The Ohio Department of Medicaid Population Health and Quality Strategy 2026-2028

Draft 4/14/2025

Department of Medicaid

Governor Mike DeWine | Lt. Governor Jim Tressel | Director Maureen Corcoran
50 W. Town Street, Suite 400, Columbus, Ohio 43215 medicaid.ohio.gov

Table of Contents

List of Figures

List of Tables

Executive Summary

The Ohio Department of Medicaid (ODM) is committed to population health and quality with measurement, monitoring, and continuous improvement being fundamental to improving the health and well-being of Ohio Medicaid members. The Ohio Department of Medicaid (ODM) Population Health and Quality Strategy 2026-2028 provides a comprehensive roadmap for ODM and its Medicaid managed care entities (MCEs) to align strategies related to quality of care and services, data driven outcomes measurement, quality improvement, population health management with population-specific goals, and addressing health-related social needs (HRSN) to ensure all Medicaid beneficiaries experience appropriate, timely, and positive healthcare and services.

Since 2005, Ohio has a history of implementing Medicaid managed care programs when 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 expanded to all 88 Ohio counties. Since then, numerous programs and waivers have been implemented to provide high quality healthcare and services to Medicaid beneficiaries.

In 2019, ODM launched a Medicaid managed care procurement process with a bold, new vision for Ohio's Medicaid program, the Next Generation of Ohio Medicaid Managed Care, focusing on the individual and not just the business of managed care. This was the first structural change since CMS approval of Ohio's program in 2005. On February 1, 2023, ODM implemented the Next Generation managed care plans, a new Electronic Data Interchange, and Fiscal Intermediary. These changes provided Ohio Medicaid managed care members enhanced healthcare services that best fit their individual healthcare needs and improved the provider experience by increasing transparency and visibility of care and services.

In 2024, ODM initiated the Next Generation MyCare procurement. MyCare Managed Care Plans (MCOPs) provide Medicare and Medicaid benefits, including long-term care services and behavioral health for members dually eligible. MyCare began as a demonstration project in 29 of Ohio's 88 counties; the transition to the new program and expansion to statewide coverage will begin in January 2026.

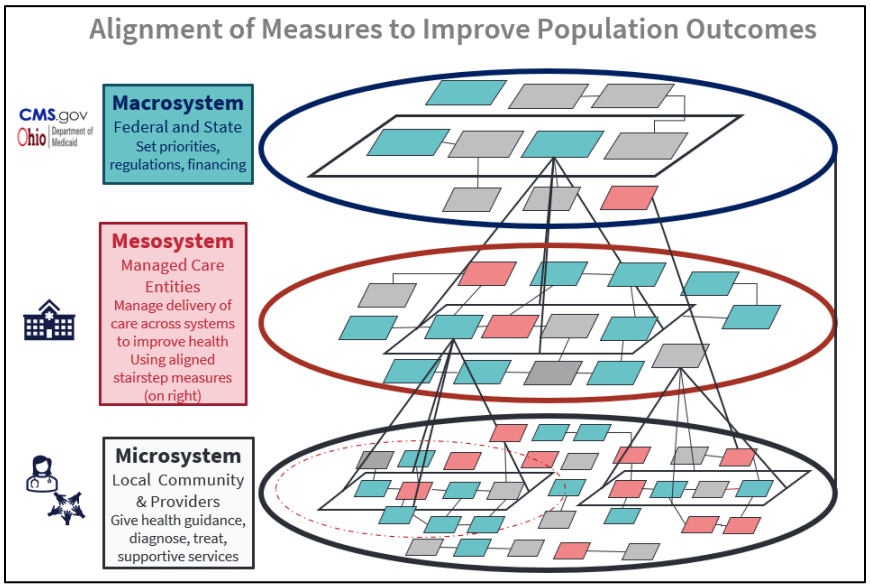
The Next Generation Ohio Medicaid Managed Care, MyCare, and the Ohio Department of Medicaid's (ODM) Population Health and Quality Strategy 2026-2028 emphasizes strong cross-agency coordination and partnership among managed care entities (MCEs), ODM program areas, health systems, providers, vendors, partner agencies, communities, and ODM.

The ODM QS Core Team spent considerable time assessing, reflecting, and establishing the overarching programmatic goals, population-specific goals, objectives, measures, and prioritized strategies for 2026-2028 with the goal of meeting CMS quality strategy expectations and requirements. The QS 2026-2028 is a three-year plan to further align cross-agency coordination and partnership for collective impact with prioritized strategies and data-driven approaches for continuous quality improvement to positively impact the healthcare and services provided to Medicaid populations.

Introduction to the ODM Population Health and Quality Strategy 2026-2028

As required by 42 CFR 438.340, the Ohio Department of Medicaid's Population Health and Quality Strategy (QS) is designed to assess and improve the quality of healthcare and services furnished by Ohio's contracted managed care organizations (MCOs), prepaid inpatient health plans (PIHPs) and prepaid ambulatory health plans (PAHPs), in accordance with State and federal laws and regulations. ODM refers to these health plans collectively as managed care entities (MCEs). The QS provides a population health management framework for Ohio Medicaid and its managed care plans to align and collaborate for collective impact to implement a coordinated and comprehensive program to advance population health and continually strive to improve healthcare access, quality of the healthcare experience, and population-specific health outcomes.

The MCEs are part of a larger Ohio health system structure, encompassing three levels of partners: the micro-level which includes community health service providers and individual physicians, as well as school-based healthcare; the meso-level which includes large health systems, academic medical centers, and accountable care organizations; and the macro-level consisting of state and federal agencies. To improve the health of the Medicaid population, entities at all levels must be aligned in collaborative work across the system. The graphic below, modified from the work of Langley et al., illustrates this alignment (Langley, et al., 2009).



Managed Care Entities

ODM contracts with several different types of managed care entities (MCEs), including: MCOs, a PIHP, a PAHP, and (beginning in 2026) MCO FIDE-SNPs. As noted above, alignment of ODM managed care with federal and state partners, as well as that with our community providers and health systems is essential for population health improvement. This quality strategy therefore not only addresses how ODM and MCEs comply with the requirements of 42 CFR 438.340 but also outlines Ohio's strategic collaboration with health systems and communities for collective impact on population-specific goals.

The seven Ohio Medicaid managed care organizations (MCOs) participating in the Medicaid managed care program are AmeriHealth Caritas of Ohio (AmeriHealth), Anthem Blue Cross and Blue Shield (Anthem), Buckeye Health Plan (Buckeye), CareSource, Humana Healthy Horizons (Humana), Molina Healthcare of Ohio (Molina), and UnitedHealthcare Community Plan (UnitedHealthcare). Beginning January 2026, four plans will be participating in Next Generation MyCare including Anthem Blue Cross and Blue Shield (Anthem), Buckeye Health Plan (Buckeye), CareSource, and Molina Healthcare of Ohio (Molina). Aetna is the PIHP for OhioRISE, and Gainwell Technologies (Gainwell) is the SPBM PAHP. More information on each MCE can be found in Appendix C.

Organization of the ODM Population Health and Quality Strategy 2026-2028

The ODM Population Health and Quality Strategy (QS) is guided by a conceptual framework that emphasizes ODM's values, overarching programmatic goals, alignment with CMS National Quality Strategy (NQS), population-specific goals, objectives and measures, and prioritized strategies employed to achieve programmatic goals. To achieve these goals, ODM and its managed care partners use approaches to population health management and quality improvement science.

Common vision and values are important in orienting toward ODM's True North. The overarching programmatic goals guide ODM and its managed care entities in the transformation to Next Generation Managed Care which is centered on the well-being of people we serve. Population-specific goals, objectives and measures prioritize strategies for achieving population well-being and allow monitoring of progress, while ODM's population health management framework provides a stepwise approach to improving the health of each population.

ODM's Values

The Ohio Department of Medicaid is continually striving to improve healthcare access, quality of the healthcare experience, and population-specific health outcomes. 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.

ODM Overarching Programmatic Goals and Prioritized Strategies

These core values, along with significant input from stakeholders during the design of Next Generation Managed Care, helped guide ODM in the choice of five overarching programmatic goals designed to move Ohio Medicaid and the managed care entities toward a Next Generation of Managed Care model that puts the individual at the center of care, while recognizing the importance of supporting providers and building connections throughout the larger health system and with community partners.

1) Improve wellness and health outcomes
2) Emphasize a personalized care experience
3) Support providers in better patient care
4) Improve care for children and adults with complex needs
5) Increase program transparency and accountability

Table 1 depicts ODM's Population Health and Quality Strategy 2026-2028 Overarching Programmatic Goals and Prioritized Strategies Employed to Achieve Overarching Goals

Table 1: ODM Overarching Programmatic Goals and Prioritized Strategies

ODM Overarching Programmatic Goals	Prioritized Strategies
All Populations	
1. Improve Wellness and Health Outcomes 2. Emphasize a Personalized Care Experience 3. Support Providers in Better Patient Care 4. Improve Care for Children and Adults with Complex Needs 5. Increase Program Transparency and Accountability	**Contractual Requirements** •ODM Next Generation Contractual Requirements for Managed Care Entities including Medicaid Managed Care Organizations (MCOs), MyCare Ohio Plans (MCOPs), OhioRISE Prepaid Inpatient Health Plan (PIHP) and Single Pharmacy Benefit Manager (SPBM-PAHP): ○ Ensure high quality and high levels of access to healthcare ○ Ensure services are delivered to maximize members' health and safety ○ Ensure individual members and their families are empowered to make healthcare decisions that suit their unique needs and goals ○ Support members' maximal choice and independence ○ Develop and implement an MCE-specific population health management strategy to maintain and improve physical and psychosocial well-being through cost-effective, person-centered health solutions that address members' needs ○ Obtain Health Risk Assessments on every newly enrolled member ○ Complete Risk Stratification to assess each member's risk level to determine individual member needs and assign Risk Tiers to indicate level of Care Coordination need ○ Address food insecurity, transportation, housing, and other health-related social needs and ensure connections to community resources are made to address member needs ○ Monitor and track the quality, timeliness and availability of healthcare services and analyze program data for population-specific performance gaps in access to healthcare services and outcomes **Programs** •Provider Network Management (PNM) & Centralized Credentialing to reduce provider administration and streamline the process for provider certification •ODMs Ohio Medicaid Enterprise System – Electronic Data Exchange (EDI) and Fiscal Intermediary (FI)

ODM Overarching Programmatic Goals	Prioritized Strategies
All Populations	
	Programs •Healthchek: Early and Periodic Screening Diagnosis and Treatment (EPSDT) Program •Ohio Section 1115 Demonstration Waiver for Substance Use Disorder Treatment •OhioRISE (Resilience through Integrated Systems and Excellence), a specialized managed care program providing coordinated care for youth with complex mental and behavioral needs • Alternative Payment Models (APM) including Comprehensive Primary Care (CPC) and CPC Kids, Comprehensive Maternal Care (CMC), with plans to implement Certified Community Behavioral Health Clinics (CCBHCs) •Maternal and Infant Support (MISP) Program focused on reducing and eliminating population-specific performance gaps in maternal and infant outcomes and infant mortality •Electronic Pregnancy Risk Assessment Form (PRAF) and Report of Pregnancy (ROP) Ohio's Online Pregnancy Notification System • Long-Term Services & Supports (LTSS) •MyCare Ohio Home and Community-Based Services (HCBS) Waiver •Electronic Visit Verification (EVV) for certain Medicaid personal care and home health services delivered in a community-based setting. •Mobile Response Stabilization Services (MRSS) for de-escalation of BH crisis, diversion from hospitalization, and provision of care in least restrictive setting •Utilization Management (CCP and EMR review) •The Ohio Medicaid School Program (MSP) in collaboration with the Ohio Department of Education and Workforce •State Directed Payments •Community Reinvestment •Ohio's Medicaid Technical Assistance & Policy Program (MedTAPP) •Structured Performance Improvement Projects (PIPs) aimed to achieve improvements in identified measure(s) for the overall Medicaid population •ODM Infant Mortality Community Partnership: A collaboration among ODM, Managed Care Organizations, and local community-based partners in the Ohio Equity Institute (OEI) counties focusing on reducing preterm birth and infant mortality •New Care Coordination Model and Risk Stratification •CAHPS Consumer Experience Survey •Alignment and streamlining of quality measures across managed care entities and programs for targeted improvement with prioritization of CMS Core Measure Sets and Quality Rating System •Leverage quality measures to improve health outcomes and set minimum performance standards (MPS) for the Overall population and for the Black population to reduce population-specific performance gaps •HEDIS Aggregate Report: The Ohio Medicaid Managed Care Program HEDIS Measurement •Monitoring of measures by MCE and review of results geographically statewide by Public Use Microdata Areas (PUMAs) including use of an Ohio Opportunity Index and a Children's Opportunity Index to understand the needs of members, including health-related social needs and changes in communities' needs over time •ODM Population Health Dashboards •ODM Incident Management System •MCO Annual Report Card •MCO Provider and Member Advisory Councils •Managed Care Plans Value-Added Services •External Quality Review •Member satisfaction surveys •Secret shopper surveys •Monitoring of member grievances and appeals

ODM Overarching Programmatic Goals	Prioritized Strategies
All Populations	
	State •Ohio Governor's expansion of School-Based Health Centers •Ohio Governor's Initiative: The Outcomes Acceleration for Kids (OAK) Learning Network. A collaborative partnership between families, MCOs', Children's Hospitals, and ODM to achieve accelerated improvements in the health and wellbeing of Ohio's youth •Ohio Governor's Initiative: All MCO collaborative Performance Improvement Project - Preterm Birth and Related Population Health Build Work •Ohio Governor's Initiative: All MCO collaborative Performance Improvement Project – Improve Follow-Up After Mental Health (MH) Emergency Department (ED) Visit for Adults (EDM-A)

Alignment of ODM Overarching Programmatic Goals and Prioritized Strategies with CMS National Quality Strategy Priority Areas and Goals

ODM utilizes numerous approaches including managed care contractual requirements, alternative payment models, state directed payments, quality improvement projects, health and safety standards, quality measurement, public reporting, population health management, and data analytics to improve healthcare for beneficiaries in Ohio.

Table 2 demonstrates how ODM Goals and Prioritized Strategies align with CMS National Quality Strategy Priority Areas and Goals

Table 2: Alignment of ODM Goals and Prioritized Strategies with CMS National Quality Strategy Priority Areas and Goals

CMS National Quality Strategy Priority Areas and Goals	
CMS Priority Areas: Outcomes and Alignment	
Outcomes Improve quality and health outcomes across the care journey	**Alignment** Align and coordinate across programs and care settings
ODM Goals • Improve wellness and health outcomes •Support providers in better patient care •Improve care for children and adults with complex needs	**ODM Goals** • Improve wellness and health outcomes •Improve care for children and adults with complex needs
ODM Prioritized Strategies •Alternative Payout Models •OhioRISE PIHP (Resilience through Integrated Systems and Excellence) •State Directed Payments • Long-Term Services & Supports (LTSS) •MyCare Ohio HCBS Waiver •Performance Improvement Projects and Quality Withold •MCO Population Health Management Strategies •Set Minimum Performance Standards (MPS) benchmarks on quality measures •Managed Care Entities contract requirements	**ODM Prioritized Strategies** •Alignment and streamlining of quality measures across MCOs and ODM programs for targeted improvement with prioritization of CMS Core Measure Sets and Quality Rating System • Single Pharmacy Benefit Manager (SPBM-PAHP) •OhioRISE PIHP (Resilience through Integrated Systems and Excellence) alignment of coordinated services for youth •Utilization management (CCP and EMR review) •Managed Care Entities contract requirements

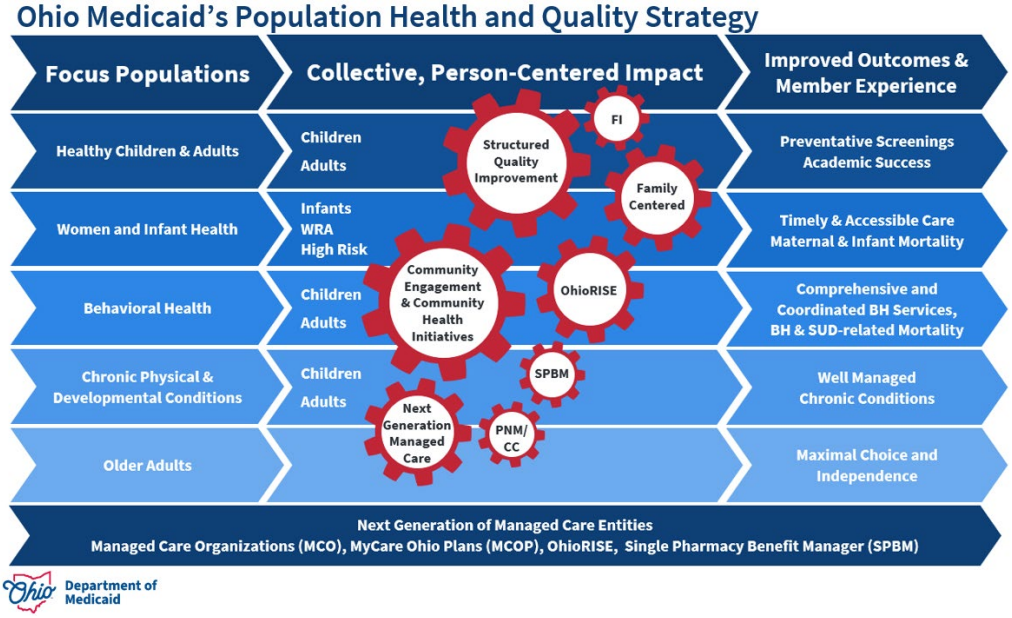
CMS National Quality Strategy Priority Areas and Goals	
CMS Priority Areas: Interoperability and Scientific Advancement	
Interoperability Accelerate and support the transition to a digital and data-driven health care system	**Scientific Advancement** Transform health care using science, analytics, and technology
ODM Goals •Support providers in better patient care •Increase program transparency and accountability	**ODM Goals** •Increase program transparency and accountability
ODM Prioritized Strategies •Provider Network Management (PNM) & Centralized Credentialing •ODMs Ohio Medicaid Enterprise System – Electronic Data Exchange (EDI) and Fiscal Intermediary (FI) •Electronic Pregnancy Risk Assessment Form (PRAF) and Report of Pregnancy (ROP) •Health Information Exchange (HIE) initiatives •ODM Population Health Dashboards	**ODM Prioritized Strategies** •Review results geographically statewide by Public Use Microdata Areas (PUMAs) •Ohio Opportunity Index (OOI) and Children's Opportunity Index (COI) to identify underlying social drivers •ODM Population Health Dashboards •Ohio's Medicaid Technical Assistance & Policy Program (MedTAPP) •Availability of data for research and evidence-based practice
CMS Priority Areas: Equity and Engagement	
Equity Advance health equity and whole-person care	**Engagement** Engage individuals and communities to become partners in their care
ODM Goals •Improve wellness and health outcomes •Emphasize a personalized care experience •Improve care for children and adults with complex needs	**ODM Goals** •Emphasize a personalized care experience •Improve care for children and adults with complex needs
ODM Prioritized Strategies •Set Minimum Performance Standards (MPS) benchmarks on quality measures by Overall population and by the Black population •Maternal and Infant Support (MISP) program (doula and lactation services) •OhioRISE PIHP (Resilience through Integrated Systems and Excellence • ODM Infant Mortality Community Partnership: A collaboration among ODM, Managed Care Organizations, and local community-based partners • Risk Stratification / Risk Tiers to identify higher risk populations •Preterm birth Risk Stratification •Ohio Section 1115 Demonstration Waiver for Substance Use Disorder Treatment Extension •Medicaid School Program (MSP) •School-Based Health Centers •Community Reinvestment	**ODM Prioritized Strategies** •New Care Coordination Model and Risk Stratification •Risk Stratification / Risk Tiers to identify higher risk populations, including preterm birth risk stratification •MCO Provider and Member Advisory Councils •Incorporation of Voice of the Customer (VOC) in Performance Improvements (PIPs) •Medicaid School Program (MSP) •School-Based Health Centers •Community Reinvestment

CMS National Quality Strategy Priority Areas and Goals	
CMS Priority Areas: Safety and Resiliency	
Safety Achieve zero preventable harm	**Resiliency** Enable A responsive and resilient health care system to improve quality
ODM Goals •Emphasize a personalized care experience •Support providers in better patient care •Increase program transparency and accountability	**ODM Goals** •Support providers in better patient care •Increase program transparency and accountability
ODM Prioritized Strategies •MCO Annual Report Cards •CAHPS Consumer Experience Survey •ODM Incident Management System •Annual External Quality Review •Monitoring of grievances and appeals • Utilization management (CCP and EMR review)	**ODM Prioritized Strategies** •Alternative Payout Models: Comprehensive Primary Care (CPC) and CPC Kids, Comprehensive Maternal Care (CMC), and Certified Community Behavioral Health Clinics (CCBHC) •Mobile Response Stabilization Services (MRSS) for de-escalation of BH crisis, diversion from hospitalization, and provision of care in least restrictive setting •MCO Provider and Member Advisory Councils

ODM Population-Specific Goals, Objectives, and Prioritized Strategies

To achieve large-scale programmatic goals, ODM has divided its covered population into five population health streams defined by demographic characteristics, diagnoses and service utilization (see Appendix E for Population Health Stream Specifications).

Figure 1. Ohio Medicaid's Population Health and Quality Strategy



1.) Healthy Children and Adults (children and adults),
2.) Women and Infant Health (infants, women of reproductive age, and high-risk women),
3.) Behavioral Health (children and adults),
4.) Chronic Physical and Developmental Conditions (children and adults),
5.) Older Adults

Each of the population health streams is shown on the left side of the graphic above under the heading "Focus Population". The middle column of the graphic further divides the populations into subpopulations (e.g., children and adults) and shows some of ODM's prioritized strategies for improving population health within all streams. The column on the far right shows the population stream specific goals. The top right corner of the graphic emphasizes ODM's focus on improving health outcomes for all populations as the utmost improvement goal for our population health and quality strategy.

Population-specific health management, involving researching; planning; and implementation of strategies, is critical to improving health outcomes that support the CMS National Quality Goals of outcomes, alignment, equity, and safety while fundamentally supporting each of ODM's Overarching Programmatic Goals. The population-specific health streams allow for focused population health management to improve the health and well-being of the stream and allow for the utilization of specific measures tied to each stream to monitor outcomes and successful improvement. These measures include HEDIS, CAHPS, CMS Child & Adult Core, and ODM defined measures.

Table 3 depicts ODM's Population Health and Quality Strategy 2026-2028 Population-Specific Goals, Objectives, and Prioritized Strategies

Table 3: ODM Population-Specific Goals, Objectives, and Prioritized Strategies

Goals	Objectives	Prioritized Strategies
Population: Healthy Children & Adults		
Subpopulation: Healthy Children **Goals:** •Increase Well-Child Visits •Improve Academic Success	1.1 Increase infant well-care visits with a primary care provider 1.2 Increase well-child visits among children 0-15 months of age 1.3 Increase well-child visits among children 15-30 months of age 1.4 Increase well-care visits among children 3-11 years of age 1.5 Increase well-child visits among adolescent children 12-17 years of age 1.6 Increase well-care visits among adolescent children 18-21 years of age 1.7 Increase screening for depression and follow-up plan, ages 12-17 1.8 Increase oral evaluation, dental services (ages 0-20) 1.9 Increase general child rating of their health plan 1.10 Increase general child rating of their health plan's customer service 1.11 Increase general child rating of getting care quickly 1.12 Increase general child rating of getting needed care 1.13 Increase general child rating of how well doctors communicate 1.14 Increase kindergarten readiness 1.15 Reduce chronic absenteeism	**Policy** •Continuous coverage of children from birth through age three (ages 0-3) •Healthchek: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program **Contractual Requirements** •ODM Ohio Medicaid Provider Agreement for MCO Service Coverage / Managed Care Network for Primary Care Providers •ODM Provider Agreement: MCO Population Health Management Strategy for Healthy Children & Adults **Program** •Alternative Payment Model: Comprehensive Primary Care (CPC) and CPC Kids •State Directed Payments •The Outcomes Acceleration for Kids (OAK) Learning Network • Minium Performance Standards (MPS) for well-child visits •Medicaid in Schools Program (MSP) •New Care Coordination Model •Utilization Management •MCO value added services including transportation **State** •Ohio Governor's expansion of School-Based Health Centers

Subpopulation: Healthy Adults **Goal:** •Increase Preventative Screenings •Improve Member Experience	2.1 Increase adults' access to preventive / ambulatory health services	
	2.2 Increase breast cancer screening among adults	
	2.3 Increase colorectal cancer screening among adults	
	2.4 Increase adults' rating of their health plan	
	2.5 Increase adults' rating of their health plan's customer service	
	2.6 Increase adults' rating of getting care quickly	
	2.7 Increase adults' rating of getting needed care	
	2.8 Increase adults' rating of how well doctors communicate	
Goals	**Objectives**	**Prioritized Strategies**
Population: Women & Infants		
Goals: •Timely & Accessible Care •Decrease Maternal & Infant Mortality	3.1 Increase the timeliness of prenatal care	**Policy** • Day one enrollment in Medicaid managed care to ensure pregnant women who are enrolling for the first time are immediately connected to care coordination services •Extended postpartum coverage to 12 months •Continuous coverage of children from birth through age three (ages 0-3) •Coverage of Doula Services •Coverage of Lactation Consulting Services •Coverage of Nurse Home Visiting (NHV) Services • Healthchek: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program **Contractual Requirements** •ODM Provider Agreement: MCO Service Coverage / Managed Care Network for Maternal Care Providers •ODM Provider Agreement: MCO Population Health Management Strategy for Women & Infants •Eliminate barriers to promising treatments including smoking cessation screening and treatment **Program** •Alternative Payment Model: Comprehensive Maternal Care (CMC) •Maternal and Infant Support Program (MISP) focuses on reducing and eliminating population performance gaps in maternal and infant outcomes and reducing infant mortality •State Directed Payments •New Care Coordination Model •Minium Performance Standards (MPS) for preterm birth, timeliness of prenatal care, postpartum care, chlamydia screening, and cervical cancer screening •ODM Infant Mortality Community Partnership: A collaboration among ODM, Managed Care Organizations, and local community-based partners in the Ohio Equity Institute (OEI) communities
	3.2 Increase the number of women who have a prenatal visit by nine weeks gestation	
	3.3 Reduce Preterm Births	
	3.4 Increase postpartum care	
	3.5 Increase contraceptive care for postpartum women	
	3.6 Increase primary care visits for mother	
	3.7 Increase primary care visits for women of reproductive age	
	3.8 Increase chlamydia screening among women ages 21 to 24	
	3.9 Increase cervical cancer screening among women	

		•Ohio's Online Pregnancy Notification System (PRAF 2.0) method for providers to notify ODM and MCOs of an individual's pregnancy to prevent loss of Medicaid coverage during pregnancy and facilitate efficient and timely linkage to needed services •MCO value added services including transportation **State** •Ohio Governor's Initiative: All MCO collaborative Performance Improvement Project - Preterm Birth and Related Population Health Build Work
Goals	**Objectives**	**Prioritized Strategies**
Population: Behavioral Health Children & Adults		
Subpopulation: Behavioral Health Children **Goals:** •Increase Availability of Comprehensive & Coordinated BH Services •Reduce BH & SUD Related Mortality	4.1 Increase 7-day follow-up after emergency department (ED) visits for substance abuse among children & adolescents	**Policy** •Rate increases for community behavioral health services including hospital delivered BH services •Health risk assessment, Healthchek (EPSDT) **Contractual Requirements** •ODM Provider Agreement: MCO Service Coverage / Managed Care Network for MH & SUD Providers •ODM Provider Agreement: MCO Population Health Management Strategy for Behavioral Health Children & Adults **Program** •OhioRISE (Resilience through Integrated Systems and Excellence) (CANS assessment) •All MCO collaborative Quality Withold Performance Improvement Project (QW-PIP) to increase the rate of 7-day follow up after ED visit for substance use •Certified Community Behavioral Health Centers (CCHBC) for comprehensive, coordinