reporting Only	Reporting Only	MPS
Healthy Children	Race	3rd Grade Reading	ODM	Reporting Only	Reporting Only	MPS
Healthy Children	Race	Graduation Rates	ODM	Reporting Only	Reporting Only	MPS
Healthy Children		Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents:	NCQA/HEDIS	Reporting Only	Reporting Only	Reporting Only

Population Stream	Required Stratification	Performance Measure	Measurement Steward	Performance Target SFY 2023 (MY 2022)	Performance Target SFY 2024 (MY 2023)	Performance Target SFY 2025 (MY 2024)
		Counseling for Nutrition, Counseling for Physical Activity				
Chronic Physical & Developmental Conditions		Asthma in Younger Adults Admissions Rate (PQI 15-AD)	AHRQ	Reporting Only	Reporting Only	Reporting Only
Chronic Physical & Developmental Conditions		Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admissions Rate (PQI5-AD)	AHRQ	Reporting Only	Reporting Only	Reporting Only
Chronic Physical and Developmental Conditions		HIV Viral Load Suppression	HRSA	Reporting Only	Reporting Only	Reporting Only
Chronic Physical & Developmental Conditions		PQI 1: Diabetes Short-Term Complications Admission Rate (PQI01-AD)	AHRQ	Reporting Only	Reporting Only	Reporting Only
Chronic Physical & Developmental Conditions	Race	Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)	NCQA/HEDIS	MPSO	MPS	MPS
Chronic Physical & Developmental Conditions	Race	Hemoglobin A1c Control for Patients with Diabetes – HbA1c Control (<8.0%)	NCQA/HEDIS	MPSO	MPS	MPS
Chronic Physical & Developmental Conditions		Eye Exam for Patients with Diabetes	NCQA/HEDIS	MPSO	MPS	MPS
Chronic Physical & Developmental Conditions		Kidney Health Evaluation for Patients with Diabetes– 18–64, 65-74, 75- 85, Total	NCQA/HEDIS	Reporting Only	MPS	MPS
Chronic Physical & Developmental Conditions		Blood Pressure Control for Patients with Diabetes	NCQA/HEDIS	MPSO	MPS	MPS
Chronic Physical & Developmental Conditions	Race	Controlling High Blood Pressure	NCQA/HEDIS	MPSO	MPS	MPS
Chronic Physical & Developmental Conditions		Cardiac Rehabilitation – Initiation, Engagement 1, Engagement 2,	NCQA/HEDIS	Reporting Only	Reporting Only	Reporting Only

Population Stream	Required Stratification	Performance Measure	Measurement Steward	Performance Target SFY 2023 (MY 2022)	Performance Target SFY 2024 (MY 2023)	Performance Target SFY 2025 (MY 2024)
		Achievement - 18-64, 65 and older, Total				
Chronic Physical & Developmental Conditions		PQI 8: Heart Failure Admission Rate	AHRQ	Reporting Only	Reporting Only	Reporting Only

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.
MPSO = Minimum performance standard determined in accordance with ODM MCP Minimum Performance Standards Outliers (MPSO) Methodology
MPS = Minimum performance standard determined in accordance with ODM MCP Minimum Performance Standards Measurement Years CY 2023 and CY 2024 Methodology

Goal 2. Create a Personalized Care Experience Customized for Ohioans Served

Strategies and Initiatives

The individuals served by Ohio Medicaid are at the center of the newly redesigned managed care program. Customizing services to meet individual and family needs is essential to achieving population health and a positive care experience for the individual. The strategies described below provide the structure necessary to customize services to individuals and families.

Timely Identification of Needs

Identification of individual and population health needs is essential for improving population health. ODM's managed care program utilizes several mechanisms to identify the needs of members and populations.

At the individual level, MCOs are required to assess the social and medical needs of all members using a standardized health risk assessment (HRA) form. As required by 42 CFR 438.208, the needs of new members must be assessed within 90 days of the effective date of enrollment and additional attempts must be made if the initial attempt is unsuccessful.

Additional assessments tailored to sub-population needs (e.g., pregnant women, children, and youth whose needs are served by multiple systems) are also used. For example, for women who are identified as pregnant, the electronic versions of the Pregnancy Risk Assessment Form (PRAF) and the Report of Pregnancy (ROP) allow clinicians to quickly communicate pregnancy and pregnancy-related needs to Medicaid and the MCOs, allowing for maintenance of Medicaid enrollment during pregnancy, as well as efficient connection to services such as WIC, smoking cessation, and nurse home visiting.

For individuals who may be eligible for the OhioRISE program, comprehensive Child and Adolescent Needs and Strengths Assessments (CANS) are completed by the OhioRISE plan care management entity (CME). The CME conducts the CANS every six months or whenever there is a change in a member's condition or circumstances that warrants a reassessment. The results of the CANS assist the OhioRISE plan in assessing the member's functional progress within the course of OhioRISE plan treatment as facilitated by the CME.

At a macro-level, claims analysis and geographically based opportunity indices are used to determine the needs of populations, subpopulations, as well as the supports available in communities in which they live, work and play.

Neither the identification nor the monitoring of needs is insufficient to improve outcomes. Therefore, ODM is implementing several operational approaches to improve the care experience. These include tailored care coordination, specialized programs such as OhioRISE, the integration of member and family perspectives into the design of programs and initiatives, an enhanced awareness to implicit bias and cultural humility, as well as other initiatives aimed at improving the care experience.

Care Coordination Across the Care Continuum

Care coordination encompasses the full spectrum of activities, ranging from short-term assistance to meet care gaps to longer-term, intensive, and holistic care management for members with the most intense needs. Care coordination identifies and addresses physical, behavioral, and psychosocial needs of members, supports member goals and choices through a person-centered, trauma-informed, and culturally attuned approach, and provides care continuity while honoring member experience and choice. Care Coordination is discussed in more detail in Section 2 of this document.

Tailored program delivery—OhioRISE

Among all Medicaid youth under age 21, over one-third have family members or caregivers with a past or current opiate use disorder (OUD), substance use disorder (SUD), or a primary diagnosis of serious mental illness. Many of these youth receive services from multiple entities, including the Ohio Department of Job and Family Services (foster care and adopted youth), the Ohio Department of Mental Health and Addiction Services, Ohio Department of Youth Services (DYS); Ohio Family and Children First councils (OFCF), County Alcohol, Drug and Mental Health Boards (ADAMH); County Boards of Developmental Disabilities (BDD).

The design of OhioRISE was informed by input from stakeholders that included families, advocates, providers, provider associations, partner state agencies, helped to refine ODM's approach to Medicaid managed behavioral health services for children and youth involved in multiple state systems or with other complex behavioral health needs. The need to address an inconsistency in the availability of services needed by multi-system youth (MSY) and their caregivers requires that ODM and its partner state agencies continually focus on tailoring the structure and design of the OhioRISE program to focus on the needs of MSY children and youth.

Specialized Services for High-Risk Populations

MCOs are required to either provide or arrange for specialized (or non-traditional) services to be delivered via different community models (e.g., nurse home visiting, group prenatal care, Pathways Hub models, community health workers) as appropriate for high-risk populations such as women who are at risk of a preterm birth, members undergoing treatment for addiction, members involved with the justice system, members enrolled in the OhioRISE plan, and multi-system youth and children.

MCOs must provide services and resources tailored by population, community, and risk tier along the care continuum from low to high risk. As part of its *Population Health Management and Quality Strategy*, the MCO must include a description of specialized services and other

resources (e.g., health and wellness programs, 24/7 medical advice line, care coordination) for each population stream tailored to risk level and community demographics.

MCOs must build working relationships with locally based organizations to support the provision of services and resources to members. MCOs must ensure services are designed to be person-centered, meet the member's needs, and honor member preference, while not duplicating other services paid for by the MCO or ODM. MCOs are required to assess and enhance these services using continuous quality improvement principles. For example, person-centered transportation that considers the needs and preferences of an individual might be structured so that it can be ordered "on-demand" via cell phone app, includes options such as car-seats for accompanying children, allows riders to choose the driver they want to ride with based on previous riders' ratings, and gives riders the opportunity to rate their own experience with the service. The transportation services would then be assessed and refined based on rider feedback.

Culturally relevant care delivery strategies that foster respect and empathy

Culturally relevant care delivery strategies consider all characteristics of the members they serve. This involves actively working to understand perspectives of populations served and working to tailor services to meet member needs. For example, in communities that have experienced a disproportionately high degree of infant mortality, ODM assesses the perspective of women of reproductive age every six months to inform policy and programmatic development aimed at reducing infant mortality. Women have expressed several barriers to accessing healthcare including a lack of trust in the healthcare system, lack of effective communication from Medicaid providers, lack of provider empathy, and lack of Medicaid coverage of alternative providers and services.

Member feedback regarding trust, empathy, and communication led ODM to work with Ohio's academic medical centers to develop a series of simulated training modules aimed at improving cultural awareness and empathy among entities, organizations, and individuals working with the Ohio Medicaid population. These Medicaid Care Experience Simulations (MCarES) took the form of virtual reality trainings that harness the power of immersive experiences to reduce implicit bias and improve cultural competency. Examples of these trainings can be found at Medicaid Care Experience Simulation Project | Ohio Colleges of Medicine Government Resource Center (osu.edu).

Information regarding coverage of services and trust in the healthcare system informed the development of the Ohio's Maternal Infant Support Program (MISP) which aims to improve retention of Medicaid coverage during pregnancy and postpartum, increase services available to women during pregnancy, and provide a patient-centered maternity medical home that will improve the quality of care to women during pregnancy.

Intensive listening sessions with stakeholders helped ODM understand the needs of children and youth involved with multiple systems and highlighted the need highly integrated a multi-agency approach with intensive care coordination. As a result, ODM has designed OhioRISE, a program specifically targeted towards addressing the needs of children and youth with complex behavioral health and multi-system needs.

Single Pharmacy Benefit Manager (SPBM)

The shift from multiple, MCO-contracted pharmacy benefit managers to a single pharmacy benefit manager simplifies and improves information exchange between pharmacies, providers, and MCOs, leading to improved member care coordination and allowing additional member-valued services and benefits like home delivery, 90-day medication refills, and medication management and adherence programs that benefit all members.

Community Reinvestment

Each MCO must demonstrate a commitment to improving health outcomes in local communities in which it operates through community reinvestment activities. The MCO's community reinvestment must be used to support population health strategies within the region or regions the MCO serves. The MCO must not use community reinvestment funding to pay for Medicaid covered services.

Each MCO must contribute 3% of its annual profits to community reinvestment and increase the percentage of contributions by 1% each subsequent year, for a maximum of 5% of the MCO's annual profits. ODM encourages the MCO to work collaboratively with other ODM-contracted MCOs in the region to maximize the collective impact of community reinvestment funding.

Community reinvestment as a population health improvement strategy is discussed in more detail in Section 2 of ODM's *Population Health and Quality Strategy*.

Objectives, Measures, and Performance Targets

Population Stream	Required Stratification	Performance Measure	Measurement Set	Performance Target SFY 2023 (MY 2022)	Performance Target SFY 2024 (MY 2023)	Performance Target SFY 2025 (MY 2024)
Objective 2.1 Improve members' satisfaction with their health plan						
Healthy Children	OhioRISE Plan Population	General Child Rating of Health Plan (CAHPS Health Plan Survey)	NCQA/HEDIS/CAHPS	MCO: MPSO (Survey conducted in CY 2023) OhioRISE: Reporting Only	MCO: MPS (Survey conducted in CY 2024) OhioRISE: MPS TBD	MCO: MPS (Survey conducted in CY 2025) OhioRISE: MPS TBD
Healthy Children	Race	General Child – Customer Service Composite (CAHPS Health Plan Survey)	NCQA/ HEDIS/ CAHPS	MPSO- (Survey conducted in CY 2023)	MPS (Survey conducted in CY 2024)	MPS (Survey conducted in CY 2025)
Healthy Adult		Adult Rating of Health Plan (CAHPS Health Plan Survey)	NCQA/HEDIS/CAHPS	MPSO (Survey conducted in CY 2023)	MPS (Survey conducted in CY 2024)	MPS (Survey conducted in CY 2025)
Healthy Adult		Adult – Customer Service Composite (CAHPS Health Plan Survey)	NCQA/ HEDIS/ CAHPS	MPSO (Survey conducted in CY 2023)	MPS (Survey conducted in CY 2024)	MPS (Survey conducted in CY 2025)
Objective 2.2 Improve the satisfaction of OhioRISE families and youth with OhioRISE services						

Population Stream	Required Stratification	Performance Measure	Measurement Set	Performance Target SFY 2023 (MY 2022)	Performance Target SFY 2024 (MY 2023)	Performance Target SFY 2025 (MY 2024)
Behavioral Health-Children	OhioRISE Plan Population	Satisfaction Survey for Mobile Response and Stabilization Services (Families/Youth)	Steward: ODM Data Source: OhioRISE Plan Reported by: OhioRISE Plan	Reporting Only	Reporting Only	MPS TBD
Behavioral Health-Children	OhioRISE Plan Population	Satisfaction Survey for Intensive Home-Based Treatment (Families/Youth)	Steward: ODMData Source: OhioRISE Plan Reported by: OhioRISE Plan	Reporting Only	Reporting Only	MPS TBD
Behavioral Health-Children	OhioRISE Plan Population	Satisfaction Survey for Intensive Care Coordination (Families/Youth)	Steward: ODM Data Source: OhioRISE Plan Reported by: OhioRISE Plan	Reporting Only	Reporting Only	MPS TBD
Objective 2.3 Improve Provider Satisfaction with the OhioRISE Plan						
Behavioral Health-Children	OhioRISE plan Population	Satisfaction Survey of OhioRISE plan providers	Steward: ODM Data Source: OhioRISE Plan Reported by: OhioRISE Plan	Reporting Only	Reporting Only	MPS TBD

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. *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.*

MPSO = Minimum performance standard determined in accordance with ODM MCP Minimum Performance Standards Outliers (MPSO) Methodology

MPS = Minimum performance standard determined in accordance with ODM MCP Minimum Performance Standards Measurement Years CY 2023 and CY 2024 Methodology

Goal 3. Support Providers in Continuously Improving Patient Care

Strategies and Initiatives

ODM uses several strategies to support providers in continuously improving patient care. These include removing administrative barriers, and redundant contractual requirements as well as instituting clinically focused quality improvement projects, aligning with academic medical centers as key design partners, enhancing care coordination, monitoring of over- and under-utilization, and deploying value-based payment models. Each of these is described in more detail below.

Removal of administrative barriers

Modernized Provider Network Management System

With guidance from the Centers for Medicare and Medicaid Services (CMS), ODM developed a modernization roadmap for the process of updating the Department's management information systems. This modernization roadmap includes a transition to a modular system called the Ohio Medicaid Enterprise System (OMES) that will support ODM in meeting several modernization goals.

One module of this system is the Provider Network Management (PNM) provider enrollment subsystem. PNM features and enhancements are designed to streamline processes and reduce administrative burdens for providers, including:

- Accepting the same National Provider Identifier (NPI) for multiple provider types and allowing multiple provider Medicaid IDs to be associated to one NPI.
- Giving providers the ability to view specialties and effective dates.
- Allowing provider change or update requests submitted in the PNM to also be reviewed and accepted within the PNM, eliminating the need for email or letters to communicate acceptance.
- The provision of a comprehensive provider directory at the state level.
- The ability to opt in or out of text message notification for providers.
- The elimination of paper agreements for long-term care facilities – all agreements are available online and do not require mailing back and forth for signatures.

Centralized Credentialing

Along with the go-live of the PNM, ODM is implementing a single, centralized provider credentialing process. There are many expected benefits of this centralized approach, including:

- Providers subject to credentialing will only undergo one credentialing and recredentialing process at the state level vs. a separate, redundant process for credentialing each Ohio Medicaid MCO.
- A NCQA certified Credentialing Verification Organization (CVO) to serve as ODM's single point of contact for providers as they undergo credentialing and recredentialing reviews.
- By establishing delegate agreements with hospital systems and a delegate review process, ODM can deem credentialing work already completed by these providers and reduce or eliminate the need for individual providers such as physicians, nurse practitioners, etc. who engage in multiple credentialing processes.

Fiscal Intermediary

In 2019, when the Ohio Department of Medicaid began reimagining managed care, the two Requests for Information (RFIs) received provided feedback regarding the need to streamline and simplify administrative tasks. One component of ODM's response to address these pain points within Next Generation Medicaid managed care is implementation of a Fiscal Intermediary.

The fiscal intermediary lightens provider administrative load and streamlines processes by serving as a single point of entry for all provider claims and prior authorization requests. The fiscal intermediary not only facilitates processing of and transitioning of claims and requests to Ohio Medicaid's MCEs, it also receives updates back from those organizations and is able to convey these to providers, expediting the review and reimbursement cycle. The fiscal intermediary also provides ODM with greater insight into claims and prior authorizations requests, allowing more efficient and effective identification and addressing of trends.

Single Pharmacy Benefit Manager

Through the SPBM, pharmacists and prescribers see benefits from streamlining and consolidation of processes previously provided by multiple, individually contracted PBMs. For example, pharmacists are now able to streamline inventory based on the Unified Preferred Drug List (UPDL) and a single set of guidelines. Moving to a SPBM also reduces administrative burden on providers by simplifying clinical and prior authorization policies and claims processes and providing one standard point of contact.

Clinical- and Payer-best Practice

ODM is committed to the promotion of evidence-based practices. MCEs must continuously improve all aspects of the care delivery system to optimize the health of members. This is achievable through inclusion of input from members, providers, and other partners across the care continuum. Input from members, providers and other partners should be proactively sought and regularly integrated into the design, implementation, evaluation, and refinement of MCO services.

MCEs must develop and apply clinical and payer best practice guidelines for service delivery decisions pertaining to utilization management (UM), member grievance and appeals, provider dispute resolution, member education, coverage of services, QI projects, addressing disparities and other areas to which these guidelines apply.

Clinical and payer best practices, including examples of evidence-based practice guidelines, are discussed in more detail in Section 2 of this document.

Quality Improvement Projects (QIPs)

ODM promotes the development of payer-best practices through requirements that MCEs engage in quality improvement projects, including EQRO-validated performance improvement projects, that focus on the patient experience. Recent efforts have focused on assisting Medicaid members in obtaining needed healthcare and health-related services during the COVID-19 pandemic and improving the care of members with diabetes. MCEs are encouraged to obtain the perspective of members and providers in determining barriers to optimal care and in collaboratively designing interventions to address these barriers. Notable partners have included the Ohio Chapter of the American Academy of Pediatrics, the Ohio Hospital Association, the Ohio Perinatal Quality Collaborative, and disease-specific clinical advisory groups.

Specialized Services

The OhioRISE program

The OhioRISE plan will support providers through the following strategies: developing and enhancing initiatives to assist providers in identifying and recruiting staff for key supervisory and direct service positions; creating opportunities for network providers to locate formal and informal supports for OhioRISE members with unique services and support needs; and partnering with providers to develop and implement innovative approaches to workforce and network development including new service and payment strategies.

Additionally, ODM's designated Centers of Excellence (COE) will support development of evidence-based practices and services, ongoing fidelity reviews, and workforce development. As a foundational part of the redesigned delivery system, the COEs will work in collaboration with ODM and other state and local partners to build and sustain a comprehensive standardized assessment process, effective services, and care coordination approaches for children with complex behavioral health needs and their families. Additionally, they will assist Ohio's system transformation efforts by supplying the provider network with the orientation, training, coaching, mentoring, and other functions/supports needed to build and sustain the delivery of evidence-based services within a system of care framework. COEs will support prevention and early intervention services that will need to be in place to implement the Family First Prevention Services Act.

Value Based Payment Models

Ohio's Comprehensive Primary Care Program

Ohio's CPC program offers financial incentives for primary care practices to provide more coordinated care with the goal of improving access to and quality of care and reducing the total short- and long-term cost of patient care (e.g., lowering the frequency of high-cost services such as inpatient stays and emergency services). The program launched for Ohio Medicaid on January 1, 2017, and now includes nearly 1.25M members statewide (~40% of total Medicaid population). CPC is a patient-centered medical home program, which provides comprehensive patient-centric care by administering population health improvement activities, including team-based care, same day access to primary care services, and other evidence-based practices.

CPC practices may be eligible for two additional payment streams: (1.) per-member-per-month (PMPM) payments from Medicaid to support activities required by the CPC program, and (2.) annual shared savings payments to reward practices for achieving total cost of care savings paid by Medicaid along with the contracted MCOs. Upon joining the program, practices must attest to meeting a minimum set of program activity requirements. To be eligible to receive payment, practices must meet these requirements as well as 50% of applicable clinical quality metrics and 50% of program efficiency metrics.

Value-based payment as a population health improvement strategy is discussed in more detail in Section 2 of this document.

Objectives, Measures, and Performance Targets

CPC objectives, measures, and performance targets are shown in the table below. It is, important to note that CPC performance targets are aligned with several other programmatic goals and are therefore included in multiple measures in this introductory section of ODM's *Population Health and Quality Strategy*.

Population Stream	Stratification	Performance Measure	Measurement Set	Performance Target SFY 2023 (MY 2022)	Performance Target SFY 2024 (My 2023)	Performance Target SFY 2025 (My 2024)
		Objective 3.1: Improve Preventive Care				
Healthy Children	Race	Well-Child Visits in the First 30 Months of Life Well-Child Visits in the First 15 Months of Life, Six or More Well-Child Visits	NCQA/HEDIS	MCO: MPSO OhioRISE: N/A	MCO: MPS OhioRISE: Reporting Only	MCO: MPS OhioRISE: MPS TBD
Healthy Children	Race	Well-Child Visits in the First 30 Months of Life—Well-Child Visits for age 15 Months-30 Months, Two or More Visits	NCQA/HEDIS	MCO: MPSO OhioRISE: N/A	MCO: MPS OhioRISE: Reporting Only	MCO: MPS OhioRISE: MPS TBD
Healthy Children	Race	Child and Adolescent Well-Care Visits	NCQA/HEDIS	3-11 years MCO: MPSO OhioRISE: N/A	3-11 years MCO: MPS OhioRISE: Reporting Only	3-11 years MPS OhioRISE: MPS TBD
				12-17 years MCO: MPSO OhioRISE: N/A	12-17 years MCO: MPS OhioRISE: Reporting Only	12-17 years MCO: MPS OhioRISE: MPS TBD
				18-21 years MCO: MPSO OhioRISE: N/A	18-21 years MCO: MPS OhioRISE: Reporting Only	18-21 years MCO: MPS OhioRISE: MPS TBD
				MCO: Total Reporting Only	MCO: Total MPS	MCO: Total MPS
Healthy Children	Race	Lead Screening in Children	NCQA/HEDIS	MPSO	MPS	MPS
Healthy Children	Race	Developmental Screen First Three Years	Oregon University	Reporting Only	Reporting Only	Reporting Only
Healthy Children	Race	Annual Dental visits	NCQA/HEDIS	MCO: MPSO OhioRISE: N/A	MCO: MPS OhioRISE: Reporting Only	MCO: MPS OhioRISE: MPS TBD

Healthy Children		Fluoride Varnish (CPC)	ODM	Reporting Only	Reporting Only	Reporting Only
Healthy Children		Preventive Dental Services	(416 Report)	Reporting Only	MPS	MPS
Healthy Children		Sealant Receipt on Permanent First Molars	ADA	Reporting Only	Reporting Only	Reporting Only
Healthy Children		Childhood Immunization Status (Combo 3)	NCQA/HEDIS	MPSO	Reporting Only	MPS
Healthy Children		Childhood Immunization Status (Combo 10)	NCQA/HEDIS	Reporting Only	Reporting Only	Reporting Only
Population Stream	**Stratification**	**Performance Measure**	**Measurement Set**	**Performance Target SFY 2023 (MY 2022)**	**Performance Target SFY 2024 (MY 2023)**	**Performance Target SFY 2025 (MY 2024)**
Healthy Children		Immunizations for Adolescents (Combo 1)	NCQA/HEDIS	Reporting Only	Reporting Only	Reporting Only
Healthy Children		Immunization for Adolescents (HPV)	NCQA/HEDIS	Reporting Only	Reporting Only	Reporting Only
Healthy Children		Immunizations for Adolescents (Combo 2)	NCQA/HEDIS	MPSO	Reporting Only	Reporting Only
Healthy Children		Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Percentile Documentation	NCQA/HEDIS	MCO: MPSO OhioRISE: N/A	MCO: MPS OhioRISE: Reporting Only	MCO: MPS OhioRISE: MPS TBD
Women's Health	Race	Timeliness of prenatal care	NCQA/HEDIS	MPSO	MPS	MPS
Women And Infant Health	Race	Postpartum care	NCQA/HEDIS	MPSO	MPS	MPS
		Objective 3.2 Improve Screening Rates				
Women And Infant Health		Breast Cancer Screening	NCQA/HEDIS	MPSO	MPS	MPS
Women And Infant Health		Cervical Cancer Screening	NCQA/HEDIS	MPSO	MPS	MPS
Behavioral Health-Children		Tobacco Use: Screening and Cessation (Ages 12-17)	AMA-PCPI	MCO: Reporting Only OhioRISE: N/A	MCO: Reporting Only OhioRISE:	MCO: Reporting Only OhioRISE: MPS TBD

					Reporting Only	
Behavioral Health-Adult		Tobacco Use: Screening and Cessation (Ages 12-17)	AMA-PCPI	≥12%	>12%	>12%
		Objective 3.3: Improve Chronic Condition Management				
Chronic Physical & Developmental Conditions	Race	Hemoglobin A1c Control for Patients with Diabetes- HbA1c poor control (>9.0%)	NCQA/HEDIS	MPSO	MPS	MPS
Chronic Physical & Developmental Conditions	Race	Hemoglobin A1c Control for Patients With Diabetes – HbA1c Control (<8.0%)	NCQA/HEDIS	MPSO	MPS	MPS
Population Stream	**Stratification**	**Performance Measure**	**Measurement Set**	**Performance Target SFY 2023 (MY 2022)**	**Performance Target SFY 2024 (MY 2023)**	**Performance Target SFY 2025 (MY 2024)**
Chronic Physical & Developmental Conditions		Eye Exam for Patients with Diabetes	NCQA/HEDIS	MPSO	MPS	MPS
Chronic Physical & Developmental Conditions		Blood Pressure Control for Patients with Diabetes	NCQA/HEDIS	MPSO	MPS	MPS
Chronic Physical & Developmental Conditions		Kidney Health Evaluation for Patients With Diabetes– 18–64, 65-74, 75- 85, Total	NCQA/HEDIS	Reporting Only	MPS	MPS
Chronic Physical & Developmental Conditions		PQI 1: Diabetes Short-term Complications Admission Rate (PQI01-AD)	AHRQ	Reporting Only	Reporting Only	Reporting Only
Chronic Physical & Developmental Conditions		Statin Therapy for Patients with Diabetes, Received Statin Therapy	NCQA/HEDIS	MPSO	MPS	MPS
Chronic Physical & Developmental Conditions	Race	Controlling High Blood Pressure	NCQA/HEDIS	MPSO	MPS	MPS
Chronic Physical & Developmental Conditions		Cardiac Rehabilitation – Initiation, Engagement 1,	NCQA/HEDIS	Reporting Only	Reporting Only	Reporting Only

		Engagement 2, Achievement - 18-64, 65 and older, Total				
Chronic Physical & Developmental Conditions	Race	Statin therapy for patients with cardiovascular disease, Received Statin Therapy, Total	NCQA/HEDIS	MPSO	MPS	MPS
Chronic Physical & Developmental Conditions		Pharmacotherapy Management of COPD Exacerbation	NCQA/HEDIS	Dispensed Systemic Corticosteroid Within 14 calendar days: Reporting Only	Dispensed Systemic Corticosteroid Within 14 calendar days: Reporting Only	Dispensed Systemic Corticosteroid Within 14 calendar days: Reporting Only
				Dispensed a Systemic Bronchodi-lator within 30 calendar days: Reporting Only	Dispensed a Systemic Bronchodi-lator within 30 calendar days: Reporting Only	Dispensed a Systemic Bronchodi-lator within 30 calendar days: Reporting Only
Chronic Physical & Developmental Conditions		PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD)	AHRQ	Reporting Only	Reporting Only	Reporting Only
Chronic Physical & Developmental Conditions		PQI 5: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)	AHRQ	Reporting Only	Reporting Only	Reporting Only
Chronic Physical & Developmental Conditions		HIV Viral Load Suppression	HRSA	Reporting Only	Reporting Only	Reporting Only
Chronic Physical & Developmental Conditions		Asthma in Younger Adults Admissions Rate (PQI15-AD)	AHRQ	Reporting Only	Reporting Only	Reporting Only
Chronic Physical & Developmental Conditions		COPD or Asthma in Older Adults Admissions Rate (PQI5-AD)	AHRQ	Reporting Only	Reporting Only	Reporting Only
		Objective 3.4: Improve Behavioral Health Management				

Population Stream	Stratification	Performance Measure	Measurement Set	Performance Target SFY 2023 (MY 2022)	Performance Target SFY 2024 (MY 2023)	Performance Target SFY 2025 (MY 2024)
Behavioral Health-Children		Follow-Up After Hospitalization for Mental Illness	NCQA/HEDIS	MCO: 7-day Follow-up, Ages 6-17 MPSO OhioRISE: 7-day Follow-up, Ages 6-17, Ages 18-20, Total 6-20 Reporting Only	MCO: 7-day Follow-up, Ages 6-17 MPS OhioRISE: 7-day Follow-up, Ages 6-17, Ages 18-20, Total 6-20 Reporting Only	MCO: 7-day Follow-up, Ages 6-17 MPS OhioRISE: 7-day Follow-up, Ages 6-17, Ages 18-20 MPS TBD Total 6-20 Reporting Only
Behavioral Health-Children		Antidepressant Medication management-Effective Acute Phase Treatment, Effective Continuation Phase Treatment	NCQA/HEDIS	Acute Phase MCO: Ages 17 and Younger Reporting Only OhioRISE: Ages 17 and Younger, Ages 18-20, Total (13-20) N/A	Acute Phase MCO: Ages 17 and Younger MPS OhioRISE Ages 17 and Younger, Ages 18-20, Total (13-20) Reporting Only	Acute Phase MCO: Ages 17 and Younger MPS Age-17 and younger, Ages 18-20, MPS TBD Total (13-20) Reporting Only
				Continuation Phase MCO: Ages 17 and Younger Reporting Only OhioRISE: Ages 17 and Younger, Ages 18-20, Total (13-20) N/A	Continuation Phase MCO: Ages 17 and Younger MPS OhioRISE: Ages 17 and Younger, Ages 18-20, Total (13-20) Reporting Only	Continuation Phase MCO: Ages 17 and Younger MPS OhioRISE: Ages 17 and Younger, Ages 18-20 MPS TBD Total (20 and younger) Reporting Only
Behavioral Health-Children		Use of First-Line Psychosocial Care	NCQA/HEDIS	MCO: MPSO	MCO: MPS	MCO: MPS

		for Children and Adolescents on Antipsychotics, Total		OhioRISE: Reporting Only	OhioRISE: Reporting Only	OhioRISE: MPS TBD
Behavioral Health-Children	Race	Follow-up Care for Children Prescribed ADHD Medication-Initiation	NCQA/HEDIS	MCO: MPSO OhioRISE: N/A	MCO: MPS OhioRISE: Reporting Only	MCO: MPS OhioRISE: MPS TBD
Behavioral Health-Children	Race	Follow-up Care for Children Prescribed ADHD Medication-Continuation and Maintenance Phase	NCQA/HEDIS	MCO: MPSO OhioRISE: N/A	MCO: MPS OhioRISE: Reporting Only	MCO: MPS OhioRISE: MPS TBD
Behavioral Health-Children	Race	Follow-Up After Emergency Department Visit for Mental Illness	NCQA/HEDIS	MCO: Ages 6-17, 7-Day Follow-up MPSO	MCO: Ages 6-17, 7-Day Follow-up MPS	MCO: Ages 6-17, 7-Day Follow-up MPS
				MCO: 30-Day Follow-up MPSO OhioRISE: 7-Day Follow-up: Ages 6-17, Ages 18-20, Total (6-20) Reporting Only OhioRISE: 30-Day Follow-up: Ages 6-17, Ages 18-20, Total (6-20) Reporting Only	MCO: 30-Day Follow-up MPSO OhioRISE: 7-Day Follow-up: Ages 6-17, Ages 18-20, Total (6-20) Reporting Only OhioRISE: 30-Day Follow-up: Ages 6-17, Ages 18-20, Total (6-20) Reporting Only	MCO: 30-Day Follow-up MPSO OhioRISE: 7-Day Follow-up: Ages 6-17, Ages 18-20, Total (6-20) Reporting Only OhioRISE: 30-Day Follow-up: Ages 6-17, Ages 18-20 MPS TBD Total (6-20) Reporting Only
Behavioral Health-Children		Use Of Opioids At High Dosage – Ages 17 And Younger	NCQA/HEDIS	Reporting Only	MPS	MPS
Behavioral Health-Children		Use Of Opioids From Multiple Pharmacies And Multiple	NCQA/HEDIS	Multiple Pharmacies Reporting Only	Multiple Pharmacies MPS	Multiple Pharmacies MPS

		Prescribers – Ages 17 And Younger		Multiple Prescribers and Pharmacies Reporting Only	Multiple Prescribers and Pharmacies Reporting Only	Multiple Prescribers and Pharmacies Reporting Only
Behavioral Health-Children		Risk Of Continued Opioid Use-Ages 17 And Younger	NCQA/HEDIS	Reporting Only	Reporting Only	Reporting Only
Behavioral Health-Children		Initiation and Engagement of Substance Use Disorder Treatment	NCQA/HEDIS	Initiation MCO: Ages 13-17 MPSO OhioRISE: Total (Ages 13-20) Reporting Only Engagement MCO: Engagement Ages 13-17 MPSO OhioRISE: Ages 13-17, Ages 18-20, Total 13-20 Reporting Only	Initiation MCO: Ages 13-17 MPS OhioRISE: Initiation Total (Ages 13-20) Reporting Only Engagement MCO: Engagement Ages 13-17 MPSO OhioRISE: Ages 13-17, Ages 18-20, Total 13-20 Reporting Only	Initiation MCO: Ages 13-17 MPS OhioRISE: Initiation Total (Ages 13-20) MPS TBD Engagement MCO: Engagement Ages 13-17 MPSO OhioRISE: Ages 13-17, Ages 18-20, Total 13-20 Reporting Only
Behavioral Health-Children	Race; OhioRISE Plan Population	MCO: Follow-Up After Emergency Department Visit for Substance Use Disorder	NCQA/HEDIS	MCO: 7-Day Follow-up Ages 13-17 MPSO MCO: 30-Day Follow-up MPSO OhioRISE: 30-Day Follow-up Ages 18-20, Total Reporting Only	MCO: 7-Day Follow-up Ages 13-17 MPS MCO: 30-Day Follow-up MPS OhioRISE: 30-Day Follow-up Ages 18-20, Total Reporting Only	MCO: 7-Day Follow-up Ages 13-17 MPS MCO: 30-Day Follow-up MPS OhioRISE: 30-Day Follow-up Ages 18-20, MPS TBD Total Reporting Only

Behavior Health-Adults		Initiation and Engagement of Substance Use Disorder Treatment-Ages 18-64	NCQA/HEDIS	MCO: Initiation Ages 18-64 MPSO	MCO: Initiation Ages 18-64 MPS	MCO: Initiation Ages 18-64 MPS
				MCO: Engagement Ages 18-64 MPSO	MCO: Engagement Ages 18-64 MPS	MCO: Engagement Ages 18-64 MPS
Behavior Health-Adults	Race	Follow-Up After Hospitalization for Mental Illness	NCQA/HEDIS	MCO: 7-Day Follow-up, Ages 18-64 MPSO 7-day Follow-up, Total Reporting Only 30-Day Follow-up Ages 18-64 MPSO OhioRISE: 7-Day Follow-up: Ages6-17, Ages 18-20, Total 6-20 Reporting Only	MCO: 7-Day Follow-up, Ages 18-64 MPS 7-day Follow-up, Total Reporting Only 30-Day Follow-up Ages 18-64 MPS OhioRISE: 7-Day Follow-up: Ages 6-17, Ages 18-20, Total 6-20 Reporting Only	MCO: 7-Day Follow-up, Ages 18-64 MPS 7-day Follow-up, Total Reporting Only 30-Day Follow-up Ages 18-64 MPS OhioRISE: 7-Day Follow-up: Ages 6-17, Ages 18-20, MPS Total 6-20 Reporting Only
Behavior Health-Adults		Antidepressant Medication Management—Effective Acute Phase Treatment, Effective Continuation Phase Treatment—Ages 18 and older	NCQA/HEDIS	Acute Phase MCO: Ages 18 and older MPSO OhioRISE: Ages 18-20 N/A	Acute Phase MCO: Ages 18 and older MPS OhioRISE: Ages 18-20 Reporting Only	Acute Phase MCO, Ages 18 and older MPS OhioRISE: Ages 18-20 MPS TBD
				Continuation Phase MCO: Ages 18 and Older MPSO	Continuation Phase MCO: Ages 18 and Older MPS	Continuation Phase MCO: Ages 18 and Older MPS

				OhioRISE: Ages 18-20 N/A	OhioRISE: Ages 18-20 Reporting Only	OhioRISE: Ages 18-20 MPS TBD
Behavior Health-Adults	Race	Follow-up After Emergency Department Visit for Mental Illness	NCQA/HEDIS	7-Day Follow-up, Ages 18-64 MPSO 30-Day Follow-up, Ages 18-64 MPSO	7-Day Follow-up, Ages 18-64 MPS 30-Day Follow-up, Ages 18-64 MPS	7-Day Follow-up, Ages 18-64 MPS 30-Day Follow-up, Ages 18-64 MPS
Behavior Health-Adults	Race	Follow-up After Emergency Department Visit for Substance Use	NCQA/HEDIS	7-Day Follow-up, Ages 18-64 MPSO	7-Day Follow-up, Ages 18-64 MPS	7-Day Follow-up, Ages 18-64 MPS
				30-Day Follow-up, Ages 18-64 MPSO	30-Day Follow-up, Ages 18-64 MPSO	30-Day Follow-up, Ages 18-64 MPSO
Behavior Health-Adults		Use Of Opioids At High Dosage—Ages 18 And Older	NCQA/HEDIS	Reporting Only	MPS	MPS
Behavior Health-Adults		Use of Opioids from Multiple Pharmacies and Multiple Prescribers --Ages 18 and Older	NCQA/HEDIS	Multiple Pharmacies MPSO	Multiple Pharmacies MPS	Multiple Pharmacies MPS
				Multiple Prescribers MPSO	Multiple Prescribers MPS	Multiple Prescribers MPS
				Multiple Pharmacies and Prescribers MPSO	Multiple Pharmacies and Prescribers MPS	Multiple Pharmacies and Prescribers MPS
Behavior Health-Adults		Risk of Continued Opioid Use – Ages 18 and Older	NCQA/HEDIS	Reporting Only	Reporting Only	Reporting Only
		Objective 3.5: Improve Health Outcomes				
Women And Infant Health	Race	Percentage of Live Births Weighing Less than 2,500 grams	CHIPRA	<=9.2%	<=9.2%	<=9.2%
Women And Infant Health	Race	Preterm Births (PTB)	NCQA	Reporting Only	Reporting Only	Reporting Only
Chronic Conditions		PQI 8: Heart Failure Admission Rate	AHRQ	Reporting Only	Reporting Only	Reporting Only

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.
MPSO = Minimum performance standard determined in accordance with ODM MCP Minimum Performance Standards Outliers (MPSO) Methodology
MPS = Minimum performance standard determined in accordance with ODM MCP Minimum Performance Standards Measurement Years CY 2023 and CY 2024 Methodology

Goal 4. Improved Care for Children and Adults with Complex Needs

Individuals with complex needs include those with multiple or severe chronic conditions, individuals with behavioral health needs, children served by multiple state systems such as children in foster care, children with developmental disabilities (e.g., multi-system youth), and children with behavioral health needs.

Strategies and Initiatives

Special Services for High-risk Populations

OhioRISE

OhioRISE is designed to address the behavioral health treatment and support needs of children and youth with serious behavioral health concerns who are often involved in multiple public youth-serving systems (e.g., behavioral health, child protection services, juvenile justice, developmental disabilities, and education). The program will support both the youth and their families for whom more traditional approaches to treatment have not been adequate.

The goal of OhioRISE is to keep youth in their homes, communities, and schools by assessing for and delivering the appropriate intensity of services needed, thus reducing unnecessary out-of-home placement and potential custody relinquishment. Through collaborative work across state agencies and with local partners, the state team has identified that children and youth involved in multiple systems need specific, specialized services to be healthy and successful in their lives and communities. These services include intensive and moderate care coordination services provided by CMEs, mobile response and stabilization services (MRSS), intensive home-based treatment (IHBT), inpatient behavioral health services, psychiatric residential treatment facilities (PRTF), SUD services, psychiatry services, and other behavioral health services.

Value-based payment models

Care Innovation and Community Improvement Program

The Care Innovation and Community Improvement Program (CICIP) was developed to increase alignment of QI strategies and goals among ODM, MCOs, and four public and nonprofit hospital participating agencies (agencies): the MetroHealth System; UC Health; University of Toledo Medical Center; and The Ohio State University Wexner Medical Center.

CICIP goals align with ODM goals to improve healthcare for Medicaid beneficiaries. For July 2022 to June 2025, the quality measures for the CICIP program are as follows:

- Rate of Opioid Solid Doses Dispensed (without Suboxone) for members of practitioners prescribing opiates.
- Rate of members receiving opioids also receiving Benzodiazepines.
- Rate of members with opioid scripts receiving greater than 80 mg Morphine Milligram Equivalent (MME).

- Initiation and engagement of alcohol and other drug dependence (Healthcare Effectiveness Data and Information Set [HEDIS] measure).
- Follow-up after inpatient stay for mental health within seven calendar days (HEDIS measure).
- Timeliness of prenatal care (HEDIS measure)
- Postpartum care (HEDIS measure)
- Emergency room utilization reduction.
- Continuity of pharmacotherapy for OUD*
- Rate of MAT for OUD*
- Number of members with electronically submitted pregnancy risk assessment form (PRAF 2.0)*

*Reporting Only

Improvement Projects

MOMS+ Dyad Care Project

The Ohio Department of Medicaid is collaborating with the Ohio Perinatal Quality Collaborative to develop and test best practices for caring for the mother-baby dyad throughout the first year postpartum. The project aims to retain the mother in care while ensure the infant has all needed care during the first year of life. Essential strategies include partnerships across the healthcare, behavioral health, and social services systems; the use of standardized communication tools (e.g., PRAF 2.0) to facilitate communication of, and follow-up regarding identified needs; and the use of checklists of recommended clinical care.

Chronic Conditions Improvement Projects

Chronic Conditions Improvement Projects also address this goal by working to identify, standardize, and spread best clinical and payer practices for treating chronic conditions, such as hypertension and diabetes. Improvement projects are addressed in more detail in Section 3 of the *Quality Strategy*.

Objectives, Measures, and Performance Targets

Population Stream	Stratification	Performance Measure	Measurement Set	Performance Target SFY 2023	Performance Target SFY 2024	Performance Target SFY 2025
Objective 4.1 Improve Initiation and Engagement in SUD Treatment						
Behavioral Health-Children		Initiation and Engagement of Substance Use Disorder Treatment	NCQA/HEDIS	Initiation MCO: Ages 13-17 MPSO OhioRISE:	Initiation MCO: Ages 13-17 MPS OhioRISE: Initiation Total (Ages 13-20)	Initiation MCO: Ages 13-17 MPS OhioRISE: Initiation Total (Ages 13-20)

Population Stream	Stratification	Performance Measure	Measurement Set	Performance Target SFY 2023	Performance Target SFY 2024	Performance Target SFY 2025
				Total (Ages 13-20) Reporting Only Engagement MCO: Engagement Ages 13-17 MPSO OhioRISE: Ages 13-17, Ages 18-20, Total 13-20 Reporting Only	Reporting Only Engagement MCO: Engagement Ages 13-17 MPSO OhioRISE: Ages 13-17, Ages 18-20, Total 13-20 Reporting Only	MPS TBD Engagement MCO: Engagement Ages 13-17 MPSO OhioRISE: Ages 13-17, Ages 18-20, Total 13-20 Reporting Only
Behavioral Health-Adults		Initiation and Engagement of Substance Use Disorder Treatment	NCQA/HEDIS	Initiation Ages 18-64 MPSO	Initiation Ages 18-64 MPS	Initiation Ages 18-64 MPS
				Engagement Ages 18-64 MPSO	Engagement Ages 18-64 MPS	Engagement Ages 18-64 MPS
Objective 4.2 Improve Chronic Condition Management						
Chronic Physical & Developmental Conditions	Race	Comprehensive Diabetes Care – HbA1c Poor Control (>9.0%)	NCQA/HEDIS	MPS	MPS	MPS
Chronic Physical & Developmental Conditions		Comprehensive Diabetes Care – HbA1c Testing	NCQA/HEDIS	MPS	MPS	MPS
Chronic Physical & Developmental Conditions		Comprehensive Diabetes Care – Eye Exam (Retinal) Performed	NCQA/HEDIS	MPS	MPS	MPS
Chronic Physical & Developmental Conditions		Comprehensive Diabetes Care – Blood Pressure Control (<140/90 mm Hg)	NCQA/HEDIS	MPS	MPS	MPS
Chronic Physical & Developmental Conditions		Comprehensive Diabetes Care: Medical Attention for Nephropathy[vii]	NCQA/HEDIS	MPS	MPS	MPS
Chronic Physical & Developmental Conditions	Race	Controlling High Blood Pressure	NCQA/HEDIS	MPS	MPS	MPS

Population Stream	Stratification	Performance Measure	Measurement Set	Performance Target SFY 2023	Performance Target SFY 2024	Performance Target SFY 2025
Chronic Physical & Developmental Conditions		Statin Therapy for Patients with Cardiovascular Disease, Received Statin Therapy, Total*	NCQA/HEDIS	MPS	MPS	MPS
Chronic Physical & Developmental Conditions		Pharmacotherapy Management of COPD Exacerbation	NCQA/HEDIS	Dispensed Systemic Corticosteroid within 14 calendar days: Reporting Only	Dispensed Systemic Corticosteroid within 14 calendar days: Reporting Only	Dispensed Systemic Corticosteroid within 14 calendar days: Reporting Only
				Dispensed a Systemic Bronchodilator within 30 calendar days: Reporting Only	Dispensed a Systemic Bronchodilator within 30 calendar days: Reporting Only	Dispensed a Systemic Bronchodilator within 30 calendar days: Reporting Only
		PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD)	AHRQ	Reporting Only	Reporting Only	Reporting Only
		PQI 5: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD	AHRQ	Reporting Only	Reporting Only	Reporting Only
		HIV Viral Load Suppression	HRSA	Reporting Only	Reporting Only	Reporting Only
		Asthma in Younger Adults Admissions Rate (PQI15-AD)	AHRQ	Reporting Only	Reporting Only	Reporting Only
		COPD or Asthma in Older Adults Admission Rate (PQI5-AD)	AHRQ	Reporting Only	Reporting Only	Reporting Only
Objective 4.3 Decrease Inappropriate Prescribing						
Behavioral Health-Children		Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics, Total	NCQA/HEDIS	MCO: MPSO OhioRISE: Reporting Only	MCO: MPS OhioRISE: Reporting Only	MCO: MPS OhioRISE: MPS TBD
Behavioral Health-Children	OhioRISE plan Population	*Antipsychotic Medications*: Rate of children on any antipsychotic medication stratified	ODM Source SPBM	Reporting Only	MPS TBD	MPS TBD

Population Stream	Stratification	Performance Measure	Measurement Set	Performance Target SFY 2023	Performance Target SFY 2024	Performance Target SFY 2025
		by with and without a claim for Medicaid Behavioral Health service per 1,000 eligible beneficiaries for each quarter of the SFY and annual aggregate Methodology A: # of enrolled children on antipsychotic medication with a claim for Medicaid Behavioral Health services/# of eligible beneficiaries with a claim for Medicaid Behavioral Health services * 1,000 Methodology B: # of enrolled children on antipsychotic medication without a claim for Medicaid Behavioral Health services/# of eligible beneficiaries without a claim for Medicaid Behavioral Health services * 1,000				
Behavioral Health-Children	OhioRISE plan Population	*Antipsychotic Medications*: Rate of children on 4 or more antipsychotics per 1,000 eligible beneficiaries stratified by age for each quarter of the SFY and annual aggregate Methodology: # of enrolled children on 4 or more antipsychotics/# of eligible	ODM Source: Claims	OhioRISE: Reporting Only	OhioRISE: Reporting Only	OhioRISE: MPS TBD

Population Stream	Stratification	Performance Measure	Measurement Set	Performance Target SFY 2023	Performance Target SFY 2024	Performance Target SFY 2025
		beneficiaries * 1,000 Ages 0 – 6, 7 – 12, 13 – 17, 18 – 21				
Behavioral Health-Children		Use of Opioids at High Dosage	NCQA/HEDIS	MPS	MPS	MPS
Behavioral Health-Children		Use of Opioids from Multiple Pharmacies and Multiple Prescribers	NCQA/HEDIS	Multiple Pharmacies MPS	Multiple Pharmacies MPS	Multiple Pharmacies MPS
				Multiple Prescribers MPS	Multiple Prescribers MPS	Multiple Prescribers MPS
Behavioral Health-Children		Risk of Continued Opioid Use	NCQA/HEDIS	Reporting Only	Reporting Only	Reporting Only
Behavioral Health-Adults		Use of Opioids at High Dosage	NCQA/HEDIS	MPS	MPS	MPS
Behavioral Health-Adults		Use of Opioids from Multiple Pharmacies and Multiple Prescribers	NCQA/HEDIS	Multiple Pharmacies MPS	Multiple Pharmacies MPS	Multiple Pharmacies MPS
				Multiple Prescribers MPS	Multiple Prescribers MPS	Multiple Prescribers MPS
				Multiple Pharmacies and Prescribers MPS	Multiple Pharmacies and Prescribers MPS	Multiple Pharmacies and Prescribers MPS
Behavioral Health-Adults		Risk of Continued Opioid Use	NCQA/HEDIS	Reporting Only	Reporting Only	Reporting Only
Objective 4.4. Improve Medication Management						
Behavioral Health-Children	OhioRISE plan population	Antidepressant Medication Management – Effective Acute Phase Treatment, Effective Continuation Phase Treatment-Ages 17 and younger	NCQA/HEDIS	Acute Phase MCO: Reporting Only OhioRISE (Ages 18-20): Reporting Only	Acute Phase MCO: MPS OhioRISE (Ages 18-20): Reporting Only	Acute Phase MCO: MPS OhioRISE (Ages 18-20): Reporting Only

Population Stream	Stratification	Performance Measure	Measurement Set	Performance Target SFY 2023	Performance Target SFY 2024	Performance Target SFY 2025
				Continuation Phase MCO: Reporting Only OhioRISE (Ages 18-20): Reporting to MCO	Continuation Phase MCO: MPS OhioRISE (Ages 18-20): Reporting to MCO	Continuation Phase MCO: MPS OhioRISE (Ages 18-20): Reporting to MCO
Behavioral Health-Adults		Antidepressant Medication Management – Effective Acute Phase Treatment, Effective Continuation Phase Treatment—Ages 18 and older	NCQA/HEDIS	Acute Phase MPSO	Acute Phase MPS	Acute Phase MPS
				Continuation Phase MPSO	Continuation Phase MPS	Continuation Phase MPS
Objective 4.5. Increase Appropriate Service Utilization						
Behavioral Health-Children	OhioRISE plan Population	Mental Health Utilization, All Rates (Except Inpatient)	NCQA/HEDIS	Reporting Only	Reporting Only	Reporting Only
Behavioral Health-Children	OhioRISE plan Population	Mental Health Utilization – Inpatient	NCQA/HEDIS	MCO: MPS OhioRISE: MPS-Reporting to ODM	MCO: MPS OhioRISE: MPS-Reporting to ODM	MCO: MPS OhioRISE: MPS-Reporting to ODM
Behavioral Health-Adults		Mental Health Utilization, All Rates (Except Inpatient)	NCQA/HEDIS	Reporting Only	Reporting Only	Reporting Only
Behavioral Health-Adults		Mental Health Utilization – Inpatient	NCQA/HEDIS	MPS	MPS	MPS
Behavioral Health-Children	OhioRISE plan Population	*Length of Stay (LOS) for Behavioral Health (BH) Inpatient Hospitals:* Average LOS per utilizer for BH Inpatient Hospital stratified by service type for each quarter of the SFY and annual aggregate Methodology: Sum of LOS for	ODM Source: Claims	Reporting Only	MPS TBD	MPS TBD

Population Stream	Stratification	Performance Measure	Measurement Set	Performance Target SFY 2023	Performance Target SFY 2024	Performance Target SFY 2025
		each service type X/# of children in service type X				
Behavioral Health-Children	OhioRISE plan Population	*LOS for Psychiatric Residential Treatment Facility (PRTF):* Average LOS per utilizer for PRTF stratified by service type for each quarter of the SFY and annual aggregate Methodology: Sum of LOS for each service type X/# of children in service type X	ODM Source: Claims	Reporting Only	MPS TBD	MPS TBD
Behavioral Health-Children	OhioRISE plan Population	*Awaiting Discharge:* Rate of children in Behavioral Health Inpatient or PRTF who could be discharged medically but are awaiting discharge per 1,000 eligible beneficiaries by service type for each quarter of the SFY and annual aggregate Methodology: # of enrolled children awaiting discharge from Behavioral Health Inpatient or PRTF/# of eligible beneficiaries in Behavioral Health Inpatient or PRTF * 1,000	ODM Source: daily report from Behavioral Health Inpatient/ PRTF facilities Or possibly Auth	Reporting Only	MPS TBD	MPS TBD

Population Stream	Stratification	Performance Measure	Measurement Set	Performance Target SFY 2023	Performance Target SFY 2024	Performance Target SFY 2025
Behavioral Health-Children	OhioRISE plan Population	*Length of Time Awaiting Discharge*: Average LOS per utilizer in Behavioral Health inpatient or PRTF who could be discharged but are awaiting placements (stuck youth) by service type for each quarter of the SFY and annual aggregate Methodology: Sum of LOS for enrolled children awaiting placement in Behavioral Health inpatient or PRTF/# of enrolled children in Behavioral Health Inpatient or PRTF awaiting placement	ODM Source: daily report from Behavioral Health Inpatient/ PRTF facilities Or possibly Auth	Reporting Only	MPS TBD	MPS TBD

Population Stream	Stratification	Performance Measure	Measurement Set	Performance Target SFY 2023	Performance Target SFY 2024	Performance Target SFY 2025
Behavioral Health-Children	OhioRISE plan Population	Emergency Department (ED) Utilization: Rate of children with a claim for an ED encounter for Behavioral Health related issue per 1,000 eligible beneficiaries for each quarter of the SFY and annual aggregate Methodology: # of enrolled children with a claim for an ED encounter for Behavioral Health/# of	ODM Source: Claims	Reporting Only	MPS TBD	MPS TBD
Objective 4.6. Increase Appropriate Follow-up Care						
Behavioral Health-Children	Race	Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase	NCQA/HEDIS		MPS	
Behavioral Health-Children	Race	Follow-Up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase	NCQA/HEDIS		MPS	
Behavioral Health-Children	OhioRISE plan Population, Race	Follow-Up After Hospitalization for Mental Illness	NCQA/HEDIS	7-Da Follow-up, Ages 6 – 17 MCO: QW; OhioRISE: Reporting Only	7-Day Follow-up, Ages 6 – 17 MCO: QW; OhioRISE: Reporting Only	7-Day Follow-up, Ages 6 – 17 MCO: QW; OhioRISE: Reporting Only
				7-Day Follow-up Ages 18-20 OhioRISE Reporting Only	7-Day Follow-up Ages 18-20	7-Day Follow-up Ages 18-20
				7-Day Follow-up, Total OhioRISE: Reporting Only	7-Day Follow-up, Total OhioRISE: Reporting Only	7-Day Follow-up, Total OhioRISE: Reporting Only
				30-Day Follow-up, Total	30-Day Follow-up, Total	30-Day Follow-up, Total

Population Stream	Stratification	Performance Measure	Measurement Set	Performance Target SFY 2023	Performance Target SFY 2024	Performance Target SFY 2025
				OhioRISE: MPS	OhioRISE: MPS	OhioRISE: MPS
Behavioral Health-Children	Race	Follow-Up After Emergency Department Visit for Mental Illness	NCQA/HEDIS	7-Day Follow-up MCO: MPS OhioRISE: Reporting Only	7-Day Follow-up MCO: MPS OhioRISE: MPS	7-Day Follow-up MCO: MPS OhioRISE: MPS
				30-Day Follow-up MCO: MPS OhioRISE: Reporting Only	30-Day Follow-up MCO: MPS OhioRISE: MPS	30-Day Follow-up MCO: MPS OhioRISE: MPS
Behavioral Health-Children	Race	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence, Total	NCQA/HEDIS	7-Day Follow-up MPS	7-Day Follow-up MPS	7-Day Follow-up MPS
				30-Day Follow-up MCO: MPS OhioRISE: Reporting to MCO	30-Day Follow-up MCO: MPS OhioRISE: Reporting to MCO	30-Day Follow-up MCO: MPS OhioRISE: Reporting to MCO
Behavioral Health-Adults	OhioRISE plan Population (Ages 18-20), Race	Follow-Up After Hospitalization for Mental Illness	NCQA/HEDIS	7-Day Follow-up MCO: Ages 18-64 QW OhioRISE: Ages, 18-20 Reporting Only	7-Day Follow-up, MCO: Ages 18-64 QW OhioRISE: Ages 18-20	7-Day Follow-up, MCO: Ages 18-64 QW OhioRISE: Ages 18-20
				7-Day Follow-up, Total Reporting Only	7-Day Follow-up, Total Reporting Only	7-Day Follow-up, Total Reporting Only
				30-Day Follow-up, Total MCO: MPS; OhioRISE: Reporting Only	30-Day Follow-up, Total MCO: MPS; OhioRISE: Reporting Only	30-Day Follow-up, Total MCO: MPS; OhioRISE: Reporting Only
Behavioral Health-Adults	Race	Follow-Up After Emergency Department Visit for Mental Illness	NCQA/HEDIS	7-Day Follow-up MPS	7-Day Follow-up MPS	7-Day Follow-up MPS
				30-Day Follow-up MPS	30-Day Follow-up MPS	30-Day Follow-up MPS
Behavioral Health-Adults	Race	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence, Total	NCQA/HEDIS	30-Day Follow-up MPS	30-Day Follow-up MPS	30-Day Follow-up MPS

Population Stream	Stratification	Performance Measure	Measurement Set	Performance Target SFY 2023	Performance Target SFY 2024	Performance Target SFY 2025
		Objective 4.7. Reduce out-of-home & out-of-state placements (residential care & foster care)				
Behavioral Health-Children	OhioRISE plan Population	Rate of Out-of-Home Placement: Rate of children in out-of-home placement per 1,000 eligible beneficiaries aggregate and by service type for each quarter of the SFY and annual aggregate Methodology: # of enrolled children with a claim for an out-of-home service type X/total # of eligible beneficiaries * 1,000	ODM Source CANS or Claims	Reporting Only	Reporting Only	
Behavioral Health-Children	OhioRISE plan Population	Rate of Out-of-State Residential Placements Methodology: Year One: Report on the # of out-of-state residential placements. Year 2 ODM will develop the specifications for this measure from baseline data collected in Year 1.	ODM Source: Claims	Possible MPS	Possible Quality Withhold	Possible MPS
		Objective 4.8 Reduce Poor Social and Health Outcomes				
Behavioral Health-Children	OhioRISE plan Population	Foster Care Placement Disruptions Due to Behavioral Health: Rate of children who had an unplanned change in foster care placement due to a	ODM Source: CANS or Provider report	Reporting Only	MPS TBD	MPS TBD

Population Stream	Stratification	Performance Measure	Measurement Set	Performance Target SFY 2023	Performance Target SFY 2024	Performance Target SFY 2025
		Behavioral Health000 eligible beneficiaries for each quarter of the SFY and annual aggregate Methodology: # of enrolled youth in foster care who had an unplanned change in placement due to a Behavioral Health need/# of eligible beneficiaries in foster care * 1,000				
Behavioral Health-Children	OhioRISE plan Population	Charged Offenses: Rate of children with any charged offense per 1,000 eligible beneficiaries for each quarter of the SFY and annual aggregate Methodology: # of youth with any charged offense/ # of eligible beneficiaries * 1,000	ODM Source: CANS	Reporting Only	MPS TBD	MPS TBD
Behavioral Health-Children	OhioRISE plan Population	Suspensions: Rate of suspensions (in-school and out of school) per 1,000 eligible beneficiaries for each quarter of the SFY and annual aggregate Methodology: A: # of eligible beneficiaries suspended/# of eligible beneficiaries enrolled school * 1,000	ODM Source: CANS	Reporting Only	MPS TBD	MPS TBD
Behavioral Health-Children	OhioRISE plan Population	Expulsions: Rate of expulsions per 1,000 eligible beneficiaries	ODM Source: CANS	Reporting Only	MPS TBD	MPS TBD

Population Stream	Stratification	Performance Measure	Measurement Set	Performance Target SFY 2023	Performance Target SFY 2024	Performance Target SFY 2025
		for each quarter of the SFY and annual aggregate Methodology: # of eligible beneficiaries who were expelled/# of eligible beneficiaries who were enrolled in school * 1,000				

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.
MPSO = Minimum performance standard determined in accordance with ODM MCP Minimum Performance Standards Outliers (MPSO) Methodology
MPS = Minimum performance standard determined in accordance with ODM MCP Minimum Performance Standards Measurement Years CY 2023 and CY 2024 Methodology

Goal 5. Increased Program Transparency and Accountability.

ODM is committed to constantly improving the managed care program. This requires quickly identifying problems and issues through transparent accountability mechanisms. Examples of strategies used to promote transparency and accountability are provided below. Others are described in more detail elsewhere in this quality strategy.

Strategies and Initiatives

Fiscal Intermediary for all Provider Claims and Prior Authorization Requests

As part of the larger effort to modernize ODM's management information systems, ODM has hired a fiscal intermediary to create the single clearinghouse for all provider claims and prior authorization requests, validating transactions and routing requests to the appropriate managed care organization for resolution and reimbursement. In addition to streamlining the claims process, the fiscal intermediary will strengthen ODM's ability to assess compliance with Medicaid managed care regulations, review encounter data, and track performance measures. The use of a fiscal intermediary is aimed at the objectives of:

- reducing the time needed for managed care claim processing,
- increasing real-time access to critical healthcare transactions, and
- increasing effectiveness in meeting member and provider needs by improving the agility of programs, policies, and services

Single Pharmacy Benefit Manager (SPBM)

In 2019, ODM began the process of transitioning the Ohio Medicaid pharmacy benefit program from multiple MCO-managed pharmacy benefit managers (PBM) to a single state PBM serving all Medicaid managed care enrollees.

Pharmacy Pricing and Audit Consultant (PPAC)

In April 2021, ODM hired Myers and Stauffer as its pharmacy pricing and audit consultant (PPAC). The PPAC is central to achieving transparency in managing pharmacy benefits. It will be responsible for determining ODM's reimbursement methodology, conducting Cost of Dispensing (COD) and Actual Acquisition Cost (AAC) surveys, maintaining accurate and up to date AAC rates, and conducting oversight of the financial and operational functions of both the SPBM and the ODM's fee-for-service pharmacy benefits administrator (FFS PBA).

The PPAC will assist and support ODM in the performance of two critical pharmacy services functions: 1) pharmacy reimbursement and benefit design, and 2) pharmacy program oversight and auditing.

The PPAC will be central to achieving transparency through its work in determining reimbursement methodology, conducting Cost of Dispensing (COD) and Actual Acquisition Cost (AAC) surveys, maintaining accurate and up to date AAC rates, and conducting oversight of the functions of both the SPBM and the ODM's fee-for-service pharmacy benefits administrator (FFS PBA). The success of this pharmacy benefit administration model, and the PPAC specifically, will be demonstrated by fair, accurate and value-based reimbursement to pharmacies, oversight ensuring the SPBM and the FFS PBA comply with ODM's expectations, improved provider and member satisfaction, and continuous improvement of the pharmacy program.

Checks and balances were built into this model to avoid consolidation of power and functions, increase transparency and accountability, monitor, and close loopholes, and increase member and provider satisfaction. The firm of Meyers and Stauffer is partnering with ODM to ensure the full and complete payment of pharmacy claims; prohibit any steering to related pharmacies by the SPBM; ensure the SPBM is not receiving any unallowable rebates, refunds, claw backs, or payments; and support ODM by reviewing all audit documents the SPBM and PPACA provide and by conducting certain audits of the SPBM or PBA.

The redesign of the pharmacy program aims to achieve the objectives of:

- improving management of pharmacy benefits, and
- increasing financial accountability

Demographics and Expenditures Dashboards

The demographics and expenditures of the Ohio Medicaid program are made publicly available and can be accessed at: https://www.medicaid.ohio.gov/RESOURCES/Reports-and-Research/Medicaid-Managed-Care-Plan-Enrollment-Reports.

Managed Care Dashboards

The Ohio Department of Medicaid, Office of Managed Care publishes quarterly dashboards that visually depict Medicaid and MyCare Managed Care performance in the following areas:

- Member complaints, appeals, and state hearings.
- Inpatient psychiatric stays for children (ages <=21) and adults (ages >21) stratified by stays of less than 16 days and 16 days or more, and number of admissions.
- Provider panel compliance.
- Medicaid provider complaints, prior authorization, and prompt pay.

The dashboards, available at https://medicaid.ohio.gov/Managed-Care/Dashboards, provide a publicly available view of performance in these areas.

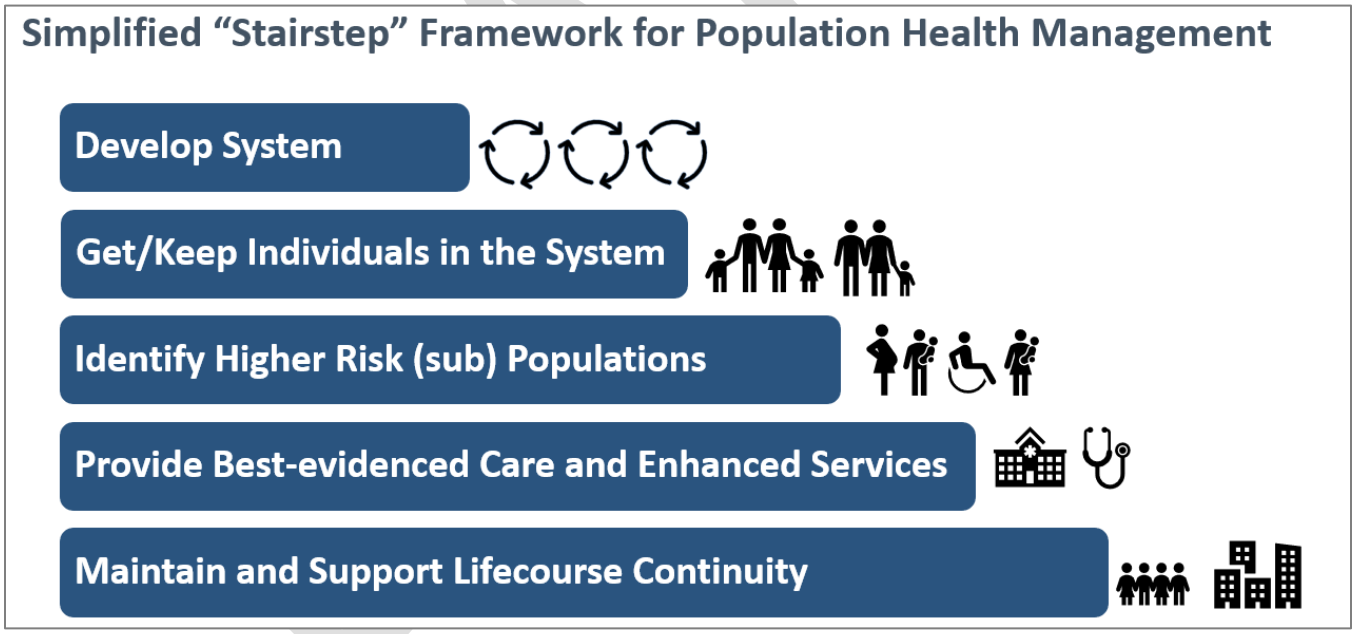
MCO Report Card

Every year, ODM compiles HEDIS and CAHPS measures into indices that assess MCO performance across five domains: (1.) getting care; (2.) doctors' communication and service; (3.) keeping children healthy; (4.) living with illness; and (5.) Women and Infant Health. Significant member and provider input were incorporated into determining the content of the report card. More detail and a screenshot of the report card can be found Section 3, Monitoring and Evaluation, of ODM's *Population Health & Quality Strategy*.

Section 2. ODM's Population Health Approach

Ohio's delivery system reforms build upon changes over the last several years focused on the foundational aspects of population health management. This "Stairstep" Framework consists of the following components: (1.) developing the system, (2.) getting everyone in the system, (3.) identifying risks and needs, (4.) provision of personalized care and enhanced services, and (6.) maintaining and supporting health throughout the life course.

Figure 10. Population Health Stairstep Framework



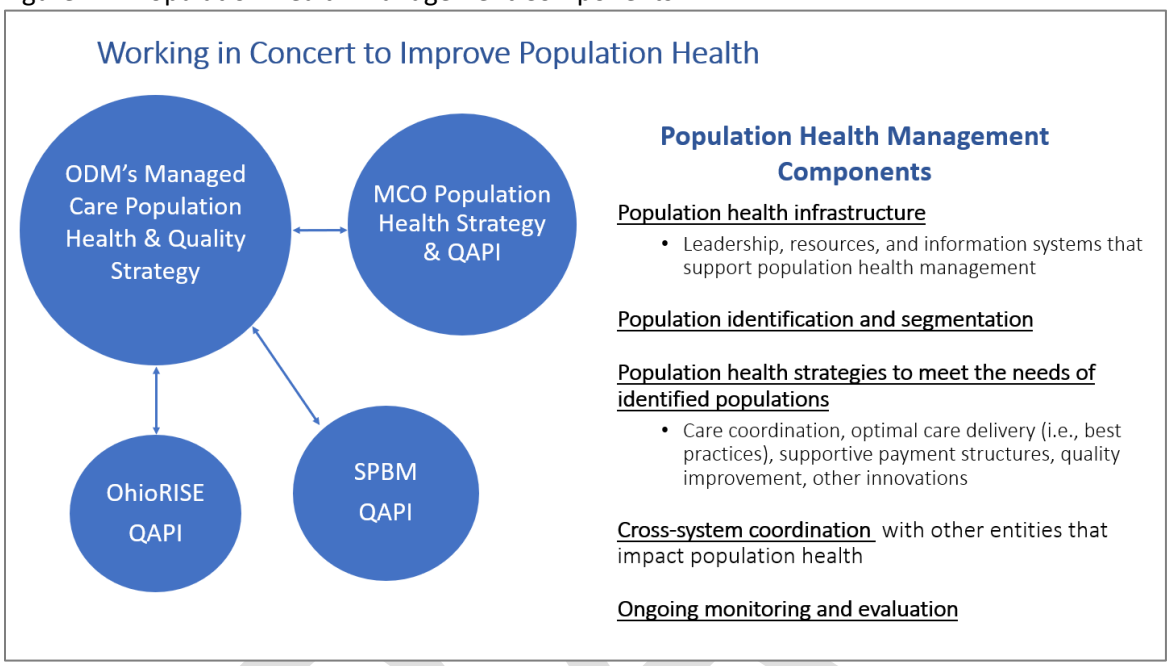
These changes are detailed in the History of Managed Care portion within Section 1 of *ODM's Managed Care Population Health and Quality Strategy* and are reflected in the "next generation" managed care provider agreement language that explicitly requires all MCEs to contribute to population health improvement through the use of a population health management framework.

The Population Health Management Stairstep Framework allows an appreciation of the complexity of health care systems in Ohio while highlighting key functions in managing the health of populations. Each component is defined within ODM's Primer for Population Health Management for Next Generation Managed Care (Appendix A)

Population Health Management

While ODM orchestrates Medicaid's population health approach, each MCO is required to develop and implement a population health management strategy which aligns with that of ODM, includes ODM's population health management principles, and coordinates efforts across the MCO, OhioRISE plan, and SPBM for its members.

Figure 11. Population Health Management Components



The utmost aim of Ohio's population health strategy is to improve the health of the entire Medicaid population. This highlights the central role of health equity in achieving population health. To this end, each MCO's population health strategy must strive to keep individuals and their families at the center of all efforts to identify and meet population needs through the following efforts:

- Removing barriers to care through supporting alternative sites and providers of care (telehealth, community-based providers) and simplifying/streamlining interactions with the MCO from the perspectives of both the member and the provider.
- 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.
- Connecting with communities, including having a physical presence in the communities where MCO members live.

Additionally, each MCO's population health strategy must demonstrate that wellness is valued through investments and promotion of preventive, health promotion, and wellness services, including primary care; ensuring health equity in all policies, practices, and operations; recognizing the significance of behavioral health needs to overall health and wellbeing, and emphasizing a strengths-based approach to behavioral health that fully integrates physical and behavioral healthcare.

On an annual basis, each MCO must submit its population health management strategy (PHMS) to ODM for review and approval. Each MCO is also required to continually evaluate its effectiveness in

progressing towards its objectives and goals, its collaboration with OhioRISE and the statewide SPBM, the institutionalization and maintenance of effective practices, and its ongoing incorporation of insights from previous evaluations. The MCO's PHMS includes its quality assessment and performance improvement (QAPI) program which describes its quality and health equity strategies, improvement projects and initiatives, and includes its annual evaluation.

Each MCO's population health management strategy must place health equity at the forefront and include the following structural elements to support population health improvement:

- **Population Health Infrastructure**, including the leadership, resources, and information systems needed to support the MCEs' roles in advancing ODM's population health management strategy.
- The MCO's approach toward **Population Identification and Segmentation** to inform the development and implementation of population health strategic initiatives. Population identification and segmentation includes the assignment of members in alignment with ODM-identified population streams and the MCO's risk stratification framework, criteria, and thresholds.
- **Population Health Strategic Approaches**, including health equity care coordination, quality improvement, optimal care delivery, value-based payment structures, and other innovative approaches that are being employing to meet population health goals through supporting person-centered care and enhanced services.
- **Cross-System Coordination** between the MCO, the OhioRISE plan, the SPBM, and community quality partners such as Ohio Family and Children First (OFCF), the Cystic Fibrosis Foundation, the Ohio Chapter of the American Academy of Pediatrics, the Ohio Pharmacists Association, and other state agencies.
- **Monitoring and Evaluation** activities related to each MCE's quality assessment and performance improvement program, as well as external quality reviews to inform and improve its population health management strategy.

OhioRISE plan and the SPBM are required to support MCO population health management activities by coordinating with ODM, the MCOs, and the SPBM; and sharing available individual and aggregate data. The OhioRISE plan must also support the alignment of care coordination activities and serve as the subject matter expert for children and youth with behavioral health needs.

The OhioRISE plan is required to play a primary role in driving population health efforts for high-risk children with behavioral health conditions by assisting ODM and the MCOs in developing cross-cutting population health and quality improvement initiatives for high-risk children and youth within the behavioral health conditions population stream. To that end, the OhioRISE plan must provide consultation to ODM, the MCOs, the SPBM and other ODM-contracted managed care entities in the following areas: development and implementation of population health strategies for this population stream; in the collection, analysis, and reporting of quality measures; in service system and clinical issues; in health equity issues; and in strategic initiatives and quality improvement activities. The OhioRISE plan also plays a key role in evaluating population health approaches within this population stream.

ODM requires that the MCOs, OhioRISE plan, and SPBM enter into agreements that specify the roles and activities of the OhioRISE plan and SPBM in contributing to the MCO's population health management strategy and in supporting ODM's population health management approach.

Each required component of the MCO population health management strategy is described in more detail below.

Population Health Management Infrastructure

ODM requires that each MCE's population health management approach has the fundamental infrastructure needed to succeed. Required population health management infrastructure includes senior leadership support, maintenance of a robust information system and related analytics, and adequate staffing and resources to support strategic population health improvement activities (data analytics care coordination, health equity, quality improvement).

Senior Leadership Support

ODM requires MCE senior leaders to create and foster an ongoing dynamic culture of innovation and healthcare excellence by promoting a culture focused on supporting an optimal healthcare delivery system through collaborative, cross-system population health management efforts that focus on health equity. MCE engagement in high impact leadership activities as described in *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*[viii] supports these efforts.

MCE senior leadership must provide direction and oversee all population health improvement activities, including on-going, rapid-cycle improvement of the quality of care and services provided by the MCE and its subcontractors and providers. Doing this effectively requires consistent, frequent, and strategic use of data and analytics to identify improvement opportunities, evaluate initiative effectiveness, and incorporate results and lessons learned into business processes.

Relevant staff (e.g., member services, provider relations, health equity, utilization management) are required to be engaged in population health improvement efforts (e.g., care coordination and quality improvement efforts) to inform and address barriers to optimal care and health outcomes.

MCE senior leadership must ensure that improvement activity results are shared across the organization, with other ODM-contracted managed care entities, care coordination entities (CCE), and ODM. This requires transparent communication and coordination among the leadership team, the chief executive officer (CEO) and relevant functional areas of the organization. Sharing lessons learned allows the MCEs to work more efficiently and collaboratively in the development and implementation of efforts to improve population health and health equity.

Adequate Staffing and Resources

MCEs must allocate sufficient staffing to their population health activities to support each strategic initiative and respond to the needs of internal and external stakeholders. ODM specifically requires that the MCEs ensure that staffing is sufficient in the following areas: data analytics, health equity, quality improvement, and care coordination. However, as noted above, MCE senior leadership must ensure that other areas of the organization (e.g., member support, provider support, utilization management) are also included, as needed, in population health improvement activities.

Information System and Analytics

Each MCEs must have a data information system that meets the requirements of 42 CFR 438.242 and that can support ODM's and the MCOs' population health management strategies. To that end, MCE information systems must be able to integrate and analyze data from multiple data sources to address individual- and population-level needs (e.g., claims, grievances and appeals, eligibility data).

MCEs must also 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.

At a minimum, the data information systems of each MCO and the OhioRISE plan must be able to perform the following essential activities to support population health management:

- Integrate information from multiple sources [e.g., enrollment data, electronic health records and lab data, claims data, care coordination data, data from other MCEs] to facilitate internal MCE communication and coordination for individual members and population streams.
- Inform population identification, risk assignment, stratification, and assignment of care coordination status.
- Identify providers and community-based organization involvement.
- Identify population health improvement opportunities and choice of an appropriate population health management approach.
- House data to support the MCE's population health management strategy and related initiatives.
- Provide data needed to monitor the effectiveness and impact of the MCOs' population health strategies, including the effectiveness of the MCE's response to addressing identified needs and improving outcomes.

MCEs are required to maintain information systems that support them in performing timely information system improvements, testing, and execution necessary to operationalize MCO- and ODM-coordinated population health efforts. This includes the ability to use information from health information exchanges (HIE) and electronic health records (EHR) necessary for near real time understanding of member needs and reporting metrics, such as electronic clinical quality measures (eCQM).

The data systems of the MCOs and OhioRISE plan must integrate key member information to facilitate internal communication and care coordination related to a specific member, as well as to inform population health improvement initiatives. Examples of key sources of information include enrollment data, data from health risk assessment (HRA) and other assessments, clinical (e.g. EHR and HIE data), claims data, care coordination data, data from improvement projects, data from other MCEs (e.g., SPBM) and their subcontractors (e.g., transportation providers), and data from local, state and community entities (e.g., immunization registry data from the Ohio Department of Health). MCEs are required to search for and proactively incorporate useful data sources to improve services to and interactions with members, families, communities, and network providers.

MCE health information systems must support health equity efforts by allowing for the identification of disparities in areas such as service access, utilization, health outcomes, intervention effectiveness, social risk factors, and survey (e.g., CAHPS) results, while also allowing for the monitoring and comparison of process and outcome measures over time to inform disparity reduction efforts.

MCE information systems must efficiently and securely share data with ODM, CCEs, other MCEs, and community-based organizations regarding gaps in services, attribution, risk factors related to social determinants of health (SDOH), and referrals to services. MCEs must also efficiently and securely exchange care coordination data with providers (e.g., primary care providers [PCPs] 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) and follow state and federal privacy requirements.

For care coordination activities specifically, the MCE's information system must be able to identify the type of care coordination (i.e., Care Manager, Care Manager Plus, Care Guide, and Care Guide Plus); the primary entity providing care management and/or coordination; the person-centered care plan content, including goals, interventions, outcomes, and completion dates.

Population Identification and Segmentation

To inform population health efforts, prioritize initiatives, and optimize resource allocation, MCOs are required to stratify their membership according to ODM-identified population streams (healthy children and adults, women and infant health, children with behavioral health needs, adults with behavioral health needs, chronic conditions, including children with special healthcare needs and older adults). This requires the use of multiple sources of information, including claims, health risk assessments, demographic information from eligibility files, care management and coordination data, data indicating risk (e.g., enhanced maternal care file), and community data (e.g., opportunity indices).

Population Health Strategic Approaches

Improving Health Opportunities for All

In accordance with 42 CFR 438.206(c), MCEs must address healthcare 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.

The MCOs, the OhioRISE plan, and the SPBM must all participate in and support ODM's efforts to reduce health disparities. To ensure that care is appropriate and of high quality for the entire population, ODM has focused on improving health opportunities and reducing disparities in the healthcare experience, as well as healthcare outcomes.

As an essential element of population health, disparity reduction and improvement of health opportunities permeate all population health improvement efforts. ODM's health opportunity strategy therefore incorporate all aspects of population health management by ensuring:

- MCEs infrastructure (leadership, staffing, information technology systems, etc.) provides necessary resources and support.

- Data is used to identify disparities, design tailored interventions, and monitor results.
- Culturally effective service delivery by promoting cultural humility and awareness of implicit biases, including:
    - Engaging individuals, their families, and communities in the design of services and interventions.
    - Driving cross-system collaboration and measurement.
    - Reinvesting in communities.

Each of these is discussed in more detail below.

Health Opportunity Infrastructure

ODM requires the MCEs to have adequate population health infrastructure to fully support health equity and disparity reduction efforts. This infrastructure includes devoted leadership, staffing, resource allocation, and information technology systems necessary to support health equity and disparity reduction efforts.

Leadership to Support Health Opportunities for All

As ODM's lead orchestrator of population health improvement efforts, each MCO is required to employ a full-time, Ohio-based, health equity director with demonstrated community and stakeholder engagement experience, as well as experience in the application of science-based quality improvement methods to reduce health disparities. The health equity director works in close coordination with the MCO's population health director to oversee the strategic design, implementation, and evaluation of health equity efforts in the context of the MCO's population health initiatives. The health equity director also coordinates and collaborates with members, providers, local and state government, community-based organizations, ODM, and MyCare Ohio MCO, OhioRISE PIHP and SPBM PAHP to impact health disparities at a population level.

Each MCO's health equity director is responsible for informing other population health strategic approaches (best payer practices, quality improvement, community reinvestment) to ensure health equity remains at the forefront of all the MCE's quality improvement and population health approaches. This includes providing resources and research around health equity and social determinants of health to other MCO leadership and programmatic areas; ensuring that the perspectives of members with disparate health outcomes are incorporated into the tailoring of intervention strategies; collaborating with the MCO's chief information officer to ensure the MCO collects and meaningfully uses race, ethnicity, and language data to identify disparities; and coordinating and collaborating with members, clinical providers, local and state government, community-based organizations, ODM, and other ODM-contracted managed care entities to impact health disparities at a population level.

All efforts to improve health equity, reduce disparities, and improve cultural competence and humility are designed collaboratively across the MCEs to have a collective impact and to ensure that lessons learned are incorporated into future decision making. The OhioRISE plan and the SPBM are contractually required to participate in all ODM health equity initiatives.

The health equity director at each MCO must ensure that efforts to improve health equity, reduce disparities, and improve cultural competence are designed collaboratively with other ODM-contracted managed care entities for collective population impact and that lessons learned through the design and implementation of these efforts are incorporated into future decision-making.

Health Equity Staff

MCOs and the OhioRISE plan health equity staff must be maintained at levels sufficient to actively contribute to quality improvement projects within each of the ODM identified population health streams; attend ODM-led meetings and make connections with health equity staff from ODM, MCOs, and other ODM-contracted managed care entities; coordinate health equity work with other ODM-contracted managed care entities; and establish relationships with communities and community-based entities to inform and address local health and race equity issues. Health equity staff support care coordination entities and network providers related to OhioRISE plan's health equity and quality improvement efforts

Health Opportunities and Information technology (IT)

MCEs are required to have the necessary IT infrastructure to identify disparities, support the efficient launching of coordinated efforts for collective health equity impact, monitor efforts, and support the sustaining of successful initiatives. The MCE IT system must therefore be able to integrate information from multiple sources (e.g., claims, enrollment, prior authorization, care coordination, electronic health records) to inform health equity focused population health improvement efforts (care coordination, value-based initiatives, quality improvement, community reinvestment) and the prioritization of efforts.

ODM requires that the MCO's data system allow for the identification of disparities in areas such as service access, utilization, health outcomes, intervention effectiveness, social risk factors, and service access and satisfaction (e.g., CAHPS) so that efforts can be focused and tailored to better meet needs. The MCO's IT system also must support the monitoring and comparison of process and outcome measures over time to inform disparity reduction efforts. Systems must also allow for the monitoring of results at a sufficient cadence to support rapid cycle quality improvement efforts.

The OhioRISE plan and the SPBM information systems must allow plan specific health equity efforts, and support coordinated efforts for collective impact by allowing for efficient and secure data sharing with ODM and other MCEs.

Health Opportunities and Population Segmentation

ODM and MCE progress toward health equity requires the MCOs to segment data by demographic and social characteristics in addition to population stream and risk level. This additional segmentation allows for identification of disparities and improved allocation of resources for health equity efforts.

Health Opportunities and an Optimal Delivery System

The MCEs are required to ensure that services are delivered in a culturally appropriate and effective manner to all members by promoting cultural humility at all levels of the MCE, including promoting awareness of implicit biases and how they impact policy and processes.

MCEs must engage with individuals, families, and communities to understand community resources, ensure their perspectives are integrated into the design of disparity reduction interventions and initiatives, and that their feedback is incorporated into the design of metrics that determine the success of disparity reduction efforts.

Health Opportunities and Quality Improvement

Health equity is an essential component of all ODM managed care quality improvement efforts. ODM therefore prioritizes improvement projects on topics that have large disparities in health outcomes.

In all improvement projects, obtaining and using the perspective of members is critical to identifying the root causes of an improvement need and in designing effective interventions. This is particularly true for populations that may have had less than optimal experience with the healthcare system and are essential partners in redesigning the system to be more effective.

In addition to incorporating the voice of members into intervention design, ODM requires MCEs to stay informed of innovations and research findings that impact the health of populations experiencing disparities and incorporate these learnings into the planning of their improvement efforts.

ODM also requires that MCEs monitor data over time to determine the success of disparity reduction efforts.

Health Opportunities and Care Coordination

To increase the success of care coordination as a population health strategic approach, MCEs must incorporate care coordination and health risk assessment into their disparity reduction efforts, focus on the importance of collaborative partnerships with community entities, ensure active referral to and follow-up on identified needs related to SDOH, and ensure staff incorporate a culturally humble approach and awareness of implicit biases into their interactions with members and providers.

Health Opportunities and Utilization Management

Utilization management is often thought of as a cost-containment strategy that seeks to limit unnecessary utilization. However, monitoring of utilization also provides an opportunity to ensure that services are being adequately utilized to promote positive outcomes for all populations.

Analysis of service utilization by subpopulation demographics (e.g., race, geography) ensures that optimal care is provided to all populations. MCEs must investigate service underutilization to identify root cause, must take corrective action to correct the problem(s), and must continue to monitor to ensure sustained correction. Inter-reliability testing is used to evaluate the consistency of utilization management criteria application.

Health Opportunities and Value-based Purchasing

Value-based purchasing (VBP) can be used to support both short-term and long-term health equity goals. Equity-focused VBP emphasizes improvements in health equity, alongside improvements in overall population health (Patel, Smithey, McGinnis, & Tuck, 2021). Under VBP arrangements that aim to improve health equity, quality targets focus on reducing health disparities and achieving equity across and within defined populations.

ODM through its provider agreements with managed care entities has laid the foundation for using VBP models to support health equity goals. Current contract language requires MCEs to stratify key performance metrics and CAHPs by race and to separately monitor improvements for children and youth with complex behavioral health needs who are served by multiple state and local systems. This stratification will be used to set the baseline that will allow ODM and its contracted MCEs to set disparity reduction goals for these populations and monitor progress over time.

Health Opportunities and Cross-system Collaboration

Efforts must be coordinated vertically and horizontally across the health system to decrease disparities and increase health equity. Collaboration and coordination across the healthcare system must be conducted from a patient-centered approach in which the needs and preferences of members play a

lead role, and the context of the family and community are actively considered. This ensures that the collaborative efforts are designed to have the greatest impact for the Medicaid member.

ODM requires its MCEs to facilitate cross-system collaboration and coordination with other entities that are involved in the support, care, and treatment of Medicaid members. This includes using data to identify care needs and gaps in care. Coordination between involved entities, care coordinators, and primary care providers is essential for ensuring seamless care transitions and follow-up care, integrated behavioral and physical health, and the addressing of social needs such as food insecurity, housing instability, and transportation. Cross-system collaboration and coordination also includes the promotion of services, such as telehealth and community health workers, that facilitate care delivery.

Health Opportunities and Community Reinvestment

It is well known that neighborhoods and the built environment are important contributors to the health of populations. In many low-income communities where Medicaid members reside, the social, economic, and environmental conditions do not sufficiently support efforts to improve health outcomes. To improve the conditions in which members live, ODM is therefore requiring MCOs and the OhioRISE plan to reinvest a portion of their profits back into the communities that they serve.

MCOs are prohibited from using community reinvestment funding to pay for Medicaid covered services. ODM encourages the MCO to work collaboratively with other ODM-contracted MCOs in the region to maximize the collective impact of community reinvestment funding.

Optimal Delivery System as a Population Health Approach

As a key approach for population health improvement, ODM requires MCEs to continuously improve all aspects of the care delivery system to optimize the health of members through inclusion of input from members, families, providers, and other partners across the care continuum into the design, execution, evaluation, and refinement of MCE service delivery policy and practice.

MCEs must therefore 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, and addressing disparities.

Clinical Best Practice

Clinical best practices encompass evidence-based practice and evidence-informed practice. In accordance with 42 CFR 438.236, all MCEs must adopt practice guidelines and disseminate the guidelines in an efficient and effective format to all affected providers, as well as to members and pending members. These guidelines must: be based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field; consider the needs of members; be adopted in consultation with the MCE's contracted healthcare professionals; incorporate the results of applicable QI projects and be reviewed and updated at least quarterly. Moreover, decisions regarding

utilization management, enrollee education, and coverage of services must be consistent with these guidelines.

Examples of evidence-based practice guidelines, include the following:

- Hypertension: 2017 American College of Cardiology/American Heart Association (ACC/ AHA)
- Diabetes: ADA Standards of Medical Care in Diabetes
- Treatment for Opioid Addiction: The ASAM 2015 National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use
- Immunizations: Advisory Committee on Immunization Practices (ACIP) Vaccine Specific Recommendations
- Atypical Antipsychotic Prescribing: OhioMindsMatter Prescribing Guidelines for Psychotropic Medications

As illustrated by OhioMindsMatter, practice guidelines are at times developed through improvement activities. Currently, ODM and the Ohio Perinatal Quality Collaborative are working with pediatricians, family medicine physicians, obstetricians, and substance use treatment professionals to develop guidelines for continuity of care for the mother and infant dyad impacted by opioid use disorder.

Payer Best Practices

Payer best practices are policies and procedures that support an optimal healthcare experience for the member. They include the removal of administrative barriers to clinical best practice, as well as facilitating the use of the healthcare system and healthful behaviors by Medicaid members by ensuring network adequacy and includes a cultural humble approach that incorporates the experiences and perspectives of members and their families.

The development and integration of best payer practices requires MCEs to incorporate the perspective of members, families, communities, and providers into the provision of services. This includes creating ongoing venues for obtaining input from network providers regarding MCE policies and procedures that may hinder best clinical care (e.g., evidence-based care), as well as feedback from members, families, and communities regarding barriers to accessing services; using that input to remove barriers and design services; and incorporating feedback mechanisms to ensure that needs have been sufficiently met.

In addition, MCEs are expected to remain current on industry standards (e.g., reviewing trade journals and other literature), as well as learn from and build upon best practices from other lines of business within their parent company. This requires establishing new relationships and regular communication mechanisms with a continual focus on identifying areas that could be further improved from the perspective of members and providers. Payer best practices should also be proactively identified using science-based QI methods (e.g., Voice of the Customer, patient journeys and process maps to identify the member experience, and PDSA testing to design optimal interventions). Successful strategies to optimize member and provider experiences must be integrated into daily MCE operations and policy, rather than regulated to pilot projects or initiatives, so that there is a persistent focus on improvement.

Administrative Simplification

ODM requires MCEs to standardize and streamline requirements to reduce administrative burden for providers, by:

- Defining what constitutes an "episode of care" (i.e., one stay versus more than one stay when the member moves between levels of care).
- Standardizing some aspects of approved lengths of stay for certain services requiring prior authorization (e.g., one year for assertive community treatment, 30 days for SUD residential services).
- Developing a single method to order home monitoring devices (e.g., home blood pressure cuffs for member with high-risk hypertension and durable medical equipment).
- Standardizing prior authorization requirements for SUD residential services.
- Standardizing MCO notification of providers for submission of authorization requests to continue services that require prior authorization.
- Standardizing and specifying the type of clinical documentation required for prior authorization decision-making.
- Waiving prior authorization requirements for providers who consistently demonstrate excellence in prior authorization performance and meeting coverage criteria.

Promotion of Cultural Humility

All MCEs and MCE subcontractors are prohibited from discriminating in the delivery of services. This includes proactively identifying disparities and putting mechanisms in place (e.g., review of UM decisions) to ensure that treatment considers the individual's specific needs and is equitable regardless of member race, color, religion, gender, genetic information, sexual orientation, age, disability, national origin, military status, ancestry, health status, or need for health services. Monitoring mechanisms should be put in place for every member interaction to ensure that members are equipped with the services and supports needed to maximize their potential optimal health outcomes.

MCEs must actively participate in and support ODM's efforts to reduce health disparities, address social risk factors, and achieve health equity for all members. This requires ensuring service delivery in a culturally appropriate and effective manner to all members by promoting cultural humility at all levels of the MCE, with subcontractors, and with partner entities.

MCEs must promote cultural humility throughout the organization and with network providers while also promoting awareness of, and consciously responding to implicit bias and its impact policy and processes. MCEs are contractually required to obtain and incorporate ongoing input from members and families in the creation of initiatives to reduce disparities, and the establishment of measures and milestones by which to assess initiative success. MCEs are required to use person-centered language in all communications with individuals and members who are eligible for Medicaid services. Person-first language resources are available from national organizations, including the Centers for Disease Control and Prevention (CDC), The Arc, and the National Inclusion Project. All external, member-facing publications must be tested with members for understanding and conveyance of the intended message, as well as cultural appropriateness.

ODM requires that each MCE participate in the state's efforts to promote the delivery of services in a culturally competent manner to all members, including members with limited English proficiency (LEP), limited reading proficiency (LRP), members with disabilities, and members from diverse cultural and ethnic backgrounds, regardless of sex.

MCEs must comply with the requirements specified in Ohio Administrative Code and provider agreements for assisting members and eligible individuals with LEP. This includes free translations of marketing and member materials into non-English languages prevalent in the MCE service area. Each MCE provider directory also must include 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, individuals with visual limitations, individuals with LEP, and individuals with LRP.

MCEs must inform providers of their obligation to provide oral translation, oral interpretation, and sign language services to members. These policies must include the provider's responsibility to identify those members who may require such assistance, the process the provider is to follow in arranging for such services to be provided, and the specification of whether the MCE or the provider will be financially responsible for the costs of providing these services. Both MCEs and providers are prohibited from holding members liable for the costs of these services.

The MCEs must maintain a centralized database that includes all member primary language information, s any special communication needs (LEP, LRP, etc.) regardless of the identifying source, and the resulting provision of services are recorded. This centralized database must be readily available to MCO staff and be used in coordinating communication and services to members, including the selection of a primary care provider (PCP) who speaks the primary language of a member with LE, when such a provider is available. MCEs must share specific communication needs information with its providers (e.g., PCPs, the SPBM, and third-party administrators)], as applicable.

Upon ODM request, the MCE must provide information in this centralized database to ODM and other ODM-contracted managed care entities. 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 contractor, as well as those services reported to the contractor that were arranged by the provider).

MCEs are required to assign a staff person to coordinate, document, and assess the provision of sign language, oral interpretation, and oral translation services. Additionally, MCEs must conduct staff training sessions on subjects including disability competency, access, cultural competency and humility, person-centered care delivery approaches and independent living philosophies.

MCEs must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities.

ODM has provided specific guidance around the content of cultural competency training. ODM recommends trainings with content that helps providers identify elements of culture and privilege and explains how these elements can create bias in behaviors and/or decision-making; contributes to cultural skill development and illustrate the value of diversity; imparts cultural knowledge by helping understand the role that culture, and race/ethnicity play in the socio-psychological and economic development of diverse groups; strengthens cultural awareness by enhancing the ability to recognize cultural diversity and manage the dynamics of difference; and supports the organization’s ability to

adapt to the diversity and cultural contexts of the communities served by acquiring and institutionalizing cultural knowledge.

General Network Adequacy and Availability Standards

A foundational aspect of payer best practice is ensuring that the network of providers available is adequate to meet the needs of members. Ensuring network adequacy is essential to ensuring that members have access to all medically necessary services. ODM's contracts with MCEs require that all services be sufficient in amount, duration, and scope to be reasonably expected to achieve the purpose for which they are furnished. Additionally, the amount, duration, or scope of a required service cannot be arbitrarily denied or reduced solely because of the member's diagnosis, type of illness, or condition.

In accordance with 42 CFR 438.68, ODM has developed network adequacy standards for MCOs, the OhioRISE PIHP, and the SPBM PAHP. These standards are within ODM's provider agreements with these managed care entities and include requirements regarding sufficiency, mix and geographic distribution of providers. Standards are modified whenever ODM determines that changes have occurred in the availability of specific provider types, or in the number and composition of the eligible population.

ODM's provider agreements require all MCEs to provide or arrange for the delivery of all medically necessary, Medicaid-covered health services as described in OAC 5160-1-01 and in the glossary of this quality strategy.
MCEs must comply with provider panel access standards by considering the following: anticipated Medicaid membership; expected service usage based on a consideration of member healthcare needs; the number and types (in terms of training, experience, and specialization) of panel providers required to deliver contracted Medicaid services; the number of providers accepting new Medicaid patients; the relative geographic location and distance, as well as travel time required between panel providers and Medicaid members; and whether provider locations offer appropriate physical access for Medicaid members with disabilities.

In accordance with 438.214, ODM requires that each MCO, PIHP, and PAHP implement written policies and procedures for the selection and retention of providers that prohibit discrimination against providers serving high-risk populations or specializing in conditions that require costly treatment.

Network adequacy requirements include time and distance standards and timely appointment standards. These standards are based on anticipated Medicaid enrollment, expected service utilization, the characteristics and specific healthcare needs of Medicaid covered populations, the numbers and types of providers furnishing contracted Medicaid services, the number of network providers accepting new Medicaid patients, the geographic distance between provider locations and Medicaid member residence, the ability of network providers to ensure physical access, the ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid members with physical or mental disabilities. The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions also is considered.

Standards are modified whenever ODM determines that changes have occurred in the availability of specific provider types or in the number and composition of the eligible population.

Network Adequacy Standards are publicly available on ODMs website within ODM's provider agreements with each MCE.

Written Contracts and Medicaid Addendum.

MCOs, PIHPs, and PAHPs contracted with ODM are required to contract with network providers. 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. MCEs are prohibited from modifying the Model Medicaid Addendum except to add personalizing information such as the MCE's name.

Prior to executing a network provider contract, MCEs must submit the contract templates for ODM's review. MCEs must completely and accurately respond to ODM's questions and requests for information about network provider contracts within the timeframes established by ODM, and, upon ODM's request, must disclose to ODM all financial and other terms that apply between the MCE and any network provider.

Sole Source Contracting.

MCEs 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. If ODM approves a sole source contract, the MCE 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.

Provider Network Changes.

In addition to complying with the provider network notification requirements in OAC rule 5160-26-05 (5160 - Ohio Administrative Code | Ohio Laws), MCEs must notify ODM within one business day of becoming aware that a network provider that served 500 or more of the MCE's members in the previous 12 months failed to notify the MCE that they are no longer available to serve as a network provider.

Unless otherwise approved by ODM, when an MCE terminates a network provider that has served 500 or more of its members, ODM must be notified at least 90 days prior to the contract termination and the termination of the contract shall not take effect during the 90 calendar days after the open enrollment month ends.

Additionally, MCEs are required to notify ODM at least 90 calendar days prior to implementing any MCE-initiated changes (e.g., termination or nonrenewal of contracts, limiting contracts for a provider type or service, or reducing payment rates) 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. Unless otherwise approved by ODM, changes that could reduce the MCE's provider network by 10% or more may not take effect during the 90 calendar days after the open enrollment month ends.

Upon becoming aware of a provider-initiated hospital unit closure, MCOs must notify ODM within one business day. When a MCO is notified of a hospital termination, the MCO may request that ODM authorize an alternative notification area (other than the service area), in accordance with OAC rule 5160-26-05. Upon request, ODM will determine the authorized notification area no later than seven business days after receipt of the MCO's submission. MCOs must comply with the notification timelines outlined in OAC rule 5160-26-05.

When submitting notification to ODM about provider network changes, MCEs must include provider information, including name, provider type, address, and county where services were rendered; a copy of the termination notice, including the termination reason and the termination date; the number of members who used services from, or were assigned to, the provider in the previous 12 months; and the 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.

In addition, for hospital terminations, the MCO's notification to ODM must also include zip codes or counties of residence for members who used services in the previous 12 months; details for all PCPs and specialists affiliated with the hospital; the percent of the MCO's membership that use the terminating hospital and the percent of the MCO's membership that use the next closest network hospital; and the MCO's plan to ensure continuity of services for members in their third trimester, receiving chemotherapy, and/or receiving radiation treatment.

Notice termination of a hospital contract.

As required in OAC 5160-26-05, MCOs must submit a template for member and provider notifications to ODM along with the MCO's notification to ODM of the impending expiration, nonrenewal, or termination of a hospital's provider contract. The form and content of the member notice must be prior approved by ODM and contain an ODM designated toll-free telephone number members can call for information and assistance. The form and content of the provider notice must be prior approved by ODM. Forty-five calendar days prior to the effective date of the expiration, nonrenewal, or termination of the hospital's provider contract, the MCO shall notify in writing all members in the service area, or in an area authorized by ODM, of the impending expiration, nonrenewal, or termination of the hospital's provider contract. If the MCO receives less than forty-five calendar days' notice from the hospital provider, the MCO shall send the notice within one working day of becoming aware of the expiration, nonrenewal, or termination of the provider contract.

Notice termination of a provider contract.

When a contract for a provider is terminated, the MCO shall notify in writing all members who use or are assigned to the provider as a PCP at least forty-five calendar days prior to the effective date of the change. If the MCO receives less than 45 calendar days prior notice from the PCP, the MCO shall issue the notification within one working day of the MCO becoming aware of the expiration, nonrenewal, or termination of PCP's provider contract. The form of the notice and its content must be prior approved by ODM and must contain the PCP's name and last date the PCP is available to provide care to the MCO's members; information regarding how members can select a different PCP; and an MCO telephone number members can call for further information or assistance. ODM may also require all MCEs to notify members or providers for the expiration, nonrenewal, or termination of certain other provider contracts that may adversely impact Medicaid members.

Specific Provider Type Network Adequacy Standards

As required by 42 CFR 438.68 and 438.206, ODM has established specific standards for the following provider types: adult and pediatric primary care, women's health specialists (e.g., OB/GYNs), adult and pediatric behavioral health providers, hospitals, pharmacies, and pediatric dental. ODM's network standards encompassing other provider types can be found in Appendix B of this document and Appendix F of the Provider Agreements.

Primary Care Capacity

As required by 42 CFR 438.207, ODM requires that each enrollee have a source of primary care appropriate to his or her needs and has therefore developed strict time and distance standards (see Appendix B.

In addition to time and distance requirements, ODM determines the MCO's primary care provider (PCP) capacity for a county based on the total amount of members that the MCO's network PCPs agree to serve in that county. The PCP capacity must exceed by at least 5% the total number of members enrolled in the MCO during the preceding month in the same county.

For a PCP to count toward the minimum PCP capacity, the MCO must ensure that the PCP does not have a caseload of more than 2,000 Medicaid members for that MCO, with a maximum capacity of 2,800 across all MCOs.

To count as a pediatric primary care provider for purposes of the time and distance standards in Appendix B, the provider must maintain a general pediatric practice (e.g., a pediatric neurologist would not meet this definition unless this physician also operated a practice as a general pediatrician) and be listed as a pediatrician with the Ohio State Medical Board. In addition, half of the required number of pediatric PCPs must also be certified by the American Board of Pediatrics.

The MCO must submit specialists serving as PCPs for members needing specialized care to ODM's provider network management system as a PCP. However, specialists serving as PCPs do not count toward minimum PCP access requirements.

Dental Care Providers

ODM's MCO provider agreement sets the minimum contracting requirements for dental care providers per county. To be counted toward meeting this access standard, the dental provider must maintain a full-time practice at a site or sites located in the county and serve all ages (adults and children).

Vision Care

ODM's MCO provider agreement requires MCOs to contract with a minimum number of ophthalmologists and optometrists per county who maintain full-time practices and regularly perform routine eye exams at a site or sites located in the county. Although the MCO must contract with an adequate number of ophthalmologists as part of its provider network, only ophthalmologists who regularly perform routine eye exams can be used to meet the vision care access requirement. If optical dispensing is not sufficiently available in a county through the MCO's contracting ophthalmologists/optometrists, the MCO must separately contract with an adequate number of optical dispensers located in the county.

Women's Health Specialists

As required by 438.206, MCOs are required to ensure that female members have direct access (without referral) to a women's health specialist (e.g., obstetrician or gynecologist) for provision of women's routine and preventive healthcare services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.

MCOs must ensure access to certified nurse midwife and certified nurse practitioner services in the service area if such provider types are present within the service area. MCOs may contract directly with the certified nurse midwife or certified nurse practitioner providers, or with a physician or other provider entity that is able to obligate the participation of a certified nurse midwife or certified nurse practitioner.

If an MCO does not contract for certified nurse midwife or certified nurse practitioner services and such providers are present within the service area, the MCO must allow members to receive certified nurse midwife or certified nurse practitioner services from out-of-network providers.

To be included in ODM's provider network management system and MCO provider directories, or to counted toward the Gynecology - OB/GYN time and distance standard (see Appendix B), network certified nurse midwives, and OB/GYNs must have current hospital privileges at a hospital under contract with the MCO in the service area.

An MCO must permit members to self-refer for services and supplies allowed under Title X of the Public Health Services Act (Title X services) provided by any public or not-for-profit healthcare provider that complies with Title X guidelines/standards and receives either Title X funding or family planning funding from the Ohio Department of Health (qualified family planning providers-QFPPs). A description of Title X services is available on the Ohio Department of Health website.

MCOs must reimburse QFPPs for all Title X, medically necessary, covered services -- including on-site diagnostic services – regardless of the qualified family planning provider's network status. The MCO must work with QFPPs in the service area to develop mutually agreed upon Health Insurance Portability and Accountability Act (HIPAA) compliant policies and procedures to preserve patient/provider confidentiality and convey pertinent information to the member's PCP and/or the MCO. All family planning services must be provided in a manner that protects and enables the enrollee's freedom of choice as described in 42 CFR 441.20.

Specialty Physicians

In addition to women's health specialists, the MCO must ensure members have adequate access to other specialty physicians, such as cardiologists, gastroenterologists, gynecologists, nephrologists, obstetricians, and oncologists. The MCO must comply with ODM's time and distance standards for each specialist type. For a complete list of specialty physician types and corresponding time and distance standards, please see Appendix B. To comply with the applicable time and distance standard, the specialty physician must maintain a full-time practice at site(s) within the service area and be available to patients for at least 25 hours a week.

Hospital Services

The MCO must comply with the time and distance standards for hospitals. ODM monitors the time and distance as well as the type of hospitals (general hospital, hospital system, inpatient psychiatric hospital) MCOs contract with in each of Ohio's 88 counties. To meet these access requirements, the MCO might have to contract with an hospital located in a state bordering Ohio. If a hospital in the MCO's network elects not to provide specific covered services because of an objection on moral or religious grounds, the MCO must ensure these hospital services are available to its members through another network hospital in the service area.

According to 5160-2-02, MCOs must cover outpatient services provided within three calendar days prior to the date of admission as inpatient services. This includes emergency room and observation services.

General Acute Care Hospitals

The OhioRISE plan must contract with at least the minimum number of general acute care hospitals with psychiatric beds per county specified in Appendix B or arrange for a special/single case agreement for hospital admissions. To meet these requirements, the OhioRISE plan may contract with a hospital located in a state bordering Ohio if necessary.

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.

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 service area.

Pharmacy Services Network Adequacy

Consistent with OAC rule 5160-26-01, the statewide SPBM selected under ORC section 5167.24 is responsible for providing and managing pharmacy benefits for all Medicaid-enrolled managed care individuals. The SPBM is required to contract with all ODM-enrolled pharmacies that are active in the ODM provider network management system.

Apart from physician administered drugs, all other pharmacy services and benefits are covered by ODM's SPBM. Physician administered drugs for the treatment of medical conditions are covered by the MCO. Physician administered drugs for the treatment of mental health and SUD conditions are covered by the OhioRISE plan.

The MCOs and the OhioRISE plan must coordinate and collaborate with the SPBM as necessary to ensure that members receive medically necessary pharmacy services. As a value-added service, an MCO may provide members debit cards to purchase over-the-counter medications not covered by the Ohio Medicaid program.

MCOs must analyze prescription drug utilization data and/or reports provided by the SPBM or ODM to identify members who would benefit from the MCO's coordinated services program (CSP). The MCO must notify the SPBM of members who are enrolled in the MCO's CSP. The MCO must offer care coordination to any member who is enrolled in the CSP.

Compounding.

When medically necessary, the SPBM PAHP is required to provide or arrange for compounding service and/or same-day home delivery.

Specialty Pharmacies.

The SPBM network must include sufficient pharmacies to provide adequate access to specialty drugs for all eligible members. The network must include specialty pharmacies that are not owned or operated by the SPBM. The SPBM must accept into its pharmacy network any specialty pharmacy that meets ODM's standards and agrees to the rates established by ODM. ODM prohibits the SPBM from requiring a member to obtain a specialty drug from a specialty pharmacy owned or otherwise associated with the SPBM.

Behavioral Health Network Adequacy

Child and Adolescent Needs and Strengths Providers.

The OhioRISE plan must contract with all 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.

For CANS providers identified by ODM after the effective date of the initial ODM-OhioRISE contract 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.

Providers of Mobile Response and Stabilization Services.

The OhioRISE plan must contract with all providers identified by ODM as eligible to provide Mobile Response and Stabilization Services (MRSS), 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 MRSS provider and must collaborate with ODM on next steps.

For MRSS 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 an MRSS provider in ODM's provider network management system.

MCO Contracts with CANS and MRSS providers.

Each MCO is required to contract with behavioral healthcare providers serving the OhioRISE population in the MCO's service area. These include providers identified by ODM as eligible to complete the initial Child and Adolescent Needs and Strengths assessments which determine eligibility for OhioRISE enrollment (CANS providers), and providers identified as eligible to provide Mobile Response and Stabilization Services (MRSS).

An MCO must notify ODM if it is unwilling to contract with a particular CANS or MRSS provider and must collaborate with ODM on next steps. For CANS and MRSS providers identified by ODM after the effective date of the MCO Provider Agreement, the MCO must contract with the identified provider within 90 calendar days from the provider being identified in ODM's provider network management system. The MCO must monitor CANS and MRSS providers for compliance with ODM standards and guidance, and, as directed by ODM, must coordinate monitoring activities with other MCOs and the OhioRISE plan.

Opioid Treatment Programs.

ODM's MCO provider agreement requires MCOs to contract with at least the minimum number of Medication Assisted Treatment (MAT) prescribers per county, including all willing Opioid Treatment Programs (OTPs) licensed by OMHAS and certified by the United States Substance Abuse and Mental Health Services Administration (SAMHSA). The MCO must report any additional providers prescribing MAT not previously identified by ODM in the format and frequency specified by ODM.

The OhioRISE plan must also contract with all willing 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.

General and Child/Adolescent Psychiatrists and Psychiatric Advanced Practice Registered Nurses (APRN).

In the first year of operations , the OhioRISE plan must initially develop and implement a process for identifying the number and geographic location (by county) of general and child/adolescent psychiatrists and psychiatric APRN throughout the state that will initially participate in the OhioRISE plan's provide network. In the first year, the OhioRISE vendor will contract as necessary with all known general and child/adolescent psychiatrists to meet the needs of its members.

At the end of January of the initial contracting year , the OhioRISE plan will submit a Report on the Number and Geographic Location of General and Child and Adolescent Psychiatrists and Psychiatric APRNs. Based on this report ODM will establish time and distance standards for these practitioners for subsequent years.

Other Behavioral Health Providers and Services.

An MCO is also required to contract with several other types of behavioral healthcare providers in the MCO's service area unless there are documented instances of quality concerns. These providers include: Behavioral Healthcare Coordination Entities (BHCCEs), Ohio Department of Mental Health and Addiction Services- (OMHAS)-certified community mental health services providers (CMHSPs), OMHAS-certified substance use disorder treatment providers, Medication Assisted Treatment (MAT) prescribers.

If an MCO is unwilling to contract with a particular BHCCE provider, the MCO must notify ODM and must collaborate with ODM on next steps. If a BHCCE is identified by ODM after the effective date of the MCO Provider Agreement, the MCO must contract with the identified provider no later than 90 calendar days from the provider being identified as a BHCCE in ODM's provider network management system. MCOs must monitor BHCCEs for compliance with ODM standards and guidance using an ODM-specified, standardized protocol.

Community mental health services providers and OMHAS-certified substance use disorder treatment providers count toward the time and distance standard for Behavioral Health, Pediatric Behavioral Health, SUD-Outpatient, and SUD-Residential.

The OhioRISE plan must also contract with community mental 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 mental health services.

MCOs and the OhioRISE PIHP are also required to contract with a minimum number of other behavioral health providers, including independent marriage and family therapists, licensed independent chemical dependency counselors, licensed independent social workers, psychologists, etc., who provide services outside of community mental health services providers or OMHAS-certified substance use disorder treatment providers.

A full list of behavioral health provider and service standards can be found in Appendix B.

LTSS

The MyCare Ohio MCOs must demonstrate adequate Provider Network sufficient in number, mix, and geographic distribution, to ensure adequate access to medical, behavioral health, pharmacy, and LTSS Providers that are appropriate for and proficient in addressing the needs of the enrolled population, including physical, communication, and geographic access. MyCare Ohio MCOs must contract with at least the minimum number of LTSS providers as shown in Appendix B.

Second opinions from qualified healthcare professionals

In accordance with 42 CFR 438.206 and OAC 5160-26-08.3 (https://codes.ohio.gov/oac/5160), MCEs must allow for a second opinion from a qualified healthcare professional within or outside of the panel, as appropriate, when requested by a member. If such a qualified healthcare professional is not available within the MCE's panel, the MCE must arrange for the member to obtain a second opinion outside the panel, at no cost to the member.

Augmenting Service Availability and Capacity

Telehealth.

To augment access and availability, ODM requires the contracted MCOs and the OhioRISE plan to offer, promote, support, and expand the appropriate and effective use of telehealth. This includes:

- Educating members and providers about the availability of telehealth, considerations for using telehealth versus in-person visits, applicable requirements, and how to access telehealth options.
- Ensuring that telehealth does not replace provider choice or member preference for in-person service delivery.
- Considering telehealth as an alternative to meeting provider network access requirements.
- Supporting providers in offering telehealth, including providing "how to" guides on the technical requirements, workflows, and coding and billing.
- Ensuring that providers comply with state requirements regarding telehealth (e.g., OAC rule 5160-1-18).

Each MCE is required to submit an annual telehealth report (Telehealth Report) to ODM that includes the MCE's goals for telehealth and progress on meeting those goals, including performance measures; barriers to increased use of telehealth and the strategies to overcome those barriers; telehealth utilization, including any changes from the previous year; the MCE's activities to support increased use of telehealth, including any provider partnerships; and information regarding whether telehealth is improving access to needed services and/or helping make access more equitable.

Workforce Development. The MCOs must work with ODM, ODM-contracted managed care entities, and other stakeholders to develop and implement workforce development initiatives designed to support provider network adequacy and access. For MCOs, this includes providing qualified staff to actively participate in meetings; conducting and sharing a workforce analysis if requested by ODM; providing input to prioritize areas for workforce development; assisting with developing workforce development strategies; and implementing identified workforce strategies.

The OhioRISE plan must additionally develop and implement initiatives that will assist providers in identifying and recruiting staff for key supervisory and direct service positions; create opportunities for network providers to locate formal and informal supports for OhioRISE members with unique services and support needs; partner with providers to develop and implement innovative approaches to workforce and network development, including new service and payment strategies; and assisting ODM and state and local child-serving agencies with developing and implementing workforce development strategies, as specified by ODM.

Contracting with ODM-Enrolled Providers

In accordance with 42 CFR 438.608, MCEs must contract only with providers that are enrolled with ODM and are active providers in ODM's provider network management system. Prior to contracting with a provider or listing the provider as a network provider, the MCE must validate that the provider is active in ODM's provider network management system and enrolled for the applicable service and/or specialty. If a provider is not active in ODM's provider network management system, the MCE must direct the provider to ODM's portal to submit an application for screening, enrollment, and credentialing prior to contracting.

Unless otherwise approved by ODM, the SPBM must contract with all ODM-enrolled pharmacies that are active in ODM's provider network management system and agree to the rates established by ODM.

In the format and frequency specified by ODM, MCEs must reconcile their provider networks and ODM's provider network management system to ensure that network providers remain active in ODM's provider network management system.

Out-of-Network Providers

Adequate and timely coverage State and Federal requirements (42 CFR 438.206, OAC rule 5160-26-03, 5160-26-05) specify that if a MCO, PIHP, or PAHP is unable to provide medically necessary covered services to a member in a timely manner through its provider network, the MCE must adequately and timely cover these services by an out-of-network provider until accommodated by the MCO provider network.

If the out-of-network provider is not an active provider in ODM's provider network management system, the MCE 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.

MCOs are required to share information with out-of-network providers to assist members in accessing medically necessary, Medicaid-covered services. This information sharing is intended to assist non-panel providers in recognizing MCO membership, accessing information needed to provide services and, if applicable, successfully submitting claims to the MCO.

Coordinating with out-of-network providers with respect to payment. MCEs 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. In accordance with 42 CFR 438.114 and OAC rule 5160-59-03, the MCE must reimburse out-of-network providers either billed charges or 100% of the current Medicaid FFS rate, whichever is less.

MCEs must establish processes and procedures for the submission of claims for services delivered by out-of-network providers, including non-contracting providers of emergency services. Such information must be made available upon request to non-contracting providers, including non-contracting providers of emergency services. OAC 5160-26-03 and 5160-59-03 (ohio.codes.gov/oac/5160) prohibit establishing claims filing and processing procedures for non-contracting providers that are more stringent than those established for their contracting providers.

MCEs 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.

ODM requires all MCEs to direct all out-of-network providers who are not active providers in ODM's provider network management system to apply via the ODM portal. 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 MCE 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.

Centralized Credentialing

If credentialing is required for a specific provider type, MCEs must only use providers credentialed or approved as indicated in ODM's provider network management system. The MCE must accept ODM's credentialing status and must not request any additional credentialing or re-credentialing information

from an ODM-enrolled provider. The MCE must not credential or re-credential any ODM-enrolled providers, including provider types that are not credentialed by ODM.

MCEs must coordinate and cooperate with ODM in the credentialing and re-credentialing of network providers by providing requested demographic and business information, as well findings from the MCE's ongoing monitoring.

Timely Access to Care and Services

As required by 42 CFR 438.206, ODM's provider agreements with the MCEs require them to ensure timely access to covered services. Standards for timely access to care and services are set forth in OAC rules and include the following: immediate treatment and triage of members with emergency care needs when they first come to their primary care provider; treatment of members with persistent symptoms before the end of the following working day after their initial contact with their primary care provider; meeting requests for routine care within six weeks of the request; processing service authorization requests within fourteen calendar days of receiving the request; and authorizing emergency-prescribed outpatient drugs within seventy-two hours.

MCEs are required to provide assurance that their contracted provider hours are comparable with Medicaid FFS or commercial services and that timely access is assured through the provision of service availability 24 hours, seven days a week, when medically necessary. MCEs are required to establish mechanisms to ensure that panel providers comply with timely access requirements.

Appointment Availability Standards

MCEs are required to ensure the availability of medical, behavioral health, and dental care appointments based on a set of minimum standards for each visit type.[ix] Each MCE is required to disseminate the appointment standards to network providers and educate network providers about them. Each MCE must have and implement policies and procedures for triage to assist MCE 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 MCE's triage process must be transparent and compliant with Mental Health Parity and Addiction Equity Act (MHPAEA).
Appointment Availability Standards for MCOs and the OhioRISE plan can be found in the respective provider agreements with these MCEs.

Specialized Services and Resources as a Population Health Approach

The provision of specialized services and resources is also used to improve population health. MCEs are required to provide services and resources tailored by population, community, and risk along the care continuum from low to high risk. MCEs must also identify community services and resources that can be offered to members and build working relationships with community organizations to refer to and support provision of those services.

To this end, MCEs must contribute to the Managed Care Population Health Strategy by providing descriptions of specialized services and other resources (e.g., health and wellness programs, 24/7 medical advice line, care coordination) provided for each population stream tailored to risk level and communities. This strategic approach is interwoven with MCE efforts to promote optimal delivery systems and health equity. The provision of specialized services and resources and is supported by MCE

care coordination, quality improvement, and community reinvestment approaches to improving population health.

Efforts to provide specialized services and resources must be coordinated across MCEs. For example, 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.

Members with Disabilities or Special Healthcare Needs

> ODM defines persons with special healthcare needs as individuals who require health and related services of a type or amount beyond that required by individuals generally due to being at increased risk for chronic, physical, developmental, behavioral, or emotional conditions.
>
> ODM defines disability status as a qualifier for Medicaid based on disability. This information is included in the Medicaid enrollee files.

MCOs are responsible for ensuring that plan-specific mechanisms are implemented for identifying, assessing, and developing care plans for individuals with special healthcare needs. This includes ensuring that individuals have direct access to specialists as required by 42 CFR 438.208.

MCOs are required to share relevant information regarding individuals with special healthcare needs with other MCEs (e.g., OhioRISE plan, SPBM) as needed to meet the individual's needs. The SPBM must use information about members with special healthcare needs when processing prior authorizations for those individuals and when including these individuals in any clinical programs

When transitioning members to ODM and/or ODM-contracted managed care entities, the MCO is responsible for providing the pertinent information related to the special needs of transitioning members to ODM and/or ODM-contracted managed care entities.

ODM requires each MCE to have internal mechanisms in place (e.g., utilization analysis, satisfaction surveys, analyses of grievance and appeal data) to assess the quality and appropriateness of care, including that provided to individuals with special healthcare needs and individuals needing long term services and supports. Individuals with special healthcare needs are those individuals who either have, or are at increased risk for having, chronic, physical, developmental, behavioral, or emotional conditions that require health and related services of a type or amount beyond that required by individuals generally. In accordance with 42 CFR 438.206(c)(3), all MCEs must provide assurance that the MCE, its subcontractors, and network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities.

Each contracted MCE must provide detail regarding the methods to identify individuals with special healthcare needs and assessment of the quality and appropriateness of the services they receive. This information is provided as part of each MCE's annual QAPI submission to ODM, as is the MCE's approach to identifying and reducing health disparities.

Specialized Services for High-Risk Populations

High risk populations include but are not limited to women who are at risk of a preterm birth, members involved with the justice system, members undergoing treatment for addiction, and children and youth

with special healthcare needs. MCOs must provide or arrange for specialized (or non-traditional) services to be delivered via different models in the community (e.g., home visiting, centering, community hub, community workers) as appropriate for high-risk populations identified by the MCO, or as required by ODM. The OhioRISE plan must ensure that care coordination efforts through the OhioRISE plan and CMES work in concert with the MCO-identified or ODM-required specialized services and resources.

The MCO must assess and enhance specialized programming for each group identified by the MCO's Population Health Management Strategy using continuous QI principles.

The MCO must ensure that all services provided to high risk or special populations align with the associated ODM guidance documents for those populations. The MCO is responsible for ensuring that the community services meet health equity expectations, the member's needs, honor member preference, and do not duplicate other services paid for by the MCO or ODM.

Examples of specialized services provided to high-risk populations are provided below.

Women at Risk of Preterm Birth

MCOs must prioritize and provide enhanced care to women of reproductive age living in areas of the state with the highest degree of racial disparity in birth outcomes. Women in these communities must receive extra attention to ensure that they are continuously enrolled in Medicaid during pregnancy and the postpartum period; that adolescent females are connected to primary care and are receiving annual well visits; that there are ongoing assessments of needs and related barriers (including SDOH needs) and timely addressing of needs; and conduct ongoing monitoring and check-ins with women of reproductive age who are between pregnancies to ensure that mother and children are remaining connected to needed services and supports.

Members who are pregnant or capable of becoming pregnant who reside in a community served by a qualified community hub, as defined in ORC section 5167.173(A)(5), may also be recommended to receive HUB pathway services (by a physician, advance practice registered nurse, physician assistant, public health nurse, or another licensed health professional specified by the MCO or ODM).

For those members, the MCO must provide for the delivery of the following services provided by a certified community health worker or public health nurse, who is employed by, or works under contract with, a qualified community hub:

- Community health worker services or services provided by a public health nurse to promote the member's healthy pregnancy; and
- Care coordination performed for the purpose of ensuring that the member is linked to employment and educational/training services, housing, educational services, social services, or medically necessary physical and behavioral health services.

Members Involved with the Justice System

In 2013, the Ohio Department of Medicaid (ODM), the Ohio Department of Rehabilitation and Correction (ODRC), and other state agencies began developing plans for Ohio's Medicaid Pre-Release Enrollment Program (MPRE).[x] These agencies built on the state's collaborative work on RoMPIR (Reinstatement of Medicaid for Public Institution Recipients), a system established to suspend Medicaid enrollment when people are incarcerated and to reinstate benefits when incarcerated people receive inpatient hospital services or are released from incarceration.

The Medicaid enrollment and plan selection process for people leaving prison consists of three main steps. First, a pre-enrollment class run by peers provides people with the information necessary to understand whether they want to enroll in Medicaid and, if so, how to select from among the five available managed care plans. Potential enrollees attend the pre-enrollment class approximately 90 days before their release. Second, approximately two to three days after the pre-enrollment class, individuals attend an enrollment class, during which they fill out the necessary forms to facilitate eligibility and enrollment in Medicaid and select a managed care plan. Finally, people identified by ODRC as "critical risk"—that is, having a serious need for ongoing healthcare services to manage chronic conditions—participate in a videoconference with their MCO before release. ODM's contract with each MCO requires them to participate in these videoconferences and to follow up promptly with those identified as critical risk after they are released.

Medicaid expansion has served as a key impetus for re-entry efforts. It significantly increased opportunities to provide coverage to individuals moving into and out of incarceration and to connect individuals to services to address their health and recovery needs as they transition back into the community. Re-entry initiatives are a key component of broad statewide strategies to address the opioid epidemic given the high rates of SUD among the justice-involved population and the elevated risk of death upon release into the community.

During the 2020 COVID-19 pandemic, the five Medicaid MCOs collaborated to reduce risk of COVID-19 spread when individuals returned to their communities following a correctional stay. The collaborated to provide face masks, hand sanitizer, referral resources, and basic hygiene items for individuals returning to the community, they also tested providing cellular phones, and incentivized connections to care coordination for individuals with critical care needs.

Members Undergoing Substance Use Disorder Treatment

The MCOs and the OhioRISE plan are required to work with ODM in implementing the 1115 SUD demonstration waiver to provide services to members with an SUD diagnosis. Additional work will include developing utilization management strategies, increasing care coordination efforts, and monitoring network adequacy. The OhioRISE plan will assist in developing and integrating these activities so that they align with system of care principles and child and family-centered practice.

The MCOs and the OhioRISE plan are required to use American Society of Addiction Medicine (ASAM) level of care criteria when reviewing level of care for substance use disorder treatment provided in a community behavioral health center. When making medical necessity determinations for inpatient services for co-occurring physical health conditions, other clinical criteria (e.g., MCG® or InterQual®) in addition to ASAM criteria must be used and services must be authorized when either ASAM or MCG®/InterQual® indicate the need for inpatient services.

MCOs and the OhioRISE plan must ensure that all health plan reviewers, medical directors, peer advisors, clinical directors, and clinicians involved in conducting reconsiderations of SUD treatment service authorization denials are trained annually in the use of ASAM criteria and complete competency and inter-rater reliability testing to ensure consistent application of criteria.

All medical directors, peer advisors, clinical directors, and clinicians that have a role in the denials or reconsiderations of SUD treatment must have documented SUD and ASAM experience. At least one employed or contracted board-certified addiction medicine physician must be available for consultation with health plan staff.

Upon medical necessity review and in accordance with ASAM criteria, if a needed level of care for SUD treatment is not available, the health 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 health plan must authorize level 4.0 until access to level 3.7 withdrawal management can be assured.

Health plans must have processes in place, including the use of QI methods, provider development assistance, and corrective action plans to address providers not complying with ASAM criteria or otherwise evidencing patterns of high denial or other authorization process issues for SUD treatment services.

Children and Youth with Special Healthcare Needs (CYSHCN)

Children and youth with special healthcare needs (CYSHCN) are those who "have or are at increased risk for chronic physical, developmental, behavioral or emotional conditions and also require health and related services of a type or amount beyond that required by children generally".[xi] CYSHCN are a diverse group that includes children with medically complex health issues and children with behavioral or emotional issues. As with adults with special healthcare needs, children and youth with special healthcare needs are identified through referrals, care coordination, and utilization analyses. An estimated 22% (391,301) of Ohio children and youth under the age 21 who are enrolled in Medicaid have a special healthcare need. CYSHCN and their families often need services from multiple systems - healthcare, public health, education, mental health, and social services.

The Ohio Department of Health's evaluation of Title V identified the need to increase and improve services that promote and support transition to adulthood healthcare throughout adolescence. Through the design and implementation of OhioRISE, ODM is helping to meet the resulting priority of increasing prevalence of children and youth with special healthcare needs (CYSHCN) receiving integrated physical, behavioral, developmental, and mental health services.

With extensive stakeholder engagement, ODM learned that in addition to intensive and moderate care coordination services provided by care management entities, children and youth involved in multiple systems need Mobile Response and Stabilization Services (MRSS), Intensive Home-Based Treatment (IHBT), inpatient behavioral health services, psychiatric residential treatment facilities (PRTF), SUD services, psychiatry services, and other behavioral health services to be healthy and successful in their lives and communities.

To build capacity in these areas, the OhioRISE plan was designed to assist providers in identifying and recruiting staff for key supervisory and direct service positions; create opportunities for network providers to locate formal and informal supports for members with unique service and support needs; and partner with providers to develop and implement innovative approaches to workforce and network development including new service and payment strategies.

Centers of Excellence (COEs) are being established that support the development of evidence-based practices and services, ongoing fidelity reviews, and workforce development. The COEs work in collaboration with OMHAS, ODJFS, ODM, DYS, DODD, DOH, and OFCF to build and sustain a comprehensive standardized assessment process, effective services, and care coordination approaches for children with complex behavioral health needs and their families. The COEs also assist the State in system transformation efforts by providing the orientation, training, coaching, mentoring, and other

functions/supports needed by the provider network in order to build and sustain capacity in delivering evidence-based practices to fidelity within a system of care framework; and prevention and support services funded through the Medicaid program, as well as other child-serving agencies.

MCE efforts to promote clinical and payer best practices may be informed by monitoring of under and over utilization of services.

Quality Improvement (QI) as a Population Health Approach

MCOs, OhioRISE, and the statewide SPBM are all required to implement an ongoing, comprehensive QI program in accordance with the requirements for quality assessment and performance improvement (QAPI) programs in 42 CFR 438.330. MCEs must provide their QI strategy, structure, execution, and evaluation of its QI program to ODM as part of the annual QAPI submission.

ODM requires that MCE QI programs employ a deliberate and defined, science-informed approach that is responsive to member and provider needs and incorporates systematic methods for discovering reliable approaches to improving population health and reducing health disparities. MCE QI programs must be integrated throughout the organization such that ideas for improvement can originate and be acted upon at any employee level and in any programmatic area.

As part of its annual QAPI submission, the MCO, the OhioRISE plan, and the SPBM must establish a clearly delineated, outcomes driven QI strategy that is clearly linked to ODM's mission and vision and population health goals. The content of the QAPI feeds into the overall population health strategy, which is overseen by ODM and coordinated by the MCO.

The QI strategy within the QAPI must include: a description of the MCE's QI program structure and accountability, including administrative oversight; the MCE's strategy for building and maintaining QI capacity within the organization; the MCE's clinical and non-clinical improvement projects, including the designated performance improvement project (PIP); the MCE's strategy for communicating the results of QI initiatives throughout the organization and to ODM. The annual QAPI submission must also include an evaluation of the MCE's previous QI strategy and programmatic activities, as well as how that evaluation has contributed to refinements in the current QI strategy. Each of these is described in more detail below.

QI Program Structure and Accountability

As a population health management approach, MCEs must ensure that organizational leadership and staffing resources are sufficient to support the MCE's QI efforts. To that end, MCE oversight of its QI program must include the assignment of an ODM-approved, senior QI leadership team responsible for the QI program (e.g., QI Director, Medical Director). In addition, each MCE must ensure that the Medical Director/Chief Medical Officer (CMO) is involved and provides oversight for improvement projects with a clinical component. The lead member of the senior QI leadership team must report directly to the MCO's CEO. All MCE QI projects must have sponsorship by a senior leadership team member who is responsible for ensuring that the project is adequately staffed and resourced to achieve and sustain improvement. The project sponsor must also ensure that issues are identified and elevated on a timely basis, and that learning is effectively shared throughout the organization.

QI Capacity Development

MCEs must ensure that staff at all levels of the organization are fully equipped and committed to improving health outcomes, including:

- Providing multiple opportunities for staff training and repeated hands-on application of ODM-approved, QI science tools, methods, and principles and
- engaging and empowering 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.

To create an organizational foundation with the necessary QI skills and proficiencies, MCEs must ensure that the MCE's director-level leadership (e.g., medical director, population health director), analytic support staff, and at least one MCE staff person assigned to each improvement team have completed training that includes:

- the model for improvement (MFI) developed by the Associates in Process Improvement and popularized by the Institute for Healthcare Improvement (IHI);[xii]
- the Deming System of Profound Knowledge® (SoPK);
- listening to and incorporating information and feedback from members, providers, and other stakeholders;
- process mapping;
- SMART Aim development and the use of key driver diagrams for building testable hypotheses;[xiii]
- methods for barrier identification and intervention selection (e.g., root cause analyses, Pareto charts, failure mode and effects analysis, and the five whys technique);
- selection and use of process, outcome, and balancing measures;
- active and frequent application of rapid cycle, QI tools and methods (i.e., use of Plan-Do-Study-Act cycles and ramps) to facilitate learning;
- the use and interpretation of statistical process control charts, such as the Shewhart control chart; and
- tools for sustaining and spreading effective interventions.

Each MCE must document its ongoing efforts to build QI expertise and capacity in the QAPI submission to ODM.

MCEs must ensure that during and after quality improvement training, staff are building QI capacity through active involvement as QI team members in at least one improvement project.

Clinical and Non-Clinical Improvement Projects

ODM requires that MCEs collaborate in the design and conduct of improvement projects in clinical and non-clinical topic areas that improve population health (including health equity) across the care continuum. All improvement projects must aim to achieve significant and sustained improvement over time in population health outcomes, quality of life, and provider/member satisfaction.

MCEs must self-initiate improvement projects, as well as conduct improvement projects that ODM requires. ODM-required improvement projects may include projects in coordination with other ODM-contracted managed care entities (e.g., improvement of medication reconciliation by clinics and hospitals, medication adherence, safety, and quality), as well as the formal performance improvement projects required by 42 CFR 438.330 that are validated by ODM's external quality review organization in accordance with 42 CFR 438.338.

ODM requires MCEs to effectively use data throughout the improvement process. This includes proactively identifying improvement opportunities, stratifying data to identify disparities, using data to tailor interventions to specific populations, and longitudinally monitoring project progress and sustainability.

In conducting improvement projects, MCEs must actively incorporate member and provider perspectives into improvement activities to determine where to focus efforts, and how to design effective interventions.

MCEs must share knowledge gained from successful and unsuccessful intervention testing within improvement projects, as well as project outcomes, across MCOs and with ODM to improve population health planning statewide.

ODM-Required Improvement Projects.

The topic choice for ODM-required improvement projects is tied to the state quality strategy and focuses on one of the population health streams (women and infant health, adults and children with chronic conditions, adults and children with behavioral health needs, healthy children and healthy adults). Topics addressing population disparities in healthcare access, healthcare delivery, and health outcomes are prioritized. Many of these projects involve active collaboration with other state agencies (e.g., ODH, MHAS), state quality collaborative groups (e.g., OPQC), and clinical practice sites.

Performance Improvement Projects.

Each year, one ODM-required improvement project is used as the EQRO validated Performance Improvement Project (PIP). Other improvement initiatives are referred to more generally as Quality Improvement projects (QIPs). The most recent ODM-initiated PIPs have focused on chronic conditions. From 2017 to 2019, the PIP was reduction in racial disparities in Hypertension Control. For 2020 and 2021, the PIP was Diabetes Control. Both MyCare Ohio Plans and Medicaid MCOs focused on these topics. Overviews of these PIPs are provided below.

Hypertension Control Improvement Project.

In 2017, ODM received permission to align MCOs and MCOPs in the use of quality improvement science-based approaches to impact health outcomes. ODM launched the hypertension improvement project in December 2107. This project was the federally required PIP for the Medicaid MCOS in calendar years 2018 and 2019 and transitioned to a QIP in 2020.

During this same time period, the project also served as a QIP for the MyCare Ohio plans. The effort differed significantly from the MyCare Chronic Condition Improvement Project in that it focused on reducing disparities, utilized frequent data collection via clinical electronic health records (EHRs), required collaboration with participating practices and other MCOs, and used quality improvement science tools and methods to more rapidly determine needed adaptions in order to quickly spread successful interventions.

The Hypertension Control Improvement Project's aims emphasized the need to reduce disparities by setting a goal of improving the control of hypertension by 15% in the overall study population and 20% in the African American population. The effort involved spreading clinical best practices shown to be effective in controlling hypertension and reducing disparities. The project's clinical interventions included: accurate blood pressure measurement timely follow-up for high blood pressure and adherence to a medication treatment algorithm. Payer-interventions included facilitating timely follow-up visits with providers coverage of 90-day prescriptions, partnering with community entities such as churches and YMCAs, and facilitation of home blood pressure monitoring. Partner practice sites were selected in part for strong representation of African American patients (approximately 40% of the total study patient population).

Wave 1 of the Hypertension Improvement Project began in December 2017 and concluded in December 2019. The project resulted in an improvement in blood pressure control of 15.7% among all participating Medicaid-insured patients, but only improved by 10.6% for non-Hispanic Black Medicaid-insured patients. This continued disparity pointed to the need for interventions to be tailored to the populations with poorest outcomes in order to achieve reductions in disparities.

Wave 2 of the project began with several new clinical sites in May 2019 and concluded in March 2021. It followed the same design as Wave 1, but incorporated lessons learned, including the strength of MCOs working collaboratively on interventions with common process measures. Wave 2 of the Hypertension Improvement Project was challenged by the COVID-19 pandemic which impacted healthcare provision and access. However, participating clinical practices and MCOs continued the work with adjustments to service delivery modes (e.g., incorporation of telehealth visits).

Diabetes Performance Improvement Project.

The Diabetes Performance Improvement Project entered its active phase in May 2020, becoming the EQRO validated PIP for 2020 and 2021. The Diabetes Improvement Project is similar in design to the Hypertension Improvement in being a collaborative project of Ohio Medicaid and MyCare MCOs and a selected group of 22 clinical practices working together to determine clinical and payer best practices to improve diabetes control among participating patients.

The project's SMART Aims emphasize the need to reduce disparities by setting a goal of reducing poor control of diabetes (HbA1c measures >9%) by 15% for the overall population and by 20% for the Hispanic and non-Hispanic Black populations. The project's clinical interventions include optimization of medication regimens across conditions, standardized office practices, and screening and integration of behavioral health services within primary care. Collaborative clinical-payer interventions include diabetes self-management education (DSME); consistent access to medication, supplies, and/or equipment; and screening for social needs and linkage to

community resources. Payer interventions have focus on the provision of MCO services to support clinical interventions; expanding MCO coverage of DSME; addressing barriers of members using or attempting to access DSME services, including assistance with transportation; and partnering with community HUBs to provide coordinated care to individuals with diabetes.

Future Performance Improvement Projects will involve the newly contracted OhioRISE plan and the statewide SPBM. Improvement topics may therefore include behavioral health among children and prescribing patterns, such as atypical antipsychotic prescribing for children.

QI Communication Strategy

Effective QI activities require collaboration among the MCEs and with ODM. This includes openly communicating the results of successful and unsuccessful QI efforts, internally and externally, to foster a culture of innovation.

MCEs must develop and use a clearly defined communication strategy for QI activities that includes:

- Mechanisms for data receipt and exchange, analyzing and interpreting data, and transparently and proactively involving stakeholders and partners in applying data to inform improvement efforts.
- A description, including lines and methods of communication, of the internal mechanisms used to frequently, transparently, and proactively communicate improvement status updates across the organization, to executive leadership, and to ODM. Status updates must include lessons learned from intervention testing, advances to the theory of knowledge, and progress on process and outcome measures.
- Mechanisms for proactive, regular communication with ODM and EQRO staff regarding improvement opportunities and priorities, intervention successes, lessons learned, and future activities.
- Mechanisms and standards for responding promptly and transparently to data and information requests by ODM or the EQRO.

The MCE QI Communication Strategy is a component of the annual QAPI submission.

Quality Measures

ODM uses the quality measures and standards (see section 1, part D above) to evaluate MCO performance in key program areas (e.g., access, clinical quality, member satisfaction). As demonstrated in Section 1, Introduction, the selected measures align with specific priorities, goals, and/or focus areas of ODM's quality strategy. Most measures have one or more minimum performance standards (MPS). The MPS is used to determine sanctions for noncompliance. Most measures used for performance evaluation derive from national measurement sets (e.g., Health Care Effectiveness Data and Information Set [HEDIS], Agency for Healthcare Research and Quality [AHRQ]), widely used for evaluation of Medicaid and/or managed care industry data.

ODM-developed measures are used to measure the MCO's performance specific to the Ohio Medicaid managed care program's service delivery system. For those measures, the MCO must collect and report valid and reliable data in accordance with associated measure specifications, as well as technical

guidance and instructions provided by ODM or ODM's External Quality Review Organization conducting validation activities.

In accordance with 42 CFR 438.340, measure performance is publicly available in the annual HEDIS report.[xiv] A subset of measures is also published annually on ODM's website in the form of a Report Card. The Report Card and the full methodology are available on the Ohio Department of Medicaid's website. More detail on the Report Card can be found in Section 3, Monitoring and Evaluation.

Care Coordination as a Population Health Approach

MCO care coordination programs must identify and address physical, behavioral, and psychosocial needs of members and support member goals and choices through a person-centered, trauma-informed, and culturally attuned approach. MCO care coordination programs must also provide care continuity while honoring member experience and choice; preserving existing care relationships between members and local care coordination entities (CCEs); and developing and supporting partnerships that leverage the strengths of CCEs, the OhioRISE plan, and CMEs.

Additionally, as required by 42 CFR 438.208, each MCO's care coordination program must establish clear communication and delineation of roles and responsibilities between the MCO and other entities that are responsible for, or are contributing to, the coordination of services to eliminate duplication and gaps in services. Each MCO is required to ensure members can access care coordination and medically necessary services when needed.

An MCO may delegate any care coordination activity to a CCE in accordance with subcontracting and delegation requirements. If the MCO does not enter a delegated arrangement with the CCE, while the MCO is not required to monitor and oversee the CCE, the MCO is expected to maintain a collaborative relationship and coordinate care with the CCE to meet member needs.

To illustrate that the MCO's care coordination program meets these requirements and supports the overall population health and quality strategy, each MCO must submit a written description of the program for ODM's approval prior to implementation. Following initial approval, the MCO must submit any changes to its care coordination program to ODM for approval prior to implementation.

Each MCO is required to develop a care coordination program that honors individual care preferences while supporting and enhancing partnerships with other entities that contribute to care coordination (e.g., OhioRISE plan, SPBM, comprehensive care practices, community-based entities). The MCO's care coordination program must serve as the foundation to ensure that all members have access to quality care coordination, whether the member is receiving care coordination from a care coordination entity (CCE), the OhioRISE plan, an OhioRISE plan-contracted care management entity (CME), the MCO, or a combination thereof.

An MCO's approach to care coordination must demonstrate the qualities of a high-performing system: person and family centeredness; timely, proactively planned communication and action; the promotion of self-care and independence; emphasis on cross continuum and system collaboration; and the

comprehensive consideration of physical, behavioral, and social determinants of health. The MCO's care coordination program must reflect the following guiding principles:

- Care coordination identifies and addresses physical, behavioral, and psychosocial needs of members.
- Care coordination supports member goals and choices through a person-centered, trauma-informed, and culturally attuned approach.
- Care coordination provides care continuity while honoring member experience and choice.
- The MCO preserves existing care relationships between members and local CCEs.
- The MCO leverages the strengths of CCEs, the OhioRISE plan, and CMEs by supporting and developing partnerships with CCEs, the OhioRISE plan, and CMEs.
- The MCO establishes clear communication and delineation of roles and responsibilities of various entities throughout the care coordination process to minimize the duplication of services and streamline service delivery.
- The MCO 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.

The OhioRISE plan's care manager is primary, requiring that the MCO's care coordination efforts support, but do not supplant OhioRISE plan coordination activities. Additionally, the OhioRISE plan's care coordination program must not duplicate care coordination activities performed for members by state and local agencies and/or their designees.

The SPBM PAHP is required to coordinate with MCOs, care coordination entities, the OhioRISE PIHP, and the OhioRISE plan-contracted care management entities, primarily through systematic and as-needed data and information exchange. In addition, the SPBM must support care coordination activities by providing clinical consultation, assisting with member access to pharmacy services, implementing member-specific edits, and conducting other activities to help improve care coordination effectiveness.

Care Coordination Infrastructure

As a key strategy for achieving population health, it is essential that each MCE's infrastructure (e.g., leadership, data systems, staffing) is sufficient to support optimal care coordination. ODM requires that each MCE assign a care coordination director who is responsible for the functioning of care coordination activities across the continuum of care, including: ensuring access to primary care, behavioral health, and coordination of health and social services for all members; developing and implementing processes; and implementing mechanisms for identifying, assessing, and developing treatment plans for members with special healthcare needs. The care coordination director must also ensure that care coordination staff are appropriately trained, and adequate in number to meet the care coordination and population health needs of members. Care coordination staffing and training requirements are described later in this section.

To support care coordination activities, it is critical that MCEs have an information technology system that, subject to state and federal privacy requirements, efficiently receives, provides, and exchanges data with ODM, CCE, other MCEs, CBO, and providers (e.g., primary care providers and behavioral health providers) to identify service gaps and risk factors, facilitates integrated care planning, and allows for confirmation and confirming of social service referrals.

MCEs are responsible for developing and maintaining the necessary data infrastructure to support providers and coordinate with other MCEs and any applicable fee-for-service systems to ensure integration of physical health and behavioral health services. Each MCE's care coordination program must safeguard confidential information in accordance with the privacy compliance requirements specified in the MCO Provider Agreement with ODM.

Each MCO's care coordination portal collects, stores, integrates, shares, and pushes out pertinent member information with/to the entities involved in coordinating the member's care (ODM, CCEs, OhioRISE plan/CMEs, and SPBM as applicable). ODM requires that MCOs' Care Coordination Portals can electronically notify entities involved in a member's care coordination of sentinel events (e.g., inpatient hospitalizations, ED visits, identified gaps in care, residential treatment admissions/discharges, mobile response and stabilization services).

The MCO's care coordination portal must be available to members, ODM, the SPBM, CCEs, and/or OhioRISE plan/CMEs, subject to access controls and requirements necessary to comply with state and federal privacy requirements.

Staffing and Training Requirements

MCEs are required to ensure that the staff who are performing care coordination functions are operating within their professional scope of practice, comply with the state's licensure and credentialing requirements, and are appropriate for the member's physical and behavioral healthcare needs.

Care coordination staff must represent a range of disciplines with complementary skills and knowledge to deliver a comprehensive, integrated care coordination program fully capable of addressing members' physical, behavioral, and psychosocial needs.

The onboarding and ongoing training for MCE care coordination staff must include health and racial equity, cultural competency and humility, person-centered care planning, trauma-informed care, motivational interviewing, grievance and appeal processes and procedures, community resources within the plan's service areas, strategies for any disease specific processes, incident reporting requirements, and Health Insurance Portability and Accountability Act (HIPAA) requirements.

Additionally, the OhioRISE plan must provide training in the use of the Child and Adolescent Needs and Strengths (CANS) process, child and family-centered planning, needs for multisystem 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, and community resources within the OhioRISE plan's service areas.

The MCO's care coordination staffing must reflect four distinct roles and levels of support from the MCO: Care Manager, Care Manager Plus, Care Guide, and Care Guide Plus. The "plus" designation indicates required collaboration with CCE and CME to leverage resources and avoid duplication. These levels of support are summarized in the table and text below.

MCO Care Coordination Single Point of Contact	MCO Care Manager	MCO Care Manager Plus	Care Guide	Care Guide Plus

Member Assigned to CCE, OhioRISE, or CME?	No	Yes	No	Yes
Additional Criteria	Member chooses to receive care management from the MCO	Member needs are greater than the CCE, OhioRISE plan, or CME can provide	Member has short-term care coordination needs	Member has short-term care coordination needs

MCO Care Manager

The MCO Care Manager serves as the single point of contact for care coordination and performs the full scope of care coordination activities and responsibilities for members who need care coordination and are not assigned to a CCE, the OhioRISE plan, and/or CME, as well as for members who choose to receive their care management from the MCO. The MCO must offer or assign a Care Manager to a member when long-term care coordination needs are identified, the level of clinical expertise to coordinate care exceeds the capabilities of the Care Guide, and when this level of support is indicated by risk stratification.

Care Manager responsibilities include conducting assessments, developing, and updating a person-centered care plan, monitoring the care plan, coordinating across the transdisciplinary care team [at a minimum, the primary care provider (PCP)], coordinating transitions of care, and incident reporting.

MCO Care Manager Plus

If the member is assigned to a CCE, the OhioRISE plan, and/or CME, but the MCO, CCE, OhioRISE plan, and/or CME collectively determine the needs of the member are greater than the capability of the CCE, OhioRISE plan, and/or CME, the MCO must assign an MCO Care Manager Plus. An MCO Care Manager Plus serves as the single point of contact at the MCO to support CCE-, OhioRISE plan-, and/or CME-delivered care coordination. The MCO must assign a Care Manager Plus to a member when long-term care coordination needs are identified, the level of clinical expertise to coordinate care exceeds the capabilities of the Care Guide Plus, and when indicated by risk stratification.

The Care Manager Plus is responsible for ensuring the member receives the full scope of care coordination services, including comprehensive assessment completion (inclusive of the health risk assessment), person-centered care plan completion, and identifying and addressing ongoing needs. The Care Manager Plus is also responsible for providing actionable data, information, and support to assist the CCE, OhioRISE plan, and/or CME in meeting the member's care needs. The Care Manager Plus must integrate information collected by the CCE into its Care Coordination Portal to minimize duplication.

MCO Care Guide

The MCO Care Guide serves as a single point of contact for care coordination when there is no CCE, OhioRISE plan, and/or CME involvement and short-term care coordination needs are identified. Care Guides must be representative and reflect the community of the populations being served. The staff member's level of clinical expertise and member's risk stratification must also be evaluated when offering/assigning an MCO Care Guide. Members needing Care Guide assistance for longer than 60

calendar days should be considered for referral to a Care Manager. The MCO Care Guide serves as the single point of contact for care coordination.

The Care Guide is responsible for: assuring completion of a health risk assessment; assisting members to remediate immediate and acute gaps in care and access; assisting members with filing grievances and appeals; connecting members to CCEs, the OhioRISE plan, or MCO Care Management if the member's needs require a higher level of coordination; providing information to members related to MCO requirements, services, and benefits; and providing members with information and/or referrals to community resources.

Care Guide Plus

An MCO Care Guide Plus serves as a single point of contact at the MCO for care coordination when there is CCE, OhioRISE plan, and/or CME involvement and short-term care coordination needs are identified. The staff member's level of clinical expertise and the member's risk stratification must also be evaluated when offering and/or assigning an MCO Care Guide Plus. Members needing Care Guide Plus assistance for longer than 60 calendar days should be considered for referral to a Care Manager. An MCO Care Guide Plus serves as the single point of contact at the MCO to support CCE-, OhioRISE plan-, and/or CME-delivered care coordination.

Care Guide Plus responsibilities include: assuring completion of a health risk assessment; assisting members to remediate immediate and acute gaps in care and access; assisting members with filing grievances and appeals; connecting members to designated CCEs, the OhioRISE plan, or MCO Care Management if the member's needs indicate a higher level of coordination is required; providing information to members related to MCO requirements, services, and benefits; and providing members with information and/or referrals to community resources.

Health Risk Assessments

MCOs must complete or ensure CCE completion of an ODM-standardized 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 MCO and, at least every 365 days thereafter. The goal of the assessment is to identify immediate clinical (physical, behavioral, and long-term service and support need, as appropriate), social and safety needs in order to facilitate timely follow-up action. The MCOs will identify the triggers for completion of comprehensive assessments or disease-specific assessments. MCOs must have criteria in place for determining when to conduct a reassessment which includes a change in member needs, a significant change event, a change in diagnosis, or a request from the member or his or her provider. Multiple attempts to conduct the HRA must be undertaken by the MCO.

When a member is not assigned to a CCE or OhioRISE plan/CME, MCOs must conduct or arrange for other assessments (e.g., comprehensive assessment, disease specific assessment, CANS assessment) to be conducted. The MCO must share results of any identification and assessment of the member's needs, including special healthcare needs, through the MCO's Care Coordination Portal to prevent duplication of those activities.

Each MCO must have a process for conducting or arranging for assessments appropriate to each member's unique circumstances and needs (e.g., physical, behavioral, social, and safety) that includes: the MCO's methods and timelines for assessment completion, including any variances by risk tier; identification of the triggers for completion; how the assessment will be used to develop and update the person-centered care plan and confirm the member's risk stratification level; how data from the

member's PCP or other providers will be used to prevent assessment effort duplication and identify the member's priories; and how members who cannot be reached or who refuse assessments will be handled by the MCO, including multiple contacts if initial contacts are unsuccessful.

The CME will be responsible for performing initial assessments as directed by the OhioRISE plan. Initial assessments consist of a comprehensive home-based assessment that occurs in the member's home or another location of the family's choice. The assessment must include information from the CANS and other tools as determined necessary; and include the development of an initial crisis/safety plan.

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.

The OhioRISE plan must have a process for identifying and coordinating with the member's MCO/CCE for other assessment data appropriate to the members' 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.

Care Coordination Risk Stratification

Each MCO and the OhioRISE plan must develop and implement a risk stratification framework as part of its care coordination program that is comprised of three tiers (i.e., from lowest to highest: low Risk [Tier 1], moderate risk [Tier 2], and high risk [Tier 3]). A risk tier must be assigned to each member. The risk stratification framework must include the criteria and thresholds for each tier to determine member assignments.

MCOs and the OhioRISE plan must both include SDOH, safety factors, and health risk assessment information in determining a member's care coordination level. MCO member risk stratification criteria and thresholds must also include the acuity of chronic conditions, substance use and/or mental health disorders, maternal risk (e.g., prior preterm birth), and inpatient or emergency department utilization. The OhioRISE plan's tiering criteria and thresholds used to determine a member's level of care coordination must also include the acuity of substance use and mental health disorders as identified through the CANS; encounter information on previous utilization of behavioral health services, including inpatient, emergency department (ED), or Mobile Response and Stabilization Services (MRSS) utilization; and the MCO person-centered plan of care or other MCO data sources and information.

MCOs must assign an initial risk stratification tier within the first month of a member's enrollment for members newly enrolled with the MCO. The MCO must review and update the risk stratification tier following the completion of the member's health risk assessment. The MCO must evaluate a member's risk stratification tier whenever there is a significant change in the member's needs or circumstances. If the MCO changes the member's stratification tier based on this evaluation, the MCO must document the change in member's need or circumstances that led to the change in stratification.

The MCO must communicate risk stratification to ODM, CCEs, the OhioRISE plan, and the single pharmacy benefit manager (SPBM).

If a member is assigned to the OhioRISE plan, 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 notification from ODM, except for crisis referrals.

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 from ODM.

ODM requires that the assigned care coordinator communicate the care coordination tier to the member and caregiver as a part of the initial outreach contact within two business days of the referral (except for crisis referrals). For crisis referrals, the assigned care coordinator must outreach to the member and caregiver no later than one business day following the referral.

The OhioRISE plan must also 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.

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.

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 the change and must inform the member verbally through the care coordinator and in writing.

The OhioRISE plan must communicate care coordination tiering information to ODM, CMEs, the member's MCO, and the single pharmacy benefits manager (SPBM) as specified by ODM.

Care Coordination Assignment

While honoring member choice, MCOs must respect, promote, and support care coordination provided by CCEs within the community. CCEs include entities associated with value based payment models (e.g., Comprehensive Maternal Coordination [CMC], Comprehensive Primary Care [CPC], and Behavioral Health Care Coordination Entity [BHCCE]); conflict-free case management agencies (PASSPORT Administrative Agencies, County Boards of Developmental Disabilities, Ohio Home Care Case Management Agencies); and other community-based care coordination models (e.g., CMEs).

MCOs must ensure that members receive necessary care coordination, whether the care coordination is performed by the MCO, CCEs contracted with the MCO, CCEs not contracted with the MCO, the OhioRISE plan or their contracted CMEs (for OhioRISE plan enrolled members), or a combination thereof. The MCO must ensure that the MCO Care Manager Plus or MCO Care Guide Plus are part of the CCE and OhioRISE plan/CME care team.

For CCEs that the MCO is not contracted with (i.e., CCEs, the OhioRISE plan, and OhioRISE plan-contracted CMEs), the MCO is responsible for ensuring member needs are met and must supplement care coordination as necessary.

The MCO must ensure that its care coordination 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.

Care Coordination Assignment for Members Not Enrolled in the OhioRISE plan

For members not enrolled in the OhioRISE plan, the MCO must make a Care Manager, Care Manager Plus, Care Guide, or Care Guide Plus available as needed or upon request, as described below. Member access to an MCO care coordinator is not solely dependent upon risk stratification.

MCO assignment of care coordination staff must consider: the assessment of the member's short and long-term care coordination needs; the member's level of needs based upon risk stratification; whether the member is receiving care coordination from a CCE; the capability of the CCE to effectively manage the member's needs; and member choice.

If a member is assigned to a CCE, the MCO must preserve and support the care coordination relationship between the CCE and the member. The MCO must ensure that the member's care coordination needs are met by the CCE and must assign an MCO Care Manager Plus or MCO Care Guide Plus as determined necessary by the MCO. The MCO must also assign an MCO Care Manager Plus or MCO Care Guide Plus if requested by the CCE. For those members not assigned to a CCE or who choose to receive care coordination from the MCO, the MCO must determine assignment to an MCO Care Manager and MCO Care Guide based upon need.

MCOs must also analyze utilization data and other indicators to identify members who may be eligible for OhioRISE and refer the member for a CANS assessment to determine OhioRISE eligibility.

MCO-Led Care Coordination

For members who are assigned to an MCO Care Manager or Care Guide, the Care Manager or Care Guide is responsible for outreaching to members to engage them in care coordination; conducting or arranging for member assessments; leading the development and updating of person-centered care plans as applicable; offering and linking members to health education, disease management, and wellness/prevention coaching; identifying and linking members to network providers; coordinating member access to covered services (e.g., scheduling appointments, arranging transportation, making referrals, and linking the member to MCO health and wellness programs); educating the member about available resources and services (e.g., value-added benefits) and assisting the member in accessing those resources and services.

Care Managers and Care Guides also communicate and exchange information with providers (e.g., PCP, specialists, labs, imaging facilities), ODM, and the SPBM to coordinate the care of the member; and share care coordination data and information with ODM and the SPBM as applicable to prevent gaps in care and duplication of efforts; identify and close gaps.

To prevent adverse outcomes, the Care Manager or Care Guide participates in discharge planning activities with the inpatient facility to support a safe discharge placement; ensuring member access to post discharge services as specified in the discharge and transition plan; and facilitating clinical hand offs between the discharging facility and other network providers involved in the care and treatment of the member. Care Managers also actively secure the necessary authorizations for the services to ensure the member's timely access to the services identified in the person-centered care plan, if applicable; and monitor to ensure that the services are delivered as recommended in the person-centered care plan, if applicable.

Care Coordination Assignment for OhioRISE plan Pending and Enrolled Members

The OhioRISE plan develops and manages a full continuum of behavioral health network providers, including regional CMEs, with the specific expertise necessary to effectively serve this population. The

OhioRISE plan is responsible for contracting for care coordination through the CMEs and other services with local service providers.

A network of regionally located CMEs serve as the “locus of accountability” for children and youth with complex challenges and their families who are involved in navigating multiple state systems. The OhioRISE plan will select CMEs with demonstrated expertise providing Integrated Care Coordination (ICC) using High-Fidelity Wraparound and with sufficient capacity to serve OhioRISE plan members.

The CMEs offer two tiers of care coordination: one for individuals who need ICC using a High-Fidelity Wraparound approach, and one that offers a moderate level of care coordination for children, youth, and families. These entities also either provide or coordinate the provision of community-based and in-home services, and other services and supports to improve health outcomes.

At a minimum, the MCO must provide the level of care coordination (Care Manager Plus or Care Guide Plus) as requested by the OhioRISE plan. If the OhioRISE plan does not identify a care coordination need or the MCO determines that a higher level of care coordination is necessary, the MCO must offer MCO care coordination necessary to meet the needs of the member.

Additionally, the MCO must provide the OhioRISE plan with up-to-date contact information for the MCO care coordination staff assigned to the member.

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.

For children and youth enrolled with an MCO, the OhioRISE plan and MCO are required to have written agreements that document the respective responsibilities, expectations, and coordination between the OhioRISE plan and the MCOs. Children and youth who are not enrolled with an MCO receive their physical health services through the fee-for-service delivery system.

CME-Led Care Coordination

For members who are assigned to a care management entity (CME) care coordinator, the OhioRISE plan must support care coordination performed by the CME.

Upon the CME’s request, the OhioRISE plan's care coordination department is responsible for assisting the CME in a timely manner with the following care coordination activities: supporting member outreach efforts; identifying, referring, and linking members to behavioral health network providers and social supports as needed (e.g., scheduling appointments, arranging transportation); and 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).

The OhioRISE plan’s care coordination department is also required to assist the CME by participating in the CME-led CFT to support the development and ongoing updates to the child and family-centered care plan, as well as 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.

When needed, the OhioRISE plan assists in the coordination of member access to MCO-covered services 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), and 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.

Upon the MCO's or CCE's request, OhioRISE plan's staff provide behavioral health clinical consultation. The OhioRISE plan's care coordination staff also assist 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, and Family and Children First Councils and providers certified by the OMHAS; assisting with bi-directional communication among the MCO/CME, SPBM, and other providers as needed in order to facilitate timely exchange of information. This includes 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. The sharing of care coordination data and information with ODM, the members' MCO/CCE, and the SPBM as applicable prevents gaps in care and duplication of efforts and helps the OhioRISE plan in identifying and taking action to close gaps in care.

The OhioRISE plan's care coordination staff are required to participate 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. They also ensure member access to post discharge services covered by the OhioRISE plan as specified in the discharge and transition plan and facilitate clinical hand offs between the discharging facility and other OhioRISE plan network providers involved in the care and treatment of the member.

OhioRISE care coordination staff secure the necessary authorizations for services in the child and family-centered care plan that are the responsibility of the OhioRISE plan; coordinate with the MCO, CCE, SPBM, and providers to ensure the members who are the responsibility of the MCO, CCE or SPBM have timely access to the services identified in the child and family-centered care plan; and monitor the services provided to ensure that they correspond to the needs and goals identified and recommended in the child and family–centered care plan.

OhioRISE plan-Led Care Coordination

For members who are assigned to an OhioRISE plan care coordinator, the care coordinator is responsible for engaging members in care coordination within the timeframes established by ODM; identifying, referring, and linking members to behavioral health network providers and social supports as needed (e.g., scheduling appointments, arranging transportation); and 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). The OhioRISE care coordinator is also responsible for leading the development and ongoing updates to the child and family-centered care plan and 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.

The OhioRISE plan care coordinator is also responsible for 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); and 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. Upon MCO or CCE

request, the OhioRISE plan care coordinator must arrange for OhioRISE plan staff to provide behavioral health clinical consultation.

The OhioRISE plan care coordinator must communicate and exchange information with providers (e.g., primary care provider [PCP], CCEs), ODM, MCOs, and the SPBM to coordinate the care of the member. All exchanges of information and communication across relevant child-serving systems (e.g., child welfare case worker, school) must be consistent with appropriate releases of information signed by the member/guardian. To prevent gaps in care and duplication of efforts, the OhioRISE plan care coordinator must share care coordination data and information with ODM, the members' MCO/CCE, and the SPBM. As the OhioRISE plan care coordinator identifies gaps in care, actions must be taken to close them.

ODM requires the OhioRISE care coordinator to participate 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; ensure member access to post-discharge services covered by the OhioRISE plan as specified in the discharge and transition plan; and facilitate clinical hand offs between the discharging facility and other OhioRISE plan's network providers involved in the care and treatment of the member.

The OhioRISE plan care coordinator must actively secure the necessary authorizations for the services in the child and family-centered care plan that are the responsibility of the OhioRISE plan; coordinate with the MCO, CCE, SPBM, and providers to ensure the member's timely access to the services identified in the child and family-centered care plan; and monitor services to ensure they are delivered as recommended in the child and family-centered care plan.

MCO Activities in Support of CCE- and OhioRISE plan-Led Care Coordination

For members assigned to a CCE and/or enrolled with the OhioRISE plan, the MCO must support care coordination performed by the CCE and/or OhioRISE plan/CME.

When requested by the CCE or the OhioRISE plan/CME (for OhioRISE plan enrolled members), the MCO's Care Manager Plus or Care Guide Plus is responsible for: timely support of CCEs and the OhioRISE plan/CME outreach efforts; facilitation of an initial Child and Adolescent Needs and Strengths (CANS) assessment, as well as other assessments when indicated or requested; and participation in CCE-led care teams and/or Child and Family Teams (for OhioRISE plan members) to support the assessment and person-centered care planning process.

Individuals employed by MCOs as a Care Manager Plus or Care Guide Plus also assist the CCE and OhioRISE plan/CME in: identifying and linking members to network providers (e.g., specialists, dentists, behavioral health providers); coordinating MCO covered services (e.g., scheduling appointments, arranging transportation, facilitating referrals, and linking members to MCO health and wellness programs); educating CCEs and OhioRISE plan/CME about resources/services (e.g., value-added benefits) that are available to member; and arranging for MCO staff to provide clinical consultation.

The MCO’s Care Manager Plus and Care Guide Plus facilitate timely exchange of information with the CCE or OhioRISE plan/CME by assisting with bi-directional communication between the CCE, OhioRISE plan/CME, and SPBM, as well as with specialists, pharmacies, labs, and imaging facilities. Through the sharing of care coordination data and information with ODM, CCEs, the SPBM, and the OhioRISE plan/CMEs, the MCO’s Care Manager Plus and Care Guide Plus also help prevent gaps in care and duplication of efforts.

In order to support safe discharge placement and prevent adverse outcomes such as readmissions or ED Visits, the MCO Care Manager Plus or MCO Care Guide Participates in discharge planning activities with the inpatient facility and the CCE and/or OhioRISE plan/CME; ensures member access to post discharge services covered by the MCO as specified in the discharge and transition plan; and facilitates clinical hand offs between the discharging facility and other MCO network providers involved in the care and treatment of the member.

The MCO's Care Manager Plus or Care Guide Plus also actively secures the necessary authorizations for the services that are the responsibility of the MCO; coordinates with the CCE, SPBM, OhioRISE plan/CME, and providers to ensure the member's timely access to the services identified in the person-centered care plan; and monitors activities to ensure that the services are delivered as recommended in the person-centered care plan.

Person-Centered Care Plans

For members assigned to an MCO Care Manager who are not assigned to a CCE and are not enrolled in the OhioRISE plan, the MCO must lead the development of a person-centered care plan based on the most recent assessment. The person-centered care plan must be updated every 12 months or whenever there is a significant change in the member's needs. The care plan must include measurable, person-centered care plan goals, interventions, and outcomes that are developed with the member and align with the priority issues identified by the member and his or her primary care provider. The MCO Care Manager is responsible for retaining the person-centered care plan and sharing it with members of the multi-disciplinary team and must validate that the member received the services in the person-centered care plan. If the services were not received, the necessary actions must be taken to address and close gaps in care.

Child and Family-Centered Care Plans

For OhioRISE plan members receiving Tier 2 – Intensive or Tier 3 – Moderate Care Coordination, CMEs must convene and facilitate a Child and Family Team (CFT), which develops and updates a child and family-centered care plan that is consistent with ODM guidelines and includes a crisis/safety plan. When OhioRISE plan members receive care coordination from the OhioRISE plan (Tier 1), the OhioRISE plan care manager must develop the child and family-centered care plan.

For all OhioRISE members, the OhioRISE plan must have a child and family-centered care planning process that includes the following:

- Child and family-centered care plan development based on the most recent assessment (e.g., CANS) and inclusion of a crisis/safety plan.
- Individual child and family-centered care plan updates.
- Tracking and complying with timeframes for the initial child and family-centered care plan development and subsequent updates.
- Developing measurable goals, interventions, and outcomes with the member in collaboration with the CFT and obtaining the member's family or caregiver's agreement.
- Aligning child and family-centered care plan goals with the priority issues identified by the CFT so the OhioRISE plan and CME can support the provider-member relationship.
- Verifying that the member received the services in the child and family-centered care plan, or if services were not received, taking necessary action to address and close gaps in care.

- Providing the member and the caregiver with the child and family-centered care plan.
- Retaining the child and family-centered care plan for Tiers 2 and Tier 3 and sharing it with members of the CFT.

Contact Schedule

For all members assigned to an MCO Care Manager, Care Manager Plus, Care Guide, or Care Guide Plus, MCOs must establish an ODM-approved minimum contact schedule that facilitates ongoing communication with the member. The ODM-approved contact schedule must include number of subsequent attempts to reach the member if the member does not respond to the initial attempt.

If a member, CCE, OhioRISE plan/CME, or SPBM outreaches to the MCO, the MCO must respond in a timeframe to meet the presenting need of the member, but no later than one business day.

Care Coordination Monitoring

Each MCO must monitor care coordination activities to ensure members' care coordination needs are met. Monitoring includes ongoing review of data indicators (e.g., emergency department, inpatient, and crisis services utilization; prescription drug utilization data provided by the SPBM; utilization patterns; readmissions; critical incidents; identified gaps in care) to inform the level and type of care coordination needed by the member. MCOs must also monitor the quality and effectiveness of MCO- and CCE-provided care coordination through the review of member and provider surveys and case reviews. Case reviews must include whether established quality, clinical best practice, and care coordination standards have been met.

When unmet member needs or care coordination delivery deficiencies are identified, the MCO, in coordination with ODM, the CCEs, OhioRISE plan/CMEs and the SPBM, must ensure expeditious resolution and systematic correction of care coordination deficiencies.

Transitions of Care

As required by 42 CFR 438.62, ODM has policies in place to ensure continued access to services when members transition from FFS to managed care, when individuals transition from receiving services from one MCE to another MCE, when an MCE's contract is terminated, and when a Medicaid member is disenrolled from an MCE for any reason other than Medicaid ineligibility. ODM's policies for each of these circumstances are provided in more detail below.

To emphasize the importance of service continuity during transitions, ODM requires MCOs and the OhioRISE plan to appoint a Transition Coordinator to serve as the primary point of contact for planning and managing all transition activities, including member transitions of care and transitions resulting from termination and/or non-renewal of the MCE.

Transitions between MCOs

Member initiated. A dual-benefits member enrolled in a MyCare participating county may request disenrollment from the MCO and transfer between plans on a month-to-month basis any time during the year. Individuals enrolled in DODD waivers can voluntarily enroll or disenroll from managed care at any time. Children in custody may request a change in enrollment at any time. The switch to a new plan will be effective the beginning of the next effective month.

For all other membership groups, requests for different plans are limited. Individuals within these other groups may request a different plan during the time-period between the date of initial enrollment and the first three months of plan membership, whether the first three months of enrollment are dual-benefits or Medicaid-only membership periods.

Plan changes can also be made during annual open enrollment which is currently scheduled in November. At least sixty days prior to the designated open enrollment month, ODM notifies eligible individuals by mail of the opportunity to change or terminate MCO membership and explains where to obtain further information.

Transitions of Care for New MCO Members

Provision of Member Information. Upon member transition, the newly enrolling MCO or MyCare Ohio plan receives member information from ODM if the member is transitioning from FFS and from the MCO if the member is transitioning from another MCO.

Additionally, to reduce gaps or duplication of services, the MyCare Ohio Plan (MCOP) provider agreement requires coordination with any Medicare Advantage Plan that is the primary payer of Medicare services. If a member transfers between MCOPs, ODM requires that the disenrolling MCOP obtain the member's written consent and promptly transfer the current assessment and care plan, inclusive of the waiver service plan, to the enrolling MCOP prior to the new enrollment effective date.

Pre-Enrollment Planning. The MCO must coordinate with and utilize data provided by ODM, another MCO, the OhioRISE plan (when applicable) and/or collected by the MCO (e.g., through assessments, new member outreach in advance of the member's enrollment effective date) to identify existing sources of care and to ensure each new member is able to continue to receive existing services without disruption. For OhioRISE plan enrolled members, the MCO must reach out to the OhioRISE plan and primary care coordination staff to engage the OhioRISE plan in pre-enrollment planning.

Continuation of Services for Members. MCOs must allow a new member to receive services from network and out-of-network providers under the circumstances described below.

If an MCO confirms that a *Group VIII-Expansion* member is currently receiving care in a nursing facility on the effective date of enrollment with the MCO. In that event, the MCO must cover the nursing facility care at the same facility until a medical necessity review is completed and, if applicable, a transition to an alternative location has been documented in the member's person-centered care plan.

If an MCO is aware of a pregnant member's enrollment, the MCO must identify the member's maternal risk and facilitate connection to services and supports in accordance with ODM's *Guidance for Managed Care Organizations for the Provision of Enhanced Maternal Care Services*. MCOs must also allow pregnant members to continue with an out-of-network provider if the member is in her third trimester of pregnancy and/or has an established relationship with an obstetrician and/or delivery hospital.

If a member has a prior authorization approved prior to the member's transition, the MCO 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 MCO. The MCO may conduct a medical necessity review for previously authorized services if the member's needs change to warrant a change in service. The MCO must render an authorization decision pursuant to OAC rule 5160-26-03.1.

MCOs may assist the member to access services through a network provider when any of the following occur: the member's condition stabilizes and the MCO can ensure no interruption to services; the member chooses to change the member's current provider to a network provider; or there are quality concerns identified with the previously authorized provider.

MCOs must cover scheduled inpatient or outpatient surgeries approved and/or pre-certified pursuant to OAC rule 5160-2-40. Surgical procedures also include follow-up care as appropriate.

MCOs must cover organ, bone marrow, or hematopoietic stem cell transplant pursuant to OAC rule 5160-2-65 and as described in the ODM-MCO provider agreement.

MCOs must provide the following services to the member regardless of whether services were prior authorized/pre-certified or the treating provider is in or out-of-network with the MCO: ongoing chemotherapy or radiation treatment; hospital treatment (if member was released from hospital 30 calendar days prior to enrollment); and private duty nursing, home care services, and durable medical equipment (DME) must be covered at the same level with the same provider as previously covered until the MCO conducts a medical necessity review and renders an authorization decision pursuant to OAC rule 5160-26-03.1.

Upon notification from a member or provider of a need to continue services, the MCO must allow a new member to continue to receive services from network and out-of-network providers when the member could suffer detriment to their health or be at risk for hospitalization or institutionalization in the absence of continued services.

Documentation of Transition of Services. MCOs must document the provision of transition of services. If the service will be provided by a network provider, the MCO must notify the network provider and the member to confirm the MCO's responsibility to cover the service. The MCO must use the ODM-specified model language for the provider and member notices and maintain documentation of all member and/or provider contacts relating to such services.

The MCO must seek confirmation from an out-of-network provider that the provider agrees to provide the service and accepts the Medicaid FFS rate as payment or a negotiated rate. If the provider agrees, the MCO must distribute materials to the out-of-network provider. If the provider does not agree, the MCO must notify the member of the MCO's availability to assist with locating another provider as expeditiously as the member's health condition warrants.

Transitions of Care Between Healthcare Settings

Each MCO, in coordination with CCEs, the OhioRISE plan, and/or CMEs as assigned, must effectively and comprehensively manage transitions of care settings to prevent unplanned or unnecessary readmissions, emergency department visits, and/or adverse outcomes. The MCO must:

- Identify members who require assistance transitioning between settings and notify the member's CCE, if assigned;
- 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 CCE, OhioRISE plan, and/or CME, as 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 services currently received by the member;
- Ensure timely notification and receipt of admission dates, discharge dates, and clinical information is communicated between MCO departments and with the CCE, OhioRISE plan/CME, care settings, and the member's PCP, as appropriate;
- 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 MCO and/or CCE;
- Obtain a copy of the discharge/transition plan and share the plan with the member's care team;
- Arrange and confirm services are authorized and delivered in accordance with the discharge/transition plan;
- Ensure that providers can obtain copies of the member's medical records as appropriate and consistent with federal and state requirements; and
- Conduct timely follow up with the member and the member's primary provider to ensure post discharge services have been provided.

Change in Enrollment for Behavioral Health Services due to an Inpatient Behavioral Health Stay

Members under the age of 21 admitted for an inpatient behavioral health stay with a primary diagnosis of mental illness or substance use disorder will be automatically enrolled in the OhioRISE plan. OhioRISE plan enrollment will be effective on day one of the inpatient behavioral health stay.

The OhioRISE plan is responsible for notifying the inpatient behavioral health facility that it is responsible for coverage of the stay, working with the facility to facilitate discharge planning, and authorizing services as needed. The MCO is required to assist the OhioRISE plan with care coordination and discharge planning.

Transitions of Care Between the MCO and the OhioRISE plan

For members whose coverage and coordination for a member whose coverage and coordination of behavioral health services is transitioning from an MCO to the OhioRISE plan, or from the OhioRISE plan to an MCO, MCOs must follow the transition of care requirements as outlined below.

Care Coordination Assignment. Upon notification from ODM that a member will be enrolled with, or disenrolled from, the OhioRISE plan for behavioral health services, the MCO must assign an MCO care coordination staff person to lead the MCO's responsibilities for the coordinating the transition of behavioral healthcare to and from the OhioRISE plan.

The MCO must ensure that the members disenrolling from the OhioRISE plan have an assigned MCO care coordination staff member for at least 90 calendar days following disenrollment to assist members with accessing needed services and resources.

Provision of Member Information. Upon notification from ODM that a member will be enrolled with the OhioRISE plan for behavioral health services, the MCO must provide member information to the OhioRISE plan as specified by ODM.

Upon notification from ODM that a member will be disenrolled from the OhioRISE plan and transitioning to the MCO for behavioral health services, the OhioRISE plan will provide member information to the MCO as specified by ODM.

Continuation of Services for Members. MCOs must allow members transitioning from the OhioRISE plan to receive behavioral health services from network and out-of-network providers, as indicated.

MCOs must honor any prior authorizations approved prior to the member's transition through the expiration of the authorization, regardless of whether the authorized or treating provider is in or out-of-network with the MCO. MCOs may conduct a medical necessity review for previously authorized services if the member's needs change to warrant a change in service. The MCO must render an authorization decision as required by OAC rule 5160-26-03.1.

An MCO may assist the member to access services through a network provider when any of the following occur: the member's condition stabilizes and the MCO can ensure no interruption to services, the member chooses to change to a network provider, or there are quality concerns identified with the previously authorized provider.

Upon notification from a member and/or provider of a need to continue services, the MCO must allow a new member to continue to receive services from network and out-of-network providers when the member could suffer detriment to their health or be at risk for hospitalization or institutionalization in the absence of continued services. The MCO must provide these services to the member regardless of whether the services were prior authorized/pre-certified or the treating provider is in or out-of-network with the MCO.

New OhioRISE plan Enrollments. The OhioRISE plan receives behavioral health information for all newly enrolled individuals from either FFS or the individual's MCO.

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 child and family-centered care plan to ensure each new member is able to continue existing behavioral health services or access different behavioral health services based on the needs of the member and their family/caregiver.

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 according to timeframes specified by ODM.

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.

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.

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 an appropriate care coordinator according to ODM-specified timeframes.

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. 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.

OhioRISE Responsibilities During MCO Transitions. When a member makes a transition from one MCO to another MCO, and remains in OhioRISE, the OhioRISE plan (and CME if one is assigned) are required have a process to ensure that the member and caregiver have the name and contact information for their MCO Care Manager Plus or Care Guide Plus care coordinator readily available to them and that it has been recorded in care coordination documents and systems of the OhioRISE plan and the CME care coordination documents. The OhioRISE plan and CME use this information to support the member and caregiver in contacting the new MCO and appropriate care coordination resources as a part of the MCO-to-MCO transition.

The OhioRISE plan and Care Management Entity Transitions. 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 between CMEs. The OhioRISE plan transition process must include the CME transition criteria, including member/family/caregiver choice; transition completion timelines, including assignment of the new care coordinator from the new CME; and the roles of OhioRISE plan care coordination staff in supporting the transition, assuring continuity of care, and engagement with the new CME/care coordinator.

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 are notified when there is a transition between CMEs or between care coordinators within a CME. ODM requires that this notification occur within five business days.

Transitions of Care from OhioRISE plan to MCO, MCOP, or FFS Behavioral Health.
The OhioRISE plan will provide the MCO or FFS with the member information of individuals transitioning from OhioRISE to either an MCO or to FFS behavioral health. For each transitioning member, the OhioRISE plan must also create a transition of care plan that includes input from current and future behavioral health providers, as well as from the member's family/caregiver regarding the services and supports that will be included in the transition of care plan.

As part of the transition of care plan, the OhioRISE plan must provide the member's new FFS providers or the MCO and its contracted CCEs with the transitioning member's behavioral healthcare and support needs for 90 calendar days following OhioRISE plan disenrollment. The transition of care plan must be provided to the MCO or FFS behavioral health provider according to the timeframes specified by ODM.

Transitions of Care Between Healthcare Settings
The prevention of unplanned or unnecessary readmissions, ED visits, or adverse outcomes requires effective and comprehensive coordination between MCO, CCEs, the OhioRISE plan, and CMEs (as

assigned) to manage transitions between healthcare settings. Effective and comprehensive coordination of healthcare setting transitions includes:

- Identifying members who require assistance transitioning between settings and notifying the member's CME, (if assigned);
- Developing a method for evaluating risk of readmission or deterioration in order to determine the intensity of required follow up for the member after discharge, and sharing this information with the CME, MCO, and CCE, as assigned;
- Designating (either directly or through the CME, if one is assigned) care coordination staff to communicate with the discharging facility and to provide the facility with the contact information for the member's care team (e.g., all care coordinators and providers of behavioral health services currently received by the member);
- Ensuring notifications, admission dates, discharge dates, and clinical information is communicated in a timely manner between OhioRISE plan's departments, CME, MCO/CCE, other behavioral health providers, and the member's PCP, as appropriate;
- Participating (either directly or through the CME, if one is assigned) in discharge planning activities with the facility, including arranging for safe discharge placement and facilitating clinical hand offs between the discharging facility and the OhioRISE plan or CME, if one is assigned;
- Obtaining (either directly or through the CME, if one is assigned) a copy of the discharge/transition plan and share the plan with the member's care team;
- Arranging for and confirming that (either directly or through the CME, if one is assigned) services are authorized and delivered in accordance with the discharge/transition plan;
- Ensuring that providers can obtain copies of the member's medical records as appropriate and consistent with federal and state law; and
- Conducting (either directly or through the CME, if one is assigned) timely follow up with the member and the member's behavioral health providers to ensure post discharge services have been provided.

Continuation of Prior Authorized Services for OhioRISE plan Members

If a new member's prior authorization for services was approved prior to OhioRISE enrollment, the OhioRISE plan must allow the member to receive services from network and out-of-network providers until the authorization expires.

If the member's needs change such that a change in services is warranted, the OhioRISE plan may conduct a medical necessity review for previously authorized services and must render an authorization decision as required by to OAC rule 5160-59-03.1.

The OhioRISE plan may assist the member in accessing services through a network provider when the member's condition stabilizes and the OhioRISE plan can ensure no interruption to services; the member chooses to change the member's current provider to a network provider; or there are quality concerns identified with the previously authorized provider.

Utilization Management Population Health Approach

Utilization management contributes to population health by allowing MCEs to ensure that members are receiving the appropriate level of care and services needed to address their needs. Each MCO and the OhioRISE plan is required to develop, implement, and maintain a Utilization Management (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 UM program must be used to inform the MCE's population health and quality improvement (QI) strategies. As with other population health management approaches, ODM requires MCEs to institute the appropriate infrastructural supports for its UM program.

To emphasize the importance of monitoring utilization, ODM requires each MCE to employ a Utilization Management Director (UM Director) to oversee the UM Program's day-to-day operational activities. The Utilization Management Director is charged with developing written policies and procedures regarding service authorization and ensuring that:

- UM policies and procedures are followed, and that review criteria for authorization decisions are consistently applied, this involves reviewing data for subpopulations, as well as looking at individual cases;
- Healthcare professionals with the appropriate clinical expertise in treating the member's condition or disease are the ones making decisions to deny services or reduce their amount;
- Notices of Adverse Action are provided in accordance with 42 CFR 438.404; and
- Member quality of care and outcomes, including access to care, are not negatively impacted by the MCE's UM program.

As part of ensuring that the MCEs have the necessary infrastructure for utilization management, ODM has also instituted staffing requirements for the MCEs. MCEs are prohibited from using generalists to review and make prior authorization decisions for specialty services.

MCOs must employ appropriately qualified, licensed staff (e.g., dentists, physician specialists, licensed behavioral health professionals) with the necessary subject matter expertise to review prior authorization requests.

The OhioRISE plan must ensure that all staff involved in UM functions (e.g., reviewing, evaluating service planning information, authorization) meet the following minimum qualifications:

- Are clinically licensed with a specialty in mental health, SUD, or child or youth services;
- 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 healthcare field, providing community-based services to children and youth, and their family and/or caregivers;
- Have a 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 and/or therapy, child protection, or child development;
- Are clinically and culturally competent and responsive with the training and experience necessary to manage complex cases in the community across child-serving systems; and

- Are trained to screen and assess crisis or emergency calls, including assessing the caller's degree of acuity/severity and clinical necessity for treatment based on ODM-approved criteria.

The OhioRISE plan may share UM staff with other MCEs. However, at least one full-time UM position must be dedicated to OhioRISE plan's functions, if the OhioRISE plan is affiliated with an Ohio Medicaid MCO and/or MyCare Ohio Plan.

Prior Authorization Requests. MCEs are required to have written policies and procedures to process prior authorization requests (OAC 5160-26-03.1, 5160-28-03.1, and 5160-59-03.1). In accordance with 42 CFR 438.210(e), the MC**E** 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.

Upon request, the MCE's policies and procedures must be made available for review by ODM, as well as by contracting and non-contracting providers.

When processing requests for initial and continuing authorizations of services, MCEs must ensure and document that the review criteria were consistently applied, that the requesting provider was consulted (if necessary).

If any service authorization request that was denied or was authorized in an amount, duration, or scope that was less than requested, the MCE must document that the decision was made by a healthcare professional who had the appropriate clinical expertise in treating the member's condition or disease, and that a written notice was sent to the member and requesting provider. The written notice must meet the requirements of division 5101:6 and rule 5160-26- 08.4 of the Administrative Code.

Written Policies and Procedures. MCOs are required to provide their contracting and non-contracting providers with a list of benefits that require prior authorization approval and the written policies and procedures for initial and continuing service authorization.

All MCOs are required to designate staff specifically responsible for resolving individual provider issues, including problems with claims payment, prior authorization, and referrals. Written information must be provided to their contracting providers detailing how to contact these designated staff.

The MCOs written policies and procedures for processing authorization requests from their providers and members must be made available for ODM's review when requested. MCOs must ensure through documentation that when requests for initial and continuing service authorization are processed the following occurs: review criteria for authorization decision are consistently applied; the requesting provider is consulted when necessary; and that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than that requested, is made by a healthcare professional who has appropriate clinical expertise in treating the member's condition or disease.

Prior Authorization Timelines. For standard authorization decisions, the MCE must provide notice to the provider and member as expeditiously as the member's health condition requires but no later than ten calendar days following receipt of the request for service.

If requested by the member, provider, or MCE, standard authorization decisions may be extended up to fourteen additional calendar days. If an extension is requested by the MCE, the MCE must submit to ODM for prior-approval, documentation as to how the extension is in the member's interest. If ODM approves the MCE's extension request, the MCE must give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision. The MCE must carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires. Service authorization decisions not reached within the required timeframes constitute a denial, and the MCEs must give notice to the member as specified in rule 5160-26-08.4 of the Administrative Code.

If a provider indicates or the MCE determines that following the standard authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCE must make an expedited authorization decision and provide notice of the authorization decision as expeditiously as the member's health condition requires but no later than forty-eight hours after receipt of the request for service.

Prior authorization decisions for covered outpatient drugs as defined in 42 U.S.C. 1396r-8(k)(2) (as in effect January 1, 2017) must be made by telephone or other telecommunication device within twenty-four hours of the initial request. In emergency situations, the MCE must authorize a 72-hour supply of the covered outpatient drug that was prescribed. If the plan is unable to obtain the information needed to make the prior-authorization decision within 72 hours, the decision timeframe has expired and the MCE must give notice to the member as specified in rule 5160-26-08.4 of the Administrative Code.

Clinical Review. For any service or prior authorization request or decision, ODM may require an additional clinical review or a different clinical review process. The MCO 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. MCOs must permit and facilitate ODM real time, read-only access to the MCO's service authorization systems, including all approval and denial documentation.

Peer-to-Peer Consultation. When an MCO denies a service authorization request from a provider, the MCO must notify and offer the provider the option to request a peer-to-peer consultation. The MCO must offer a peer-to-peer consultation within a mutually agreed upon time within 24 hours of a provider's request for a peer-to-peer consultation.

MCOs must ensure that MCO staff conducting peer-to-peer consultations are healthcare professionals who have clinical expertise in treating the member's condition and have credentials that are equivalent or higher credentials than those of the requesting/ordering provider. The MCO must use accepted clinical guidelines when conducting peer-to-peer consultations.

The MCO staff conducting the peer-to-peer consultation must clearly identify what documentation the provider must provide to obtain approval of the specific item, procedure, or service; or a more appropriate course of action based upon accepted clinical guidelines.

Retroactive Coverage Requirements. In accordance with ORC section 5160.34, MCOs are prohibited from retroactively denying a prior authorization request as a UM strategy. If prior authorization was required for a service but not obtained in accordance with ORC section 5160.34, the MCO must conduct a retrospective review of the claim.

Behavioral Health Service Authorization

Home Health Assessment Service Authorization

Medicare Certified Home Health Agencies must follow Medicare's Conditions of Participation and must complete the initial assessment visit within 48 hours of referral, within 48 hours of the patient's return home, or on the physician-ordered start of care date. When requiring prior authorization for home health assessments, the MCO must complete its prior authorization review within 48 hours of the request to permit Medicare Certified Home Health Agency compliance with Medicare's Conditions of Participation.

Coordinated Services Program

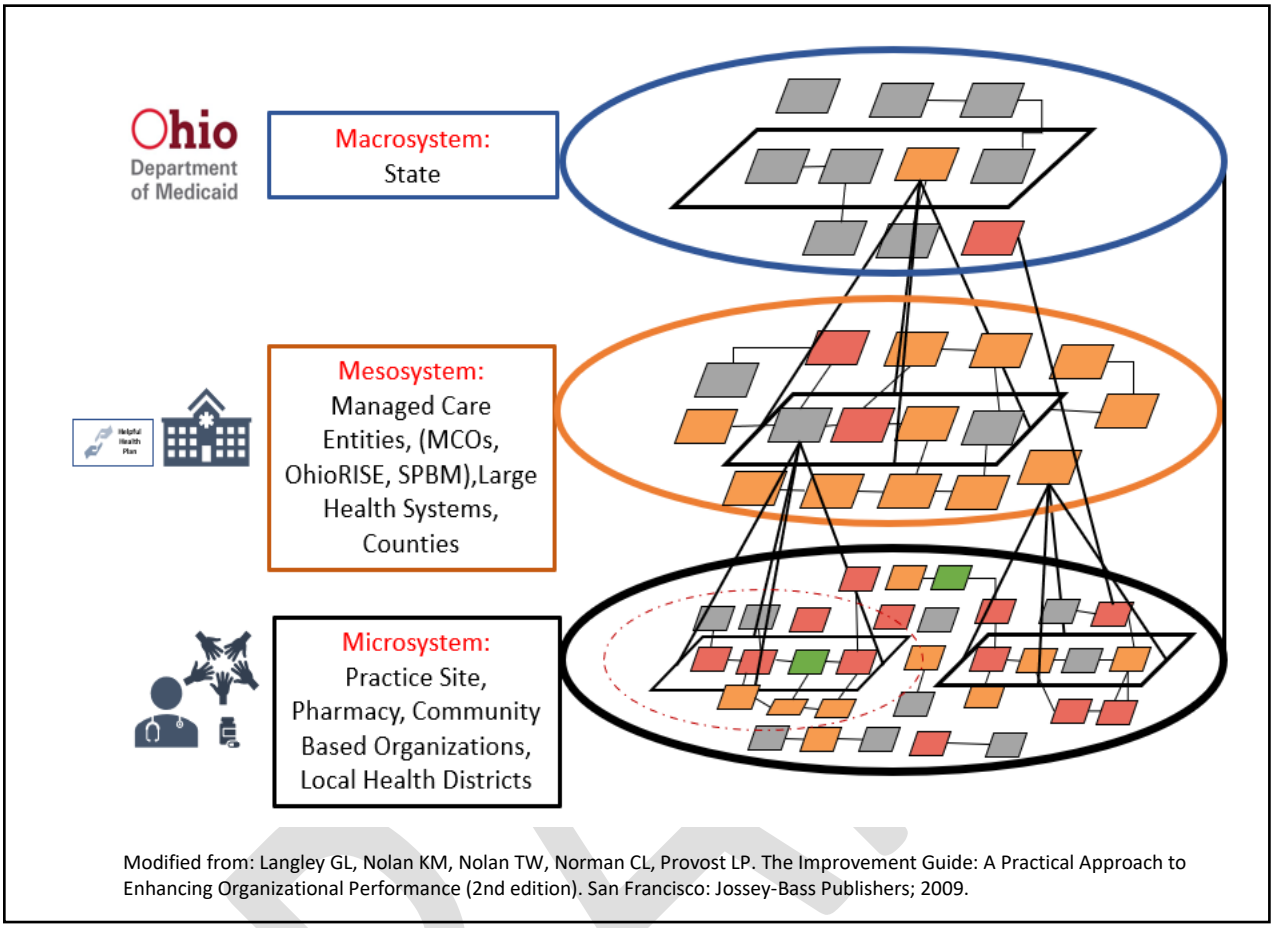
Each MCO must develop a Coordinated Services Program (CSP), as defined in OAC rule 5160-20-01, to address the overuse or misuse of services. The MCO must, at a minimum, follow all applicable provisions for initial and continued enrollment in the CSP in accordance with OAC rule 5160-20-01. The MCO must offer care coordination to any member who is enrolled in the CSP. ODM approval must be obtained prior to implementation of the CSP.

Each MCO must submit its enrollment of members in the CSP program via the "Inbound from MCO" file no later than the 15th calendar day of each month to ensure CSP enrollment is recorded in the HIPAA 834 files. Each MCO must monitor the "Outbound to MCO" file to review file submission errors and correct submissions via the "Inbound from MCO" file, including changes in CSP enrollment, new CSP enrollment, and CSP disenrollment.

The OhioRISE plan must actively participate and 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. The OhioRISE plan must support ODM's prescriber and pharmacy lock-in programs by ensuring care coordination services are provided to any CSP-enrolled member, including coordination with any MCO-based care management activities; supporting member lock-in for a specific drug, drug class, Drug Enforcement Administration (DEA) schedule, and other parameters as defined by ODM; supporting the capability to lock members into one or more specific providers (pharmacies or prescribers); and implementing provider training and transmission messages to make it clear to providers when a member has been locked into a specific prescriber or pharmacy, and the grievance procedure associated with this decision.

Cross-System Collaboration Population Health Approach

MCEs must adhere to state and federal privacy requirements while facilitating cross-system collaboration and coordination with other entities involved in the support, care, and treatment of members. These entities include care coordination entities (e.g., ODM-funded alternative payment models and conflict-free case management agencies), other MCEs and MCE care management entities (CMEs), other entities directly involved in the healthcare delivery system (e.g., hospital and provider associations), and other local entities impacting or impacted by member health (e.g., local health departments, ADAMH Boards, schools, child welfare, County Job and Family Services, justice system). As described by Langley et. al (2009) cross system collaboration is key to improvement of complex systems, such as the healthcare delivery system. Adopting this framework to align measures. as shown below, allows ascertainment of the collaborative success in driving toward common population health goals.



Modified from: Langley GL, 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.

Cross-system collaboration and coordination across the complex healthcare delivery system includes the following activities:

- Data sharing, subject to state and federal privacy requirements.
- Early identification of care needs (e.g., pregnancy, lack of preventive care, behavioral health) and connection to services.
- Identification of service gaps and assistance in closing gaps in care (e.g., scheduling appointments, arranging transportation, and facilitating referrals and linkages to MCO health and wellness programs) to optimize health outcomes.
- Addressing SDOH, such as food insecurity, housing instability, and transportation needs.
- Coordination between involved entities, care coordinators, and primary care providers.
- Integrating behavioral and physical health.
- Ensuring seamless care transitions and follow-up.
- Promotion of services that facilitate care delivery (e.g., telehealth); and
- Alignment of measures to determine success.

Value-oriented Payment Innovation

ODM requires MCOs and the OhioRISE plan to design and implement payment reform initiatives to transform the healthcare delivery system through rewarding innovation and results over volume of service delivery. This transformation is aimed at improving individual and population health outcomes and member experience while containing costs. To this end, MCOs and the OhioRISE plan must develop value-oriented payment methodologies that reduce unnecessary payment and care while promoting quality, enhancing market competition and consumerism, engaging, and partnering with providers and other payers, and promoting transparent mechanisms for engaging members in making informed provider and care choices in the selection of evidence-based, cost-effective care.

MCOs and the OhioRISE plan must not only encourage provider participation in, and support of, value-based payment initiatives, but must also support provider readiness (e.g., data and analytic capabilities, financial stability); tailor payment reform strategies to provider type (e.g., behavioral health providers, hospital providers, dental providers, federally qualified health centers), geography (e.g., rural providers) and size (e.g., small providers hospital systems); assist providers in identifying and addressing barriers to value based payment efforts; and encourage member utilization of providers that demonstrate value and quality by contributing to the design of ODM initiatives to transparently provide information to members on providers, quality, cost, and member experience by providing data and publishing results.

Partnerships with ODM, the OhioRISE plan, and or the SPBM may be initiated by the MCE or required by ODM. ODM must approve MCO-initiated value-oriented payment initiatives that involve the OhioRISE plan or the SPBM.

Specific ODM-initiated value-oriented initiatives are discussed below.

Ohio's CPC Program

Ohio CPC is an investment in primary care infrastructure intended to support improved population health outcomes. CPC is a patient-centered medical home program, which is a team-based care delivery model led by a primary care practice that comprehensively manages a patient's health needs.

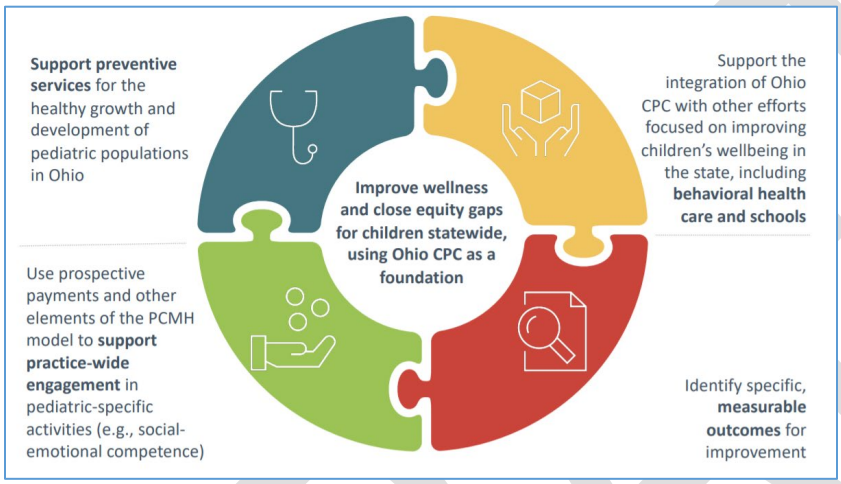
The goal of the program is to empower practices to deliver the best care possible to their patients, improving quality of care and lowering costs. Although most medical costs occur outside of a primary care practice, primary care practitioners can guide many decisions that impact those broader costs, improving cost efficiency and care quality.

Initial piloting of the CPC program provided information needed to assist members of the design team (providers, payers and patients) in making decisions regarding the Medicaid payment model, attribution methodology, and quality metrics.

Beginning in the fall of 2016, select practices were invited to enroll in the CPC program. New practices can enroll in the program on an annual basis during the fall open enrollment period. Practices only need to enroll once; enrollment will roll over from year to year. The PCMH model became available statewide in 2019 and after the timeframe when Medicaid behavioral health benefits were carved into managed care. The overall goal of the program is to enhance the state's primary care capacity in a way that fosters the integration of behavioral health into traditional medical practice.

The performance period and reporting for Ohio CPC begins in January of the year following provider enrollment in the program. Providers receive quarterly progress reports and annual performance reports.

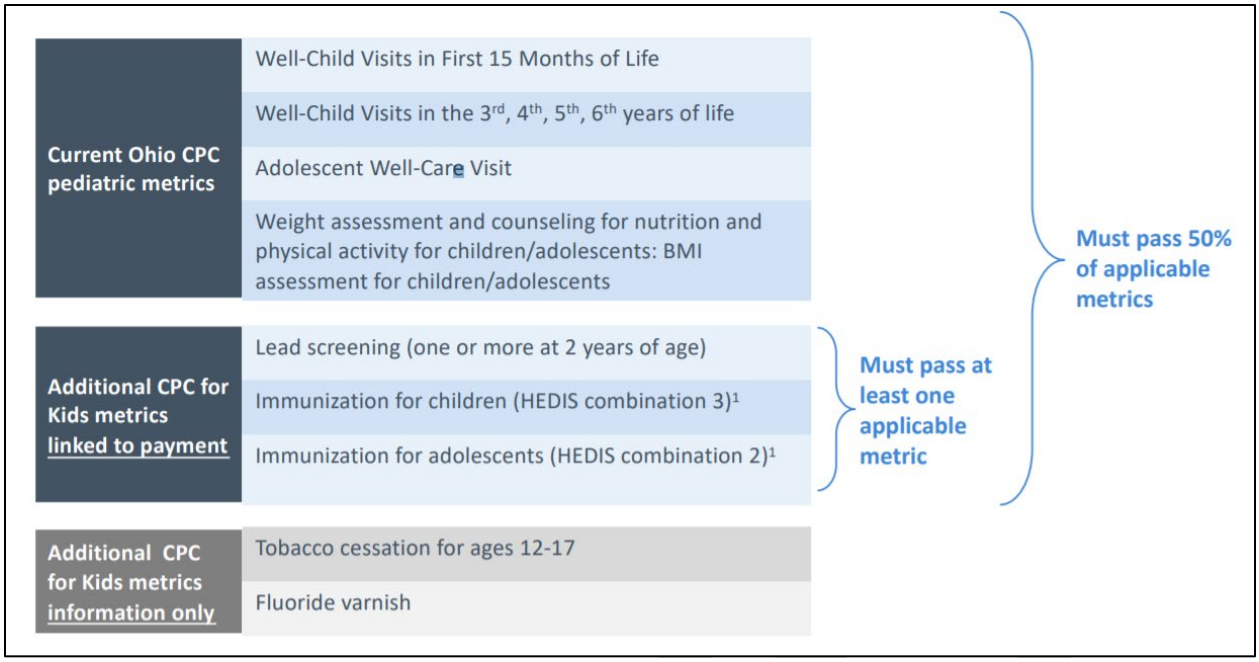
There are three types of requirements that practices must meet to receive payments through the CPC program: activity requirements, clinical quality metrics, and efficiency metrics. These requirements essentially define the core PCMH functions. Practices must meet all activity requirements, 50% of applicable quality metrics, and 50% of applicable efficiency metrics to be eligible for payment. Managed care plans have supported ODM's efforts to promote the CPC model by assisting providers with obtaining certification as a PCMH by a nationally recognized accreditation organization, creating electronic member profiles for use by providers in managing patients, and aiding providers with practice transformation.



CPC for Kids

In 2020, ODM introduced Ohio CPC for Kids, a pediatric-focused component of CPC that provides additional per-member per-month payments and opportunities for quality add-on payments in exchange for performance on additional metrics related to lead testing and immunizations, as well as additional pediatric-focused activities.

Providers participating in CPC for Kids are measured against established thresholds for the following clinical quality metrics: well-child visits in the first 15 months of life; well-child visits in the 3rd, 4th, 5th, 6th years of life; adolescent well care visits; weight assessment and counseling for nutrition and physical activity for children and adolescents; lead screenings; immunizations for children, combination 3; and immunizations for adolescents, combination. Providers must pass at least half of the metrics for which they have at least 30 patients in the denominator. In addition, providers must pass at least one of the following metrics: lead screenings; immunizations for children, combination 3; or immunizations for adolescents, combination 2.[xv] Providers received information for tobacco cessation for adolescents, and fluoride varnish, but no thresholds or passing rates were applied to those two metrics. Providers that fail to meet these standards may be disenrolled from the program.



Source: ODM working group conversations and stakeholder input
1 Includes: diptheria, tetanus, and acellular pertussis; polio; measles, mumps, and rubella; influenza type B; 5 chicken pox; pneumococcal conjugate.
2 Includes: meningococcal serogroups A, C, W, Y; tetanus, diptheria, acellular pertussis; HPV.

MCOs play a key role in supporting network Comprehensive Primary Care (CPC) practices with achieving optimal population health outcomes. ODM requires that each MCO establish a relationship with each network CPC practice and work collaboratively with the CPC to determine the level of support to be provided by the MCO based on the CPC practice's infrastructure, capabilities, and preferences for MCO assistance (e.g., addressing social determinants of health, data sharing).

In pursuing population health, MCOs must use community population health priorities to partner with CPC practices to inform their population health strategies, integrate results from CPC metrics into the MCO's overall quality improvement (QI) program; and participate in the CPC's improvement opportunities aimed at reducing healthcare disparities and improving outcomes and member experience.

Episodes of Care

Ohio's episode-based payment model seeks to reduce healthcare costs and improve quality of care by providing transparency on spend and quality across an entire episode, allowing providers new visibility into their performance and how they compare to peers. An episode of care includes all the care related to a defined medical event (e.g., a procedure or an acute condition), including the care for the event itself, any precursors to the event (such as diagnostic tests or pre-op visits) and follow-up care (such as medications, rehab, or readmission). Episodes, which are built from the perspective of a patient journey, offer a comprehensive view of the care involved in treating a condition for a patient.
Since 2015, Ohio has launched 43 episodes, 23 of which are currently tied to financial incentives. 11 episodes have been retired starting the 2019 program year and an additional two were retired in 2020.

An "episode" is a defined group of related Medicaid covered services provided to a specific patient over a specific time period. The characteristics of an episode vary according to the medical condition for which a recipient has been treated. In the Episodes of Care payment model a Principal Accountable Provider

(PAP) with decision-making responsibilities, influence over other providers, and episode expenditures, is identified and is held accountable for both the quality and cost of care delivered to a patient during an episode.

For each PAP, ODM calculates the average risk-adjusted episode reimbursement for each episode that occurs within the 12-month performance period. The average risk-adjusted reimbursement of all episodes for the PAP during the performance period is then compared to thresholds established by the department.

Incentive payments to a PAP are based upon episodes that end within a performance period. Incentive payments may be positive or negative and are calculated and made retrospectively after the end of the performance period. Incentive payments are based on the aggregate of valid, paid claims across a PAP's episodes and are not relatable to any individual provider's claim for payment. A PAP must have a minimum volume of episodes during a performance period to be eligible for an incentive payment.

For each episode type, ODM applies quality metrics to evaluate the quality of care delivered during the episode and applies these metrics to providers that are eligible for positive incentive payments to avoid the risk of incentivizing care delivery at a cost that could compromise quality. Included are quality metrics reflecting certain standards which support the delivery of adequate care during the episode.

Incentive payments are separate from, and do not alter, the reimbursement methodology for Medicaid covered services set forth in department rules located in agency 5160 of the Administrative Code.

Due to the COVID-19 pandemic, the episodes of care program was suspended for calendar years 2020 and 2021. However, ODM continues to advance the goal of tying payment to quality by improving availability of actionable data to help clinicians make better decisions when caring for patients.

Care Innovation and Community Improvement Program (CICIP)

The Care Innovation and Community Improvement Program (CICIP) was developed to increase alignment of QI strategies and goals among ODM, MCOs, and four large public and nonprofit hospitals (The MetroHealth System, UC Health, University of Toledo Medical Center, and The Ohio State University Wexner Medical Center). CICIP goals align with ODM goals to improve healthcare for Medicaid beneficiaries at risk of or with an opioid or other substance abuse disorder (SUD), along with improving care coordination.

The quality measures are as follows:

- Rate of Opioid Solid Doses Dispensed (without Suboxone) for members of practitioners prescribing opiates.
- Rate of members receiving opioids also receiving Benzodiazepines.
- Rate of members with opioid scripts receiving greater than 80 mg Morphine Equivalent Dose.
- Initiation and engagement of alcohol and other drug dependence (Healthcare Effectiveness Data and Information Set [HEDIS] measure).
- Follow-up after inpatient stay for mental health within seven calendar days (HEDIS measure).
- Emergency room utilization reduction.
- Improve opioid use disorder/maternity measures with a focus on:
    - Timeliness of prenatal care,

- Live births weighing less than 2,500 grams, and
- Postpartum care.

Comprehensive Maternal Care (CMC)

Ohio ranks near the bottom of the nation for its rate of infant mortality and faces significant racial disparities in neonatal outcomes[xvi]. As Ohio's largest source of payment for Ohio births, the Ohio Department of Medicaid aims to reduce and eliminate racial disparities in maternal and infant outcomes and to reduce infant mortality. To that end, ODM is implementing a Maternal and Infant Support Program (MISP) that will focus on providing services and strategies that are designed to advance these goals by ensuring high-quality, person-centered care is delivered to our moms and babies to improve outcomes and reduce disparities.

To fill maternity and infant care gaps and to better meet the needs of families at risk for poor birth outcomes, ODM's MISP is based on a population health, holistic, person-centered, and culturally competent approach to develop the MISP. Through MISP, Ohio Medicaid will incentivize perinatal and infant care that incorporates clinical interventions with evidence-based and evidence-informed community-based services, creating a space for improved cultural competencies and individually configured services that improve maternal and infant outcomes and patient experiences while addressing implicit bias. Personalized care will give families the clinical and community supports they need to improve outcomes, while helping them build a longitudinal trusting relationship with the healthcare system

ODM currently funds coordinated community programs to target the disparity in the African American infant mortality rate in Butler, Cuyahoga, Franklin, Hamilton, Lucas, Mahoning, Montgomery, Stark, and Summit Counties. More information about our Ohio Equity Institute Infant Mortality Grant funding and programs can be found here.

MCE-initiated Payment Reforms

MCOs and the OhioRISE plan must submit annual proposals for value-oriented payment strategies. Due to the length of experience with value-oriented payments, MCOs currently have specific APM targets based on the Healthcare Payment Learning & Action Network (HCP-LAN) APM Framework. The framework, which aligns with ODM's population approach, encompasses six goals (1.) addressing social determinants of health (SDOH), (2.) reducing ineffective care and inappropriate utilization of services, (3.) increasing data transparency and interoperability, (4.) ensuring timely data and analytics capabilities, (5.) facilitating market shifts to value, and (6.) promoting population-specific approaches.

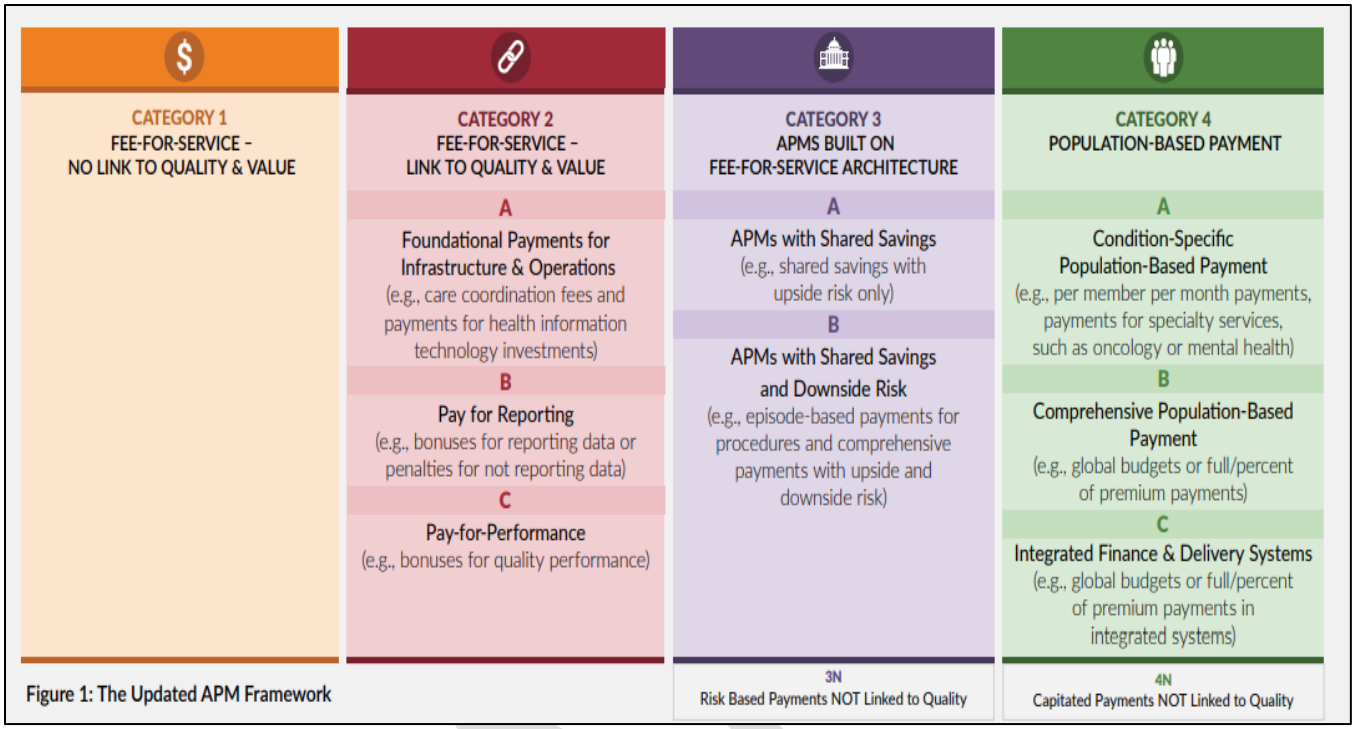


Figure 1: The Updated APM Framework

The MCO goals for CY 2023-2026 are shown in the table below. These may be added for the OhioRISE plan as the program matures.

	Small Providers (< 150 Medicaid Members)		Large Providers (≥ 150 Medicaid Members)	
	APM LAN Category 3A+*	**APM LAN Category 3B+***	**APM LAN Category 3A+**	**APM LAN Category 3B+**
CY 2023	60%	0%	70%	20%
CY 2024	70%	0%	80%	30%
CY 2025	80%	0%	90%	40%
CY 2026	90%	0%	100%	50%

* 3A+ includes 3A, 3B, 4A, 4B, and 4C. 3B+ includes 3B, 4A, 4B, and 4C

On an annual basis, each MCO is required to submit a written strategy for how the MCO will achieve APM target requirements. These strategies which are submitted to ODM must describe the following:

- How the MCO will pay providers differentially according to performance (and reinforce this payment with benefit design);
- How the MCO will design payment approaches that maintain or improve quality, or reduce waste; and
- How payments will be designed to encourage adherence to clinical guidelines; and how payment strategies will reduce unwarranted price variation

In developing APMs, MCOs must balance payment reforms with consideration of payment needed to retain network adequacy and reasonable non-hospital access. MCOs must also carefully consider which

providers can take on risk so that network adequacy standards are maintained across the entire service area.

ODM may require, at its sole discretion, that the OhioRISE plan implement any of the initiatives in the submitted proposals.

Community Reinvestment

MCOs and the OhioRISE plan must demonstrate a commitment to improving health outcomes in local communities in which they operate through community reinvestment activities. Community reinvestments must be used to support population health strategies within the region or regions the MCE serves.

MCOs must each contribute 3% of annual after-tax profits to community reinvestment and increase the contribution by 1% each subsequent year, for a maximum of 5% of annual after-tax profits. MCOs are encouraged to maximize collective impact by collaborating with other MCEs, as well as state agencies and local community entities.

ODM prohibits MCEs from using community reinvestment funding to pay for Medicaid covered services.

Interconnectedness of Population Health Strategic Approaches

The population health strategic approaches described above are interconnected, both contributing to and supporting the success of one another in achieving the shared aims of improving the health, healthcare experiences, and health outcomes of Ohio's Medicaid population. To ensure their success and adjust when needed, ODM is committed to monitoring the implementation of and evaluating the outcomes of these approaches. Section 3 provides examples of some of ODM's mechanisms for monitoring and evaluation of these approaches, along with more general contract monitoring activities.

Section 3. Monitoring and Evaluation

ODM has created a robust accountability system to ensure that MCEs are working within the framework of the *Population Health, Equity, and Quality Strategy* to improve the health and quality of care provided to individuals insured by Medicaid. Requirements and standards that clearly define ODM's expectations are set forth in Ohio Administrative Code, ODM provider agreements with managed care entities, and in guidance documents, Monitoring and evaluation mechanisms include External Quality Reviews, performance measures, periodic MCE reports, dashboards, ODM-initiated improvement project performance, and MCE evaluations of their quality improvement strategies. These are discussed in more detail below.

In accordance with 42 CFR 438.66, ODM's monitoring system addresses all aspects of MCE performance, including, but not limited to: administration and management, information systems, claims management, provider network management, service availability and access, appeal and grievance systems, medical management (e.g., utilization management and case management), quality improvement, marketing, member materials and customer services, program integrity and finances (e.g., medical loss ratio reporting).

At the most basic level, ODM monitors MCE compliance with the ODM-MCE provider agreements to ensure that the MCE is meeting contractual requirements. Compliance with contractual language is overseen by the Office of Managed Care (MCOs), the Office of Strategic Initiatives (OhioRISE plan), and the Office of Health Innovation and Quality (SPBM PAHP). When an MCE is found to be noncompliant,

the MCE must take immediate action to correct the identified area(s) of deficiency and must notify ODM of the actions taken to address noncompliance.

Sanctions for Noncompliance
When monitoring or evaluation shows that MCEs are not within compliance with the relevant ODM provider agreement, or state or federal regulations, the MCE is subject to sanctions established as required by 42 CFR 438.700. These sanctions may be financial or nonfinancial. A list of the sanctions that may be applied by ODM in CY 2022 can be found in Appendix C of this document and Appendix N of the Provider Agreements.

Between 2018 and 2020, 113 total sanctions were applied by ODM. The most common sanctions over this three- year time period related to the following noncompliance areas: MCO provider panel requirements (41), performance measures (11), late fees (10), prompt pay violations (7), prior authorization timeframes (5) and failure to follow file specifications (4).

Violation	Type of Sanctions Applied	Number of Sanctions Applied			
		2018	2019	2020	2021
Failure to Meet Provider Panel Requirements	Financial Sanction	16	17	8	19
Performance Measures	Corrective Action Plans, Financial Sanctions	5	6	0	5
Late Fees	Financial Sanctions	4	4	2	3
Prompt Pay	Financial Sanctions	5	2	0	2
Prior Authorization	Corrective Action Plans	0	5	0	0
Failure to follow file specifications	Corrective Action Plans	4	0	0	6

A. General Monitoring

NCQA Accreditation

ODM requires that MCOs and the OhioRISE PIHP hold and maintain, be actively pursuing National Committee for Quality Assurance (NCQA) accreditation for the Ohio Medicaid line of business. The plans must achieve and maintain a minimum status of “Accredited”. If an MCE receives a “Provisional” or “Denied” status from NCQA, the MCE will be subject to compliance actions outlined in the respective ODM provider agreement. At present, ODM only accepts NCQA accreditation standards. Compliance with this requirement is assessed by ODM on an annual basis based on the MCE's accreditation status posted on the NCQA "Report Cards" webpage (https://reportcards.ncqa.org) as of November 1 of each year. For the purposes of determining whether the MCE meets this accreditation requirement, ODM only accepts the use of the NCQA Corporate Survey Process to the extent deemed allowable by NCQA.

Upon ODM's request, the MCE must provide requested documents related to NCQA accreditation within the timeframe specified by ODM.

As required by 42 CFR 438.332, ODM reviews the accreditation status of its contracted MCOs, PIHPs, and PAHPs and makes this information available on the ODM website. This information is updated annually.

EQRO Activities

ODM's contracted EQRO, IPRO, validates MCE Performance Improvement Projects (PIPs), validates performance measures, performs an administrative compliance assessment, conducts a validation of network adequacy, validates encounter data, validates consumer and provider surveys (Consumer Assessment of Healthcare Providers and Systems-CAHPs), performs information systems reviews, calculates program evaluation/clinical performance measures, and conducts performance improvement projects. Contingent on CMS protocol development, the EQRO will also perform quality ratings of the MCEs.

As required by 42 CFR 438.350, annual external independent reviews of quality outcomes, timeliness of, and access to services covered under each MCO, PIHP, and PAHP are conducted by ODM's external quality review organization. The results of these reviews are available on ODM's website at: https://www.medicaid.ohio.gov/MEDICAID-101/-Quality-Strategy-and-Measures#1930254-external-quality-review-tech-report

Nonduplication of EQR Activities

ODM strives for EQR activities to be value added and to supplement ODM's oversight mechanisms. For these activities also to be cost-effective and efficient, ODM is committed to the non-duplication of activities through the use of information from Medicare or private accreditation reviews as allowed in CFR §438.360. To that end, ODM has implemented the deeming option permitted by 42 CFR §438.362. For the administrative review that was conducted in spring of 2020, QSource, ODM's EQRO, completed a crosswalk of NCQA standards with applicable CFRs to identify standards that are fully comparable and eligible for deeming. ODM accepted the recommendations issued in QSource's full report regarding federal regulations that could be deemed (see Appendix D).

As required by 438.350, ODM contracts with an EQRO to conduct annual, external, independent reviews of the quality, timeliness, and accessibility of services provided by MCOs to enrolled individuals. ODM's current External Quality Review Organization, IPRO) provides external quality review (EQR) services for Ohio's Medicaid managed care plans, including:

- Encounter Data Accuracy Studies: The EQRO is responsible for completing two encounter data accuracy studies. The first study is a delivery payment study to verify the accuracy of MCO encounter data submissions. The second study compares the accuracy and completeness of payment data stored in the MCO's claims system to payment data submitted to and accepted by ODM.
- Administration of provider and consumer satisfaction surveys

- Validation of MCO performance measures
- Administrative Reviews of MCO compliance with state and federal regulations.
- Technical Assistance: ODM relies upon the national expertise of the EQRO vendor to provide technical assistance to both the State and the MCOs to maximize efficiency and effectiveness in the administration of the managed care program. This includes the design and implementation of the performance improvement projects and identification of best clinical and administrative practices.
- Validation of Performance Improvement Projects: The EQRO validates the content of MCO Performance Improvement Projects in accordance with EQR Protocol 1 ("Validating Performance Improvement Projects") and the Model for Improvement[xvii], popularized by the Institute for Healthcare Improvement (IHI).

Annual EQRO Technical Report

In accordance with 42 CFR 438.364, ODM's External Quality Review Organization produces an annual Technical Report which summarizes the quality, timeliness, and accessibility of care furnished to members of Ohio's Medicaid program by the MCOs in key performance areas, including member satisfaction.

Information and recommendations generated by the EQRO assist ODM in determining needed changes to the quality strategy and associated guidance, monitoring, and implementation mechanisms. EQRO-identified opportunities for improvement are addressed through quality improvement projects, as well as programmatic, and policy changes. An example of how the EQRO Technical Reports inform ODM and MCE population health and health equity improvement efforts is described below.

According to the state fiscal year 2019 *EQRO Technical Report*, the majority of MCOs' percentage of HEDIS measure indicators that met the minimum performance standard (MPS) increased compared to the previous year. However, statewide performance rates were below the national Medicaid 25th percentile for three measures: Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total; Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%); and the Adult Body Mass Index (BMI). In response to the poor findings regarding diabetes control, in May of 2020, ODM launched a collaborative performance improvement project with over twenty clinical practices and Ohio's Medicaid and MyCare managed care plans. This project, which also aims to address disparities in diabetes control is described in more detail in Section 3, Population Health Approach. In January of 2021, ODM also further emphasized the importance of diabetes control by encouraging the MCOs to spread their approach to the remainder of the state and incentivized this effort by allowing the MCOs to regain a portion of their quality withhold through this work.

The EQRO findings regarding multiple concurrent antipsychotic use in children and adolescents also informed ODM's reimagined managed care delivery system, including the development of the OhioRISE program, and emphasized the need for a single pharmacy benefit manager (SPBM) which would allow for an integrating monitoring of prescribing practices. ODM is in the process of planning a PIP to address antipsychotic prescribing among children and adolescents. At minimum, this project will include participation from the OhioRISE plan and SPBM.

ODM also engaged in several monitoring activities beyond those completed by the EQRO. These monitoring and evaluation activities increase fidelity to the population health management approach, allowing for more valid and timely assessments of when and where within the managed care program improvements are needed.

B. Monitoring Population Health Management Strategy Effectiveness

Each MCO must continually evaluate the impact of its population health management strategy. The evaluation includes assessing the effectiveness of the MCO's population health approaches in assisting the MCO in progressing toward its population health goals and objectives, the MCO's collaboration with OhioRISE and the SPBM, the MCO's institutionalization and maintenance of effective practices, and how well it incorporates learnings and insights from ongoing monitoring and from previous evaluations.

In evaluating the effectiveness of the Population Health Management Strategy, each MCO must assess the sufficiency of its population health infrastructure (leadership support, resources, and information systems); the methods it uses for population identification and segmentation to align with ODM-identified population streams, including its risk stratification framework, criteria, and thresholds; the population health improvement approaches and specific approaches used to improve health outcomes and health equity; and how the MCO will collaborate and coordinate with other entities impacting population health.

The OhioRISE and the SPBM are required to support MCO population health management activities by coordinating with ODM, the MCOs, and each other. This coordination requires the sharing of available individual and aggregate data between entities. The OhioRISE plan and SPBM's evaluations of their population health and quality improvement activities are submitted within the annual Quality Assessment and Performance Improvement submission and inform the MCO's overall population health strategy.

The OhioRISE plan is required to play a primary role in driving population health efforts for high-risk children with behavioral health conditions by assisting ODM and the MCOs in developing cross-cutting population health and quality improvement initiatives for high-risk children and youth within the behavioral health conditions population stream. To this end, the OhioRISE plan must provide consultation to ODM, the MCOs, the SPBM and other ODM-contracted managed care entities in the following areas: development and implementation of population health strategies for this population stream; in the collection, analysis, and reporting of quality measures; in service system and clinical issues; in health equity issues; and in strategic initiatives and quality improvement activities. The OhioRISE plan also plays a key role in evaluating population health approaches within this population stream.

Monitoring mechanisms for each component of population health management are described below.

Monitoring of Population Health Infrastructure

Administration and Management-Leadership Support and Staffing Adequacy

MCE population health leadership and staffing requirements are set forth in the ODM-MCE provider agreements and minimal compliance is assessed annually using the Population Health Management Strategy. Additional insights into the degree to which leadership and staffing are adequate to meet population health, equity, and quality goals are gained through observation of MCE population health improvement activities, monthly medical director meetings, quality withhold improvement project progress, monthly performance improvement project template submissions, and EQRO monthly assessments of performance improvement progress.

ODM gains more in-depth glimpses into adequacy of MCE leadership support and staffing by ongoing observation of:

- MCE-specific project and initiative goals and their alignment with and contribution to ODM's population health approach.
- MCE mobilization of to support population health goals.
- MCE analytic capacity, as demonstrated by the proactive identification of improvement opportunities, disparities, and areas of focus, as well as the ability to develop and monitor measures of improvement.
- MCE timely research, connection with subject matter experts, and incorporation of member, provider and community entity perspectives to inform new improvement projects.
- Clearly articulated theories of change that allow MCEs to explain to individuals unfamiliar with their projects or initiatives how the changes they are making lead to improved outcomes.
- MCE disparity reduction efforts that incorporate the perspective of individuals, families and communities impacted by the change.
- Well-planned, rapid intervention testing, with clear articulation of lessons learned.
- Thoughtful sustaining and spreading of successful interventions.

Monitoring of Information Systems

Information system requirements are set forth in ODM's provider agreements with the MCEs. Monitoring of information systems takes several forms, including transparent access to MCE systems and data, information systems review, ODM involvement in user acceptance testing, systems audits, review of claims payment error reports, and through reviews of test files of encounter data.

Transparent Access to MCE Systems and Data

MCEs are required to provide ODM with remote connectivity and real-time query access to all data relevant to member care (e.g., encounters, care coordination information, and utilization management (UM) information). MCEs are required to provide ODM the schematic, data dictionary, and other systems documentation necessary for ODM to interpret and use the data.

Review of MCE Information Systems

ODM or its designee may review the information system capabilities of the MCE when the MCE undergoes a major information system upgrade or change, when there is identification of significant information system problems, or at ODM's discretion.

Reviews include assessment of the extent to which the MCE can maintain 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.

The reviewal process includes:

- Review of the MCE's Information Systems Capabilities Assessment (ISCA) forms, as developed by CMS;.
- Review of the completed ISCA and accompanying documents.
- Interviews with the MCE staff responsible for completing the ISCA, as well as staff responsible for the MCE's information systems.

- Analysis of information obtained through the ISCA, follow-up interviews with MCE staff, and written statement of findings about the MCE's information s.ystem.
- Assessment of the MCE's ability to link multiple data sources.;
- Examination of MCE processes for data transfers.
- Evaluation of the MCE data warehouse structure and reporting capabilities.
- Review of MCE processes, documentation, and data files to ensure they comply with state and federal specifications for encounter data submissions.; and
- Assessment of the MCE's claims adjudication process and capabilities.

User Acceptance Testing

MCEs 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: updates to existing systems; new system implementations (replacing system or component with another); new infrastructure support systems (replacing an infrastructure component [e.g., SFTP or EDI system]); file format changes; and file transmission protocol changes.

If there is a perceivable change to workflows or user screens, user acceptance testing must include training regarding these changes.

Data files that are submitted to ODM must be tested and accepted prior to implementing in production. ODM will notify the MCE in writing when a test has been deemed successful and the changes are approved.

ODM reserves the right to verify the MCE's capability to report elements in the minimum data set prior to executing the provider agreement for the next contract period.

Systems Audits

MCE and any subcontractor systems must undergo an annual third-party audit that confirms that the MCO's systems and environment comply with the NIST 800-53 Rev 4 (or current release) moderate baseline. MCE and any subcontractor systems must also utilize a third party to determine compliance with MARS-E 2.0 (or current release) standards.

If an MCE 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.

MCEs, 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.

MCEs 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.

Monitoring MCE Support of Network Provider Electronic Health Records and Health Information Exchanges

ODM requires MCOs to support their network providers in using EHRs and HIEs. ODM monitors the MCE efforts in this area through the annual MCE submission of the Network Provider EHR Adoption Report which summarizes an MCE's activities to support provider adoption and effective use of EHRs and through the annual MCE HIE Provider Support Plan which specifies how an MCE is supporting the use of HIEs.

Monitoring Claims Management--Claims Payment Systemic Errors

A claims payment systemic error (CPSE) occurs when an MCE's claims adjudication incorrectly underpays, overpays, denies, or suspends claims that impact, or have the potential to impact, five or more providers. When there are systemic errors, the MCE must report them to ODM within two business days of adjudication or identification, whichever is earlier. MCEs are required to update the status of all active CPSEs on a weekly basis and must report them at the level of the provider type.

MCEs must also report all CPSEs on a monthly CPSE report that is posted on the MCE Ohio Medicaid website. The CPSE report is required to be public facing for anyone to view and/or on the MCE's provider portal. If the provider portal is used, timely communication of the CPSE must also be made to impacted providers that are unable to access the report.

The CPSE report includes a detailed description and scope of all CPSEs, the date of first identification, the type(s) of providers impacted, the number of providers impacted, the date(s) and method(s) of all provider notification, the estimated resolution date, the timeline for fixing the CPSE, the number of claims impacted, and the date(s) or date span(s) for all claim adjustment projects or notification of claims overpayments, if applicable.

Upon request, MCEs must submit their CPSE policies and procedures to ODM for review. CPSE policies and procedures must include:

- the internal and external sources used to identify CPSEs (e.g., user acceptance testing activities, claims processing activities, provider complaints/inquiries, and ODM inquiries);
- the identification of issues impacting smaller provider types (e.g., independent providers); a description of the process and timelines to escalate from initial identification to definition of the error;
- 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;
- the timeframe to re-adjudicate claims, if applicable, or notify providers of an overpayment and the process for providers to dispute those actions;
- a description of the process to complete and submit a completed CPSE report monthly to ODM; and
- a communication process, including timelines, to timely notify providers of identified CPSEs, including any other appropriate methods (e.g., phone calls, emails).

Monitoring Data Accuracy

In addition to monitoring the MCE's larger data system, ODM also monitors the accuracy of the MCE's data. Data accuracy is important for monitoring of other population health improvement activities.

Encounter Data Accuracy Studies

ODM's EQRO is responsible for completing encounter data accuracy studies for the MCOs and the OhioRISE plan.

Data Certification Requirements for HEDIS Interactive Data Storage System Data and HEDIS Final Audit Report

In accordance with 42 CFR 438.604 and 42 CFR 438.606 and ODM requirements, MCOs 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. Each data certification letter must be signed by the MCO's Chief Executive Officer (CEO), Chief Finance Officer (CFO), or an individual who reports directly to the MCO'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.

Annual Submission of Member Level Detail Records for Specified HEDIS Measures

MCOs must submit member level detail records for specific HEDIS measures, in accordance with *ODM Specifications for the Submission of MCO Self-Reported, Audited HEDIS Results.* The required member level detail will be used to meet CMS reporting requirements for the Core Set of Children's Health Care Quality Measures for Medicaid and Children's Health Insurance Program (CHIP) (Child Core Set).

Monitoring of Population Identification and Segmentation

Each MCO submits its risk stratification framework as part of its annual Population Health management strategy submission. ODM must review and approve this framework prior to implementation.

MCOs are also required to submit a quarterly file to ODM that contains a risk stratification level for all members (i.e., MCO Risk Stratification Data Submission File), in accordance with ODM's *Medicaid Managed Care: Risk Stratification Data Submission Specifications*. MCOs also submit a quarterly Population Stream Data Submission File which allows ODM to assess the MCO's assignment of individuals to an ODM population stream.

Monitoring of Population Health Strategic Approaches

ODM requires certain population health strategic approaches (optimal delivery systems, health equity, care coordination, quality improvement, etc.) as part of each MCO's population health management strategy. Examples of monitoring and evaluation of each required population health strategic approach are described below.

Monitoring of MCE Health Equity Efforts

Each MCE must contribute to ODM's health equity strategy and must describe their efforts to reduce health disparities and improve health equity as part of the MCE's annual Quality Assurance Performance Improvement (QAPI) submission. The MCE's QAPI should clearly show how the MCE has incorporated input from members to create strategies for reducing disparities, as well as to define metrics, timelines, and milestones for monitoring success. The QAPI, as a method for monitoring quality improvement, is described in more detail below.

ODM also requires MCEs to stratify quality measures by race, allowing for increased monitoring of racial disparities over time at the MCE and state level. Measure performance also allows ODM to prioritize improvement initiatives.

Monitoring and Evaluation of Optimal Delivery System Requirements

An optimal delivery system provides access to all members while supporting evidence best practice with best payer practices that remove barriers to care and facilitate optimal service delivery. At the most basic level, monitoring and evaluation of the delivery system focus on service availability by assessing MCE compliance with network capacity and adequacy, and appointment availability requirements. The following paragraphs provide more detail on ODM's monitoring and evaluation mechanisms for this population health approach.

> **Monitoring Provider Network Capacity and Adequacy**
> As required by 42 CFR 438.206, MCOs, PIHPs, and PAHPs must monitor their networks of providers to ensure that the capacity is adequate to ensure access to covered services for all members, including those with limited English proficiency or physical or mental disabilities. The following sections explain how provider network capacity and adequacy are monitored by the MCEs and ODM.

Provider Network Development and Management Plan

ODM requires that each MCE have a provider network that is sufficient to provide timely access to all medically necessary covered services to all members, including those with limited English proficiency or physical or mental disabilities. In addition, MCEs must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities.

One mechanism used by ODM to monitor the MCE's network capacity is the Network Development and Management Plan which is submitted to ODM annually or whenever there is a significant change (as defined by ODM) in the MCE's operations that would affect the adequacy of capacity and services, including changes in the MCE's services, benefits, geographic service area, composition of or payments to its provider network, or enrollment of a new population.

All Medicaid and MyCare MCOs, as well as the OhioRISE PIHP must develop and maintain a Network Development and Management Plan that demonstrates the MCE's maintenance of a provider network that offers an appropriate range of preventive, primary care, specialty services, and LTSS that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. The MCEs are required to evaluate and update their Network Development and Management Plans on an annual basis.

All Network Development and Management Plans must include monitoring activities to ensure that access standards are met and that members have timely access to services; provider capacity issues by service and county, the MCO's remediation, resulting improvement activities, and the targeted and actual completion dates for those activities; provider network deficiencies by service and by county and interventions to address the deficiencies; and ongoing activities for provider network development and expansion taking into consideration identified network provider capacity, network deficiencies, service delivery issues, and current and future member needs.

Additionally, the OhioRISE PIHP's Network Development and Management Plan must include documentation demonstrating that the PIHP offers an appropriate range of behavioral health services adequate for the anticipated number of members; and 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 behavioral health needs of the anticipated and existing members. This includes providers in contiguous states needed for member access and care. The OhioRISE plan is required to submit this documentation quarterly or when here is a significant change (as defined by ODM) in the OhioRISE plan's operations that would affect adequate capacity and services (e.g., changes in services, benefits, service area, provider network, or payments); any time there is enrollment of a new population in the OhioRISE plan; and as otherwise directed by ODM.

The OhioRISE plan's Network Development and Management Plan is also required include how it will coordinate with the MCOs on the behavioral health contracted continuum of care to minimize disruption of care as members transition between the OhioRISE plan and an MCO; the mechanisms that will be used to address special considerations for children and youth that transition between FFS and the MCO(s) while also enrolled in the OhioRISE plan; and how activities will be monitored to ensure access standards are met. The OhioRISE plan must also include remediation and improvement activities, and the targeted and actual completion dates for those activities in it Network Development and Management Plan. 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 must also be included, as well as collaboration and coordination with State's designated Center of Excellence.

MyCare Ohio MCOs must also develop and implement a strategy to manage their provider networks with a focus on access to services for members, quality, consistent practice patterns, independent living philosophy, cultural competence, and the integration and cost effectiveness. The provider network management strategy must address all providers. Additionally, each MyCare Ohio plan must demonstrate annually that its provider network meets the stricter of 42 CFR 432.120 or Medicare medical providers and facilities, time, distance and minimum number standards updated annually on the CMS website.

Verification of Provider Network Information

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 uses these results to evaluate MCO and OhioRISE performance, including but not limited to the following two measures.

PCP Locations Not Reached. The "PCP Locations Not Reached" measure identifies the proportion of primary care provider (PCP) locations not reached during the survey. A PCP is considered "not reached" if the provider is no longer practicing at the sampled location or the provider did not return phone calls after the external quality review organization made two attempts at different times during the survey. To meet this performance standard, the MCO's "PCP Locations Not Reached" percent must be 30% or less (at least 70% of PCP locations were reached).

Number of PCP Locations Not Contracted with the MCO. The "Number of PCP Locations Not Contracted with the MCO" measure reports the proportion of primary care provider (PCP) locations no longer contracted with the MCO at the time of the survey. To meet this performance standard, the MCO's

"Number of PCP Locations Not Contracted with the MCO" percent must be 8% or less (92% or more of the PCP locations were contracted with the MCO).

Monitoring of Time and Distance Requirements

MCOs and OhioRISE submit quarterly time and distance reports to ODM. In addition, to monitoring these reports, ODM uses time and distance geo mapping software that employs the Euclidean metric to measure the maximum time and distance for each of the MCE's membership and provider network. MCEs must ensure that at least 90% of its members residing in each county have access to at least one provider/facility of each specialty type within the time and distance standards in Appendix B. If a managed care entity determines that it is not in compliance with provider network access requirements, it must notify ODM within one business day of that determination.

Monitoring of Appointment Availability

The MCOs and OhioRISE PIHP must conduct regular reviews of appointment availability and report this information to ODM semi-annually via Appointment Availability Reports. ODM assesses these against the appointment availability standards in Appendix B in the MCO Provider Agreement.

Monitoring Pharmacy Services

The MCOs and the OhioRISE plan must use the Board of Pharmacy drug database, in addition to other available resources (e.g., claims data), to monitor member utilization and provider prescribing patterns of controlled substances and other drugs. The MCEs must also accept, maintain, and use pharmacy data received from ODM or the SPBM (e.g., daily pharmacy claims data; and daily prior authorization 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 MCO's population health activities, risk stratification, identifying members in need of care coordination, supporting care coordination activities, and informing QI activities.

The MCO must collaborate with ODM and the SPBM on prescriber engagement strategies to educate and monitor the MCO's network providers regarding compliance with the State's preferred drug list, prior authorization requirements, billing requirements, and appropriate prescribing practices. The MCO must address noncompliance as it relates to adherence to the preferred drug list, failing to comply with prior authorization requirements, or operating outside industry or peer norms for prescribing practices.

Medication Treatment Management Program Description and Quarterly Updates

Each MCO 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. Each MCO must provide ODM with quarterly MTM Program Updates of key utilization and financial metrics for its MTM program.

Monitoring of OhioRISE plan Network Requirements

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).

For the purposes of ongoing CANS assessment following enrollment in the OhioRISE plan, the OhioRISE plan must ensure and monitor that the Care Management Entities (CMEs) have individuals trained in the administration of the CANS or have access to CANS assessors.

The OhioRISE plan must monitor MRSS 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 activities with the MCOs.

Monitoring and Evaluation of Quality Improvement Activities

As required by 42.CFR 438.330, each MCE must implement an ongoing quality assessment and performance improvement (QAPI) program for all services it furnishes to its members, ensuring the delivery of quality healthcare. The QAPI is a subcomponent of the Population Health Management Strategy that is focused on quality but is also used to inform other population health management approaches.

QAPI

The MCEs' QAPI programs must include performance improvement projects, collection, and submission of performance data (as outlined in Section I, Introduction, of this Quality strategy), mechanisms to detect both underutilization and overutilization of services, and mechanisms to assess the quality and appropriateness of care furnished to members with special healthcare needs. Additionally, for MyCare MCOs providing long-term services and supports, the QAPI must include mechanisms to assess the quality and appropriateness of care furnished to members using these services, including an assessment of care between care settings and a comparison of services and supports received to those that are in the member's service plan. MyCare MCOs must also participate in efforts by the state to prevent, detect, and remediate critical incidents.

MCEs report on their QAPI programs using the QAPI template within the more comprehensive Population Health Management Strategy report. ODM has structured this tool to not only assess MCE compliance with state and federal quality requirements but also to monitor the MCEs' progress in building quality improvement capacity. Each of the provider agreement requirements—developing a QI leadership team, obtaining training in quality improvement science concepts, tools and methods, and building QI capacity—are built into the annual reporting framework of the QAPI template.

The QAPI template which MCEs submit annually to ODM includes the following elements:

- QI Program Structure and Accountability
- Clinical Practice Guidelines
- Mechanisms to detect under- and over-utilization
- Quality and Appropriateness of Care Delivered to Enrollees with Special Healthcare Needs and Enrollees Receiving Long-term Services and Supports
- Addressing Health Disparities and Cultural Considerations
- Quality Improvement Strategy
- QI projects
- Annual Evaluation of QAPI program Impact and Effectiveness and Resulting Improvement Strategy Updates

The performance measures detailed in Section 1, Introduction, are submitted separately from the QAPI template which contains more narrative, descriptive information about MCE efforts to improve quality outcomes.

The QAPI template used by the MCEs when annually submitting information about their QAPI programs, is regularly reviewed, and revised to align with federal regulations and state requirements, add specificity and clarity regarding the expected content, and to reduce duplication by more closely aligning with NCQA and other requirements.

As a primary tool for documenting and assessing MCE quality programs, the MCEs' QAPIs, along with performance measure data, improvement project results, and assessments and technical reports from Ohio's EQRO, are used to facilitate ODM's annual review of the impact and effectiveness of ODM's population health approach, and the managed care quality strategy. This evaluation assists ODM in identifying areas that need additional focus.

Monitoring of Quality Improvement Projects

In addition to the summary of quality improvement projects within the annual QAPI submission, MCEs are also required to report progress on all ODM-initiated improvement initiatives at least monthly. ODM-initiated improvement initiatives include federally required performance improvement projects (PIPs), improvement projects initiated to regain a portion of the annual quality withhold amount (QW projects), and quality improvement projects in partnership with academic medical centers, or quality collaboratives.

PIPs are a type of quality improvement (QI) project in which MCEs work collaboratively with the ODM-contracted clinical lead, QI lead, academic medical centers, and recruited practices to improve an outcome. All MCEs must conduct at least 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. MCEs are required to meet with their ODM QI Liaison and the EQRO at least once monthly to share PIP progress. Two days before each meeting, the MCE submits a self-assessment modeled after the Institute for Healthcare Improvement's Collaborative Assessment Tool and submits information from the appropriate QI milestones (see Appendix E) using ODM's QI Template. This information is u used to guide the meeting dialogue and feedback. ODM and the EQRO provide feedback to the MCE during the meeting, as well as via email following meeting completion. MCEs are expected to demonstrate regular progress between meetings. The EQRO uses the ODM QI Template, as well as the ongoing assessments of progress to assist in validation of the MCE's PIP performance. On an annual basis, the EQRO releases a PIP validation report with its assessment of MCE PIP progress during the state fiscal year.

Quality Improvement projects that MCOs are participating in to earn a share of the quality withhold require the MCOs to report progress along QI milestones (see Appendix E), from the project planning and initiation phases, through initiation, to project sustaining and spreading. MCO executive leadership provides formal progress reports to ODM regarding milestone achievement according to an agreed upon cadence. In 2022, ODM began leveraging insights from the quality withhold work to encourage more rapid improvement. Planned changes include a merging of the QI and Quality Withhold templates into one standardized submission tool for all improvement projects and adding three to six months of preparatory work prior to beginning quality withhold projects to allow more time for active testing of collaborative interventions.

ODM expects the MCEs' improvement projects, including PIPs, to contribute to the achievement of Medicaid's five population health goals of:

1. Improved wellness and health outcomes
2. A positive care experience that is customized for the individual, with consideration to their family and community
3. Support of providers in continuously improving patient care
4. Improved care for children and adults with complex needs, and
5. Increased program transparency and accountability.

Each MCE is therefore expected to incorporate learning from these projects into its population health management strategy in order to ensure that insights expand beyond improvement projects activities.

Quality Measures

Quality measures are key to assessing MCE progress in improving population health. As shown in Section 1, ODM uses several performance measures to monitor MCE progress towards population health goals. ODM organizes these measures by population stream (e.g., Women and Infant Health, Healthy Children, Healthy Adults, Children with Behavioral Health Needs) to monitor progress at the population level. ODM also requires the MCEs to stratify these measures by various demographic factors to assist in identifying disparities, prioritizing initiatives, and monitoring progress towards health equity.

As required by 42 CFR 438.340, several of the quality measures and performance outcomes are published on the ODM website.

Quality Measures and Performance Outcomes Published on the ODM Website

The HEDIS Aggregate Report which provides a longitudinal summary and comparison of MCO performance is available on the ODM website.[xviii]

Several of these measures are also combined into indices and reported within the format of a Managed Care Report Card which can be used by members when selecting a managed care plan. The Report Card is described in more detail below.

Managed Care Report Cards

In 2015, ODM published its first consumer-facing Medicaid managed care report card on the ODM website. The report card compares Ohio's MMC plans across five performance areas which align with Ohio's goals and population streams: (1.) getting care; (2.) doctors' communication and service; (3.) keeping children healthy; (4.) living with illness; and (5.) women's health. Each plan is assigned up to five stars to indicate how it performs relative to other plans on each of these five indices of measures. The information used to create the Medicaid managed care report is collected from the MCOs and their members and is reviewed for accuracy by independent organizations. The most current information from the National Committee for Quality Assurance [NCQA] Healthcare Effectiveness Data and Information Set (HEDIS®) & the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is used. The managed care plan Report Card for 2020 and the Report Card Methodology can be found on the ODM website.

The Report Card was developed to support ODM's public reporting of MCO performance information to be used by members to make informed decisions about their healthcare. Because the Report Card evaluates individual MCO performance in specific areas (e.g., how well doctors involve members in

decisions about their care, and if children regularly receive checkups and important shots that helped protect them against serious illness), members have the opportunity to be better informed in certain areas of interest.

The Report Card provides a five-level rating scale with an easy-to-read "picture" of quality performance across MCOs, and it presents data in a manner that clearly emphasizes meaningful differences between MCPs (i.e., one- to five-star rating) to assist members when selecting an MCO.

Star Rating	Performance Level	Description
☆☆☆☆☆	Highest Performance	The MCP's performance is 2 or more standard deviations above the Ohio Medicaid managed care plan average.
☆☆☆☆	High Performance	The MCP's performance is between 1 and 2 standard deviations above the Ohio Medicaid managed care plan average.
★★★	Average Performance	The MCP's performance is within one standard deviation of the Ohio Medicaid managed care plan average.
★★	Low Performance	The MCP's performance is between 1 and 2 standard deviations below the Ohio Medicaid managed care plan average.
★	Lowest Performance	The MCP's performance is 2 or more standard deviations below the Ohio Medicaid managed care plan average.

The most recent Report Card was developed by Health Services Advisory Group (HSAG), ODM's previous EQRO. In creation of the Report Card, HSAG received the MCPs' CAHPS member-level data files and HEDIS data from ODM. The CAHPS 5.0H Adult Medicaid Health Plan Survey and the CAHPS 5.0H Child Medicaid Health Plan Survey (with the Children with Chronic Conditions [CCC] measurement set) were used for the adult and child populations, respectively. The CAHPS survey most recently administered in 2019 was used. The HEDIS 2019 Specifications for Survey Measures, Volume 3 was used to collect and report on the CAHPS measures. The HEDIS 2019 Technical Specifications for Health Plans, Volume 2 was used to collect and report on the HEDIS measures. MCP performance was evaluated in five separate reporting categories identified as important to consumers. Each reporting category consisted of a set of measures that were evaluated together to form a category summary score.

The reporting categories and descriptions of the measures they contain were:

- *Getting Care*: Includes adult and child CAHPS composites on consumer perceptions regarding the ease of obtaining needed care and how quickly they received that care. This category includes HEDIS measures that assess adults' and children's access to care, as well as appropriate follow-up for mental illness and if adults had a BMI assessment.

- *Doctors' Communication and Service*: Includes adult and child CAHPS composites and items on consumer perceptions about how well their doctors communicate, and shared decision making. This category includes overall ratings of personal doctors and specialists seen most often. In addition, this category includes a CAHPS measure related to medical assistance with smoking and tobacco use cessation.

- *Keeping Kids Healthy*: Includes HEDIS measures that assess how often preventive services are provided (e.g., child and adolescent immunizations, well-child visits, well-care visits for adolescents, annual dental visits, and weight assessment and counseling for children/adolescents). Further, this category also includes HEDIS measures related to follow-up

care for Attention Deficit Hyperactivity Disorder (ADHD), as well as the use of antipsychotics by children and adolescents.

- *Living with Illness*: Includes HEDIS measures that assess how well MCPs take care of people who have chronic conditions, such as asthma, diabetes, and high BP. This category also includes HEDIS measures that assess medication and pharmacotherapy management for people living with depression, asthma, or chronic obstructive pulmonary disease (COPD). HEDIS measures related to initiation and engagement of treatment for addiction are also included.

- *Women's Health:* Includes HEDIS measures that assess how often women-specific services are provided (e.g., prenatal and postpartum care, and breast cancer, cervical cancer, and chlamydia screenings). For each MCP, five summary scores were calculated from MCP scores on selected HEDIS measures and CAHPS questions and composite measures. Each summary score was a standardized score where higher values represent more favorable performance.

In the most recent report card, based on 2019 data, fifty- eight of the MCO performance measures (14 CAHPS and 44 HEDIS Measures) are used to create the annual MCO report card. These measures are used to create indices representing MCO performance in the above domains.

Consumer Assessment of Healthcare Providers System (CAHPS)

In addition to HEDIS metrics, ODM uses CAHPS results to monitor the MCOs' and the OhioRISE PIHP's performance in comparison to national and state standards. MCOs are required to stratify CAHPS to identify disparities in healthcare access, service provision, satisfaction, and outcomes. These comparisons are used to identify quality improvement opportunities related to member satisfaction and health equity.

The CAHPS Survey Data must be submitted to NCQA, the CAHPS Database, and ODM's designee consistent with the data submission requirements in the ODM CAHPS Survey Administration and Data Submission Specifications.
The OhioRISE plan must report any applicable data to the MCOs for its shared members. For those data elements or measures impacted by the scope of work of the MCO, the OhioRISE plan must coordinate and collaborate with the MCO to achieve targets.

Monitoring of Care Coordination

ODM approves each MCO's care coordination program prior to implementation. Each MCO is required to monitor its care coordination program to ensure that needs are met and to identify individual and systemic improvements.

On an ongoing basis, MCOs must review data indicators (e.g., emergency department, inpatient, and crisis services utilization; prescription drug utilization data provided by the SPBM; utilization patterns; readmissions; critical incidents; identified gaps in care) to inform the level and type of care coordination needed by the member.

MCOs must analyze utilization data and other indicators to identify members who may be eligible for OhioRISE and refer the member for a CANS assessment to determine OhioRISE eligibility.

MCOs must analyze prescription drug utilization data and/or reports provided by the SPBM or ODM to identify members who would benefit from the MCO's Coordinated Services Program (CSP). The MCO must notify the SPBM of members who are enrolled in the MCO's CSP. The MCO must offer care coordination to any member who is enrolled in the CSP.

The MCOs must monitor the quality and effectiveness of MCO- and CCE-provided care coordination through the review of member and provider surveys and case reviews. Case reviews must include whether established quality, clinical best practice, and care coordination standards have been met.

Following the identification of unmet member needs or care coordination delivery deficiencies, the MCO, in coordination with ODM, the CCEs, OhioRISE plan/CMEs and the SPBM, must ensure that the member needs are expediently met and that care coordination deficiencies are systemically corrected.

Monitoring of Utilization Management (UM)

The monitoring and evaluation of each MCO and OhioRISE plan's UM program must include: monitoring of service authorization timelines, monitoring of the consistent application of service authorization criteria, assessing whether prior authorization procedures unreasonably limit member access to covered services, review of ongoing need for prior authorization of services, use of provider feedback to identify opportunities for standardizing and streamlining service authorization processes to reduce provider administrative burden; and monitoring for updates to ODM clinical coverage criteria, evidence-based, nationally recognized medical necessity guidelines, and other professional literature to inform and update clinical coverage policies and criteria. Based upon the evaluation and assessment, the MCE must update the UM program policies, structures, and processes as necessary.

While the MCO must have mechanisms in place to ensure that its UM program interfaces with and informs the MCO's program integrity responsibilities, the MCO must demonstrate that the primary functions of its UM program are to meet the clinical needs of its members, to meet all state and federal requirements, including EPSDT, and to deliver efficient and appropriate services. The MCO 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.

All MCEs must monitor healthcare service under- and over-utilization. This includes:

- Establishing a process for setting thresholds for selected types of utilization (e.g., clinical criteria).
- Analyzing utilization by subpopulation demographics, as well as service type and geography to ensure optimal care for all populations.
- Immediately investigating any identified under-utilization of services 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-utilization.
- Communicating identified trends to MCO staff, ODM, and providers, as appropriate
- Establishing standards for timeliness of UM decisions and MCO performance against standards.
- Establishing methods to ensure that the MCO UM decision-making process is as efficient and uncomplicated as possible for the member, the provider, and the provider's staff.
- Evaluating the consistency of the application of UM criteria through inter-rater reliability testing.

In accordance with 42 CFR 438.330, each MCE must describe the mechanisms it uses to detect both under-utilization and over-utilization of services as part of its annual QAPI submission. MCEs must link

the utilization analysis documented in the QAPI to population health outcomes, and incorporate the information obtained through this analysis into their QI strategies.

Monitoring of Community Reinvestment

Each MCO and the OhioRISE plan must create and submit to ODM a Community Reinvestment Plan that details the MCE's anticipated community reinvestment activities and describes how those activities support the MCE's population health strategies.

After the first submission, the annual Community Reinvestment Plan submission must include an evaluation component that describes and quantifies the impact of community reinvestment funding on population health improvement.

Monitoring of Value Based Payment Targets

The MCO must submit a Value Based Progress Report semi-annually that addresses the MCO's progress towards meeting the requirements for value-based payment and APM targets. Each MCO must use the report template provided by ODM that include the following elements:

- Description of the MCO's value-based payment strategy.
- Type and size of provider or providers.;
- Objective of each value-based payment strategy and progress in meeting each objective.
- Type of value-based payment arrangement as specified by the Health Care Payment LAN framework (e.g., 3A or 3B).
- Sum of total medical spend.
- Sum of total net payments.

Monitoring as a tool for continued improvement

The monitoring of each population health approach, along with the EQRO's annual technical report, and each MCO's population health strategy submission informs ODM's population health improvement efforts by identifying which approaches are having the most impact and where additional attention is needed. Given the ever-changing health and social landscape, population health efforts cannot be static. ODM's efforts to monitor the managed care program's impact therefore led to ongoing refinement of the overall Population Health, Equity, and Quality Strategy which in turn leads to adjustments in the approaches of each managed care entity.

Section 4. Summary, Opportunities, and Next Steps

Summary

ODM began its population health journey in 2014, initially focusing efforts on increasing access to Medicaid insurance and building quality improvement and data capacity to allow for a data informed approach towards improving population health. Since beginning that journey, ODM has continued to refine its approach to population health, further embracing a population health management approach. Ohio's reimagined managed care program emphasizes the importance of a structured and strategic data-informed approach to identifying improvement opportunities, actively responding to identified needs, transparently monitoring, and assessing success, refining as needed, and sustaining and spreading what is found to be effective. This focus on transformative population health improvement is supported by more comprehensive and widespread value-based purchasing efforts emphasizing quality.

In July 2022, Ohio's Reimagined Managed Care will officially launch. In preparation, ODM is conducting intensive readiness reviews to assess how prepared the selected MCEs are to carry ODM's population approach forward, as well as determining the tools, guidance, and resources needed to assist them in this effort.

Future opportunities will require ODM and its MCE partners to continually enhance their capabilities to improve the care and well-being of all Medicaid insured individuals. This requires a commitment to collective impact and the cultivation of MCEs as learning organizations, with a particular focus on three components: a shared vision, team learning, and systems thinking.

Opportunities

ODM's opportunities for improvement are framed by a commitment to collective impact supported by the five disciplines that are essential for learning organizations.

Commitment to Collective Impact

Collective Impact brings organizations together in a structured way to achieve improvement through five mechanisms: (1.) a shared agenda, (2.) common measurement, (3.) mutually reinforcing activities, (4.) continuous communication, and a (5.) dedicated support structure that orchestrates the work of the group. The journey towards collective impact starts with a common agenda with a clearly defined problem and a shared vision to solve it. Shared measurement allows entities to track measures in the same way and fosters continuous improvement. Mutually reinforcing activities encourage collaborative efforts that maximize impact, while continuous communication builds trusting relationships among all participants. These mechanisms are supported by a strong infrastructure that provides the backbone for collaboration and coordination across the system.

A Common Agenda and Shared Vision

Next Generation Managed Care establishes a person-centered philosophy that requires all entities serving individuals insured by Medicaid to coordinate, collaborate, and align efforts to achieve optimal health outcomes. Stakeholder input as well as performance on quality indicators is used to set improvement priorities, and a common agenda is promoted through alignment of ODM policy, MCE contract language, and quality improvement initiatives.

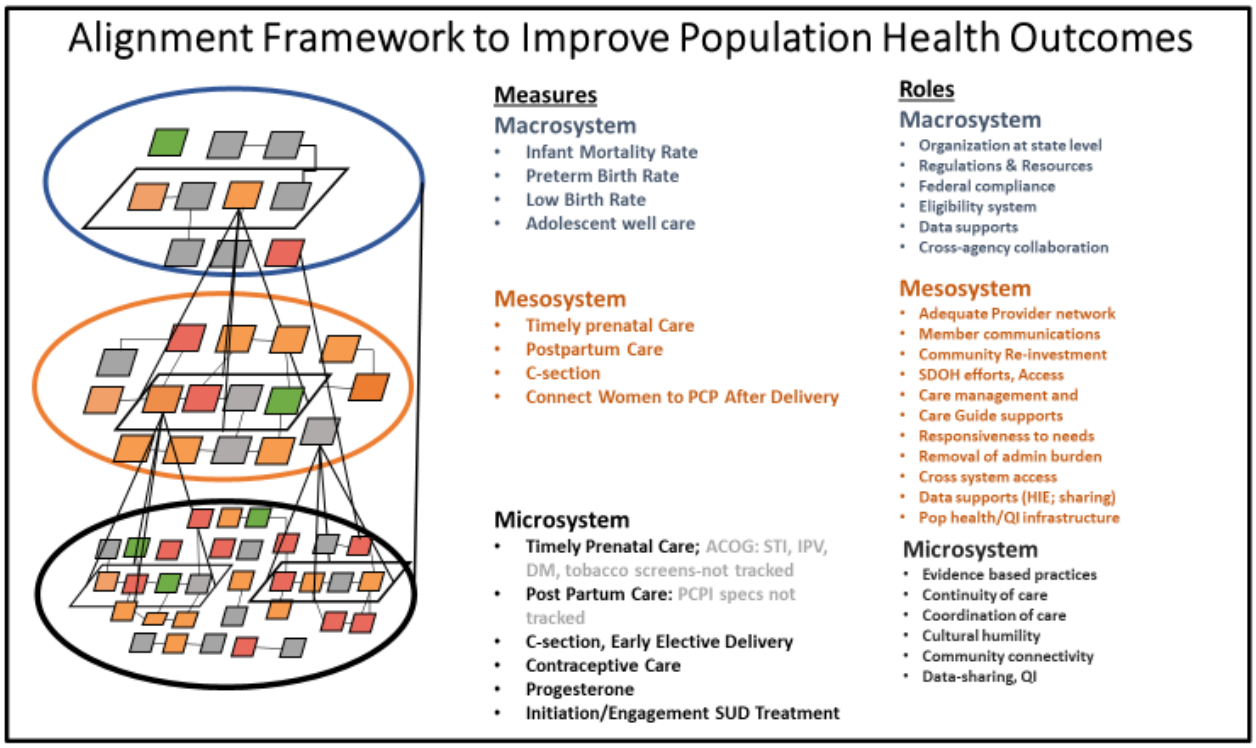
Alignment includes consistent requirements for population health and quality leadership and infrastructure, the use of the science-based quality improvement tools and methods, and quality improvement project content and reporting requirements.

ODM-initiated quality improvement projects, including performance improvement projects, focus on one common goal. MCE improvement teams and sponsorship represent individuals from each MCE serving the target population and process and outcome measures for the projects are aggregated across the MCEs to emphasize the importance of collective improvement.

Shared Measurement Systems and Measure Alignment

For the MCEs' to be successful, they will not only need to coordinate and collaborate with each other, but also identify and leverage opportunities to align efforts with other entities within the larger health system, including providers, health systems, and community-based organizations. Measures to provide insight into progress of each of these initiatives in moving population health will also need to be aligned.

ODM's alignment framework is based on Langely et al.'s "Framework of Nested Systems" within *The Improvement Guide* and Olin et al.'s Applegate Alignment Framework[xix]. These frameworks, used conjointly, outline the roles and responsibilities of each "level" of the health system and provide



structure to the alignment of measures to inform population health improvement efforts.

Work is ongoing to build the needed partnerships between macro-, meso- and micro-system entities which will allow the incorporation of member, provider, and stakeholder perspectives to proactively identify member needs and barriers, as well as the needed measures for monitoring success at each of these intervention points.

Mutually Reinforcing Activities

ODM has structured Next Generation Managed Care such that the activities of the MCOs, the PIHP, and the PAHP mutually support and coordinate with the actions of others. This requires the MCEs to identify stakeholders, build sustainable partnerships with them centered around delivering optimal member care, and then continually refining and aligning MCE actions to ensure ongoing collaboration.
For population health improvement efforts to succeed, ODM, MCEs, health systems, individual clinical providers, and communities must collaborate and coordinate efforts towards achieving well defined improvement goals, and Medicaid members must be partners in their own care. The establishment and maintenance of durable partnerships is therefore essential.

Current quality improvement initiatives include clinical advisory groups to provide input on administrative barriers to providing optimal clinical care. In addition, the perspectives of members and providers are also solicited to gain insight into how healthcare is experienced by the member and to inform the design of interventions. However, collaboration is often not sustained after project completion, resulting in a continual need to rebuild partnerships with each new undertaking. To encourage MCEs to include the perspective of members and providers into the organizations' day-to-day

business practices, ODM's most recent contracts with the newly procured MCEs include the obtaining and applying of member and provider perspectives as a contract requirement.

Continuous, Bi-directional Communication

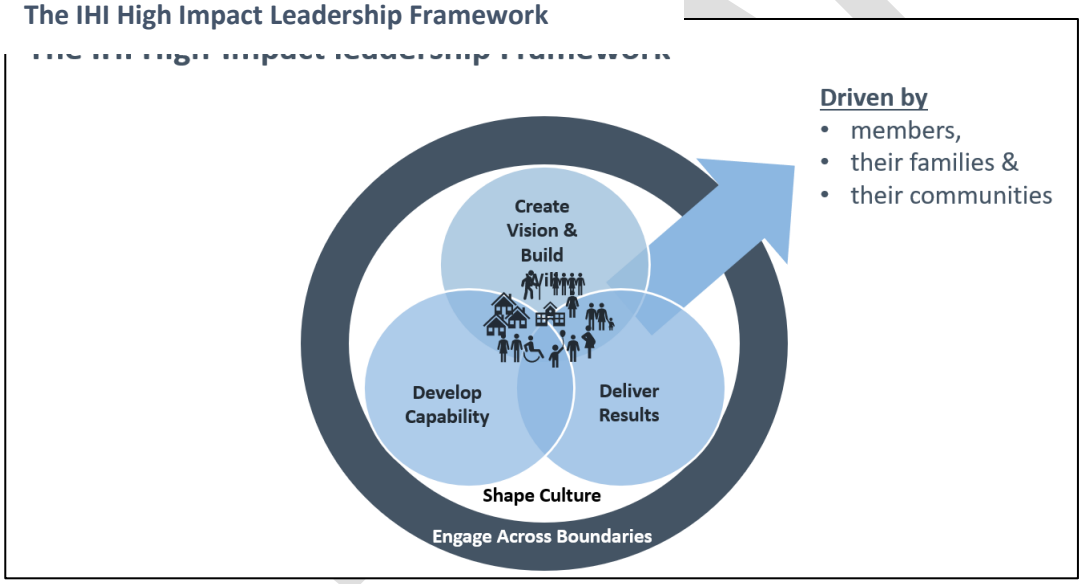
Collective impact requires open, transparent, and candid communication within and across the levels of the health system. This requires a devotion to systems thinking and a commitment to establishing and maintaining trust with other entities impacting member health. ODM has established the framework for this work by requiring that MCEs actively incorporate the perspectives of members, families, providers, and community organizations into their population health improvement and evaluation efforts. Monitoring of this process and continuing to model and support these activities from the state level, is essential for the success of these efforts.

Supportive Infrastructure

ODM's Next Generation Managed Care integrates a supportive infrastructure into the MCE Population Health and Quality Strategy through contractual requirements for MCE leadership support, analytic capabilities, staffing cross-system collaboration, and community reinvestment.

MCEs are required to incorporate the principles of High Impact Leadership[xx] which, as shown in the diagram below, conveys the interdependence of the three core leadership domains of vision and will, capability, and results, with the member at the center of all efforts. These leadership domains influence leadership behavior and action which, in turn, shape a reinforcing culture. The need for leaders to engage across traditional boundaries is highlighted by the outermost circle which requires modeling and encouraging systems thinking, cross-system collaboration, and the active engagement and maintenance

The IHI High Impact Leadership Framework



of community partners.

The IHI High Impact Leadership Framework

Next Generation Managed Care emphasizes the importance of integrated and proactive analytics as an integral part of population health management. MCEs are required to incorporate multiple data sources into all aspects of population health management, including the identification and segmentation of populations to prioritize improvement efforts, informing selection of interventions and associated measures, and assessing results of improvement efforts. MCEs are required to look outside traditional

data sources such as claims and eligibility information and include data sources more closely reflecting the member experience such as qualitative data from members themselves, population-based surveys, information from other organizations serving their members (e.g., local health departments, community-based organizations), and clinical point of contact information from electronic health records (EHRs) or health information exchanges (HIEs). MCEs are also required to actively share information to inform joint quality improvement efforts and coordination of care.

ODM requires that all MCEs appropriately staff and resource population health improvement efforts. This includes actively building capacity by integrating quality improvement into ongoing training and daily work activities throughout all levels of the MCE organization. Cross-organizational representation (e.g., health equity, member and provider relations, care coordination) assists in providing quality improvement experience to staff not working directly within the quality improvement area, emphasizing the cross-cutting nature of quality improvement efforts.

The importance of cross-system collaboration to population health improvement is highlighted through requirements that MCEs not only collaborate with each other and with ODM, but also actively seek input from and engage community partners, provider associations, and other stakeholders in improvement work. This includes modeling and encouraging systems thinking within the organization such that the perspective of and impact on other areas of the health system are considered when designing interventions. MCEs are encouraged to select balancing measures to ascertain unintended impact of improvement activities.

Next Steps

Cultivating Learning Organizations

Collective Impact Models are supported by a learning organization framework that inspires adaptive and generative learning, encouraging employees to innovate and collaborate to find the best answer to a problem. There are five characteristics of learning organizations:

- Systems thinking (looking at the whole picture rather than its component parts when addressing a problem).
- Shared vision reflecting a common agenda (encourages experimentation and innovation among multiple members).
- Personal mastery (how the individual sees the world).
- Mental models (an individual's deeply ingrained assumptions).
- Team learning (an all teach-all learn approach that encourages innovation through open and transparent dialogue and collaboration).

All five are needed to support efforts toward collective impact and ODM is actively putting the structures in place to create a learning organization culture among its MCEs.

Systems Thinking

Systems thinking is essential for understanding how different entities within the system, their characteristics, actions, and interactions contribute to an outcome. When one aspect of the system changes, it invariably impacts other parts of the system. System thinking is also essential to designing effective and highly reliable interventions. High reliability organizations use systems thinking to evaluate and design solutions that include input from the individuals being served so that it is easy for people to do the right thing. Systems thinking also requires alignment across the interdependent micro, meso,

and macro-levels of the health system to prevent unintended consequences, as well as sustain and spread effective strategies. ODM's requirement that MCEs incorporate the perspectives of members, their families, providers, and communities into the design, testing evaluation and refinement of interventions is directly in support of these goals.

Shared Vision

Shared vision focuses the efforts of learning organizations, ensuring that all work units and employees have a shared understanding of the organization's goals and objectives. This allows multiple individuals to innovate, and learn, accelerating improvement. Consistent use of quality improvement concepts and tools such as global aims, key driver diagrams and process mapping assists with ensuring a shared vision across and within MCEs. ODM requires MCEs to organize population health improvement efforts by population health stream. This includes identifying global aims that MCEs will collaboratively work with health system partners to improve, designing projects to focus on pieces of these global aims over which MCEs have influence while ensuring that member and provider perspectives are considered, and transparently sharing lessons learned to move efforts forward more quickly.

Personal Mastery and Mental Models

Mental models help individuals understand how a particular process or interaction works. Through requiring that the perspective of members, families, community entities, and providers is integrated into all aspects of managed care policies, processes, and initiatives, ODM emphasizes the importance and ongoing work needed to shift mental models toward the needs of the individuals and families being served. Within each improvement initiative, member journeys and process maps are used to identify barriers and possible interventions for focus. The incorporation of members, families, community representatives, and providers into improvement team activity helps ensure that improvement activities are member centric.

Team Learning

ODM has embraced the concept of team learning and has required that improvement teams include representatives from each participating MCE. This includes active involvement of MCE Medical Directors and CEOs in leadership and support of improvement team activities. Efforts within the Next Generation of Managed Care will require further collaboration, incorporating the work of the OhioRISE plan and the SPBM. In addition, as shown by the Applegate Alignment model, it is increasingly important to involve other areas of the health system (providers, members, and communities) in the design of interventions and in the measurement of success.

Continued cultivation of a learning organization framework will allow Ohio Medicaid to innovate more quickly and successfully, enhance the sustainability of innovations through alignment across the system, provide greater opportunity for diffusion of these innovations across the health system.

Glossary

Care Coordination – A strategy to deliberately organize and support an individual with addressing needs to achieve better health outcomes.

Care Coordination Entity (CCE) – A local community agency that provides care coordination to a specific population.

Care Management – A team-based, person-centered approach designed to assist members and their support systems in managing medical conditions and social determinants of health more effectively.

Care Management Entity (CME) – A local community agency contracted with the OhioRISE plan that provides behavioral healthcare management to OhioRISE enrolled members.

Case Management – A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet a member's health needs through communication and available resources to promote improved health outcomes.

Care management entity (CME) -- a local community agency contracted with the OhioRISE plan that provides care coordination to OhioRISE plan enrolled members. The CME will serve as the "locus of accountability" for children with complex challenges and their families who are involved in navigating multiple state systems. The CME will be responsible for providing and/or coordinating the provision of intensive care coordination, community-based and in-home services, and other services and supports to improve health outcomes.

Child and adolescent needs and strengths (CANS) – 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 allow for the monitoring of outcomes of services. CANS is designed to be the output of a functional assessment process.

Children and Youth with Special Healthcare Needs (CYSHCN)—individuals under the age of 21 who have or are at increased risk for chronic, physical, developmental, behavioral, or emotional conditions and requiring health and related services of a type or amount beyond that required by individuals generally.

Clinical Best Practice – Clinical best practice optimizes patient care and is supported by evidence-based clinical practice guidelines. Clinical best practice is patient-centered, while incorporating the context of family and community in a culturally humble manner.

Cultural Competence – Cultural Competence is a set of skills, values, and principles that acknowledge, respect, and contribute to optimal interactions between the individual and other cultural and ethnic groups with which an individual might come into contact. Developing these skills is an essential part of providing effective, equitable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Cultural Humility – Maintaining a person-centered, interpersonal stance that seeks to understand the aspects of cultural identity that are most important to the individual and recognizes the inherent value of personal history and preferences.

> *Cultural context looks at the society individuals are raised in and how their culture affects behavior. It incorporates learned values and shared attitudes among groups of people. It includes language, norms, customs, ideas, beliefs and meanings.

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.

Downstream entity – any party that enters 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.

Equitable Access – the standards as defined by the National Standards for Culturally and Linguistically Appropriate Services in Health and Healthcare (https://www.thinkculturalhealth.hhs.gov/clas

FDR – the collective term for First tier, Downstream, and Related entities.

FDR agreement – the written agreement between the MCO and an FDR to delegate administrative responsibilities or service.

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

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 MCO 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 MCO 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; mental health; cognitive, sensory or physical disability; sexual orientation; or geographic location).

Health Equity/Opportunity – Exists when everyone has a fair opportunity to be as healthy as possible. Achieving health opportunity requires removing obstacles to health, especially poverty and discrimination and their consequences: powerlessness, lack of access to good jobs with fair pay, quality education and housing, safe environments, and healthcare.

Health information exchange (HIE)- is the mobilization of healthcare information electronically across organizations within a region, community or hospital system. Participants in data exchange are called in the aggregate Health Information Networks (HIN). In practice the term HIE may also refer to the health information organization (HIO) that facilitates the exchange.

High Fidelity Wraparound Approach – a comprehensive, holistic, youth and family-driven way of responding when children or youth experience serious mental health or behavioral challenges. Wraparound puts the child or youth and family at the center.

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 MCO 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 – An alleged, suspected, or actual event that is not consistent with the routine care of, and/or service delivery to a member. Incidents include the following types of events: abuse, neglect, exploitation, misappropriation, and unexplained death.

Managed Care Entities (MCEs) – entities that include managed care organizations, prepaid inpatient health plans (e.g., OhioRISE), and prepaid ambulatory health plans (e.g., the statewide Single Pharmacy Benefit Manager-SPBM).

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.

Medical necessary or medical necessity—a determination of a medical service based on meeting the following conditions*:

- Meets generally accepted standards of medical practice.
- Clinically appropriate in its type, frequency, extent, duration, and delivery setting.
- Appropriate to the adverse health condition for which it is provided and is expected to produce the desired outcome.
- Constitutes the lowest cost alternative that effectively addresses and treats the medical problem.
- Provides unique, essential, and appropriate information if it is used for diagnostic purposes; and
- Not provided primarily for the economic benefit of the provider nor for the convenience of the provider or anyone else other than the recipient.

*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.

Medical necessity for individuals covered by early and periodic screening, diagnosis and treatment (EPSDT)-- 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.
Medical necessity for individuals not covered by EPSDT --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.

Members with Special Healthcare Needs – Individuals who have or are at increased risk for chronic, physical, developmental, behavioral, or emotional conditions and who require healthcare and related services of a type or amount beyond that required by individuals generally.

OhioRISE – A program designed to provide, manage, and coordinate comprehensive behavioral healthcare for children with serious or complex behavioral health needs who are at risk of involvement or are involved in multiple child-serving systems. Eligibility for OhioRISE and enrollment in the OhioRISE plan is determined by ODM.

OhioRISE plan – The prepaid inpatient MCE contracted with ODM to administer the OhioRISE program.

Ohio RISE Care coordination – their families by addressing needs to achieve better health outcomes. The OhioRISE program will use a three-tiered model of care coordination: intensive and moderate care coordination (tiers 3 and 2, respectively) delivered through care management entities based on a systems of care approach and a wraparound philosophy, and tier 1 care coordination performed by OhioRISE plan care coordinators, or their contracted designees as approved by ODM, for members who need less intensive care coordination.

Payer Best Practices – Best practice among payers optimizes patient care by supporting clinicians in adhering to evidence-based clinical practice guidelines through the removal of patient barriers and simplifying administrative procedures for clinicians so that the focus is on the patient population. Like clinical best practice, best payer practice is patient-centered and incorporate the context of family and community in a culturally humble manner.

Performance Improvement Project (PIP) – A type of quality improvement project (QIP) in which MCO works collaboratively with the ODM-contracted clinical lead, QI lead, and recruited practices to improve an outcome. The MCO conducts at least 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).

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 healthcare 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 wellbeing 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.

Prepaid Ambulatory Health Plan (PAHP) – 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.) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3.) does not have a comprehensive risk contract.

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 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.

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 Agreement – As defined in OAC rule 5160-26-01, a formal agreement between ODM and the MCE (MCO, OhioRISE PIHP, or SPBM PAHP) for the provision of medically necessary services to Medicaid members.

Quality Assessment and Performance Improvement (QAPI) Program – A requirement by 42.CFR 438.330 that each MCE (MCO, OhioRISE PIHP, and SPBM PAHP) must implement an ongoing quality assessment and performance improvement (QAPI) program for all services it furnishes to its members, ensuring the delivery of quality healthcare.

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

Quality Improvement –A deliberate and defined, science-informed approach that is responsive to member needs and incorporates systematic methods for discovering reliable approaches to improving population health.

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 healthcare p providers, MCOs, the OhioRISE plan, single pharmacy benefit manager, and state and county entities.

Racism –

- *Internalized Racism*-A set of private beliefs, prejudices, and ideas that individuals have about the superiority of white people and the inferiority of Black, Indigenous, and other people of color.
- *Interpersonal Racism*-Internalized Racism in action: beliefs, prejudices, and ideas that manifest in behaviors and surface in relationships between individuals and in groups. This can be implicit bias or intentional bigotry.
- *Institutional Racism* -Discriminatory treatment, unfair policies, and practices driven by internalized racism within a single institution. The result is inequitable access and outcomes for Black, Indigenous, and other people of color and communities.
- *Structural Racism*-Public policies, institutional practices, cultural representations, and other norms that embed racism across multiple institutions.
- *Systemic Racism*-The interconnection of internalized, interpersonal, institutional, and structural racism in action. It is interactions among and between institutions, in and among individuals woven together to negatively impact Black, Indigenous, and other people of color and communities

Related entity—any related party to the MCE by common ownership or control under an oral or written arrangement to perform some of the administrative services under the MCE'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 MCE 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.

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 MCO and 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.

Health-related social needs – the social and economic barriers to an individual's health. Examples include lack of education, housing safety and instability, food insecurity.

Socio-Psychological Factors – how a person's thoughts, feelings, and behaviors are influenced by actual, imagined, or implied companionship of others.

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. A person may have numerous risk factors but have fewer immediate social needs.

Stratification – A process by which clinicians, providers, and other entities report measures by different groups of members (e.g., male, female, African American, white) or combination of groups to find potential differences in care (e.g., examining a measure of how many members received routine mammography by how many African American women received the recommended care).

System of Care – A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health 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.

Value-Added Services – Consistent with 42 CFR 438.3(e)(1)(i), any services that the MCO or OhioRISE PIHP 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 payments to the MCO.

[i] https://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf?ver=2016-12-30-085452-610

[ii]The Ohio Department of Medicaid. *Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly.* 2016. Retrieved from: http://medicaid.ohio.gov/portals/0/resources/reports/annual/group-viii-assessment.pdf

[iii] https://medicaid.ohio.gov/Portals/0/Resources/Reports/MyCare_Ohio_Evaluation.pdf

[iv] 2020 Effective Transitions Winner Ohio – The SCAN Foundation

[v] Iams JD, Applegate MS, Marcotte MP, et al. A Statewide Progestogen Promotion Program in Ohio. *Obstet Gynecol*. 2017;129(2):337-346.

[vi] https://medicaid.ohio.gov/Portals/0/Resources/Reports/mcp-reportcard.pdf?ver=2017-09-19-073153-957

[vii] HEDIS has proposed that this measure be retired and will be replaced with a new measure

[viii] 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)

[ix] The MCO appointment availability standards do not replace the access requirements established by ODM for Comprehensive Primary Care (CPC) practices.

[x] ODM and ODRC were the lead agencies implementing the prerelease enrollment program, but the Ohio Department of Mental Health and Addiction Services, the Ohio Department of Health, and the Medicaid managed care plans were active partners.

[xi]McPherson M, Arango P, Fox H, Lauver C, McManus M, Newacheck PW, Perrin JM, Shonkoff JP, Strickland B. A new definition of children with special health care needs. Pediatrics. 1998 Jul;102(1 Pt 1):137-40. doi: 10.1542/peds.102.1.137. PMID: 9714637.

[xii] 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.

[xiii] http://www.ihi.org/resources/Pages/Tools/Driver-Diagram.aspx

[xiv] The publicly facing HEDIS Report represents the most recent data available. The impact of COVID-19 on 2020 office visits, claims filed, and medical chart review, did not allow for meaningful HEDIS results for calendar year 2020.

[xv] Combination 2 includes the antigen vaccines including four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenzae type B (HiB); three hepatitis B (HepB); and one chicken pox (VZV).Combination 3 includes the vaccines for Combination 2 along with four pneumococcal conjugate (PCV).

[xvi] Ohio Department of Health Quarterly Infant Mortality Scorecard.

[xvii] Langley GL, 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.

[xviii] The publicly facing HEDIS Report represents the most recent data available. The impact of COVID-19 on 2020 office visits, claims filed, and medical chart review, did not allow for meaningful HEDIS results for calendar year 2020.

[xix] Su-chin Serene Olin PhD , Gary L. Freed MD, MPH , Sarah H. Scholle DrPH , Mary S. Applegate MD, FAAP, FACP , Aligning To Improve Pediatric Healthcare Quality, Academic Pediatrics (2021), doi: https://doi.org/10.1016/j.acap.2021.08.021.

[xx] 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)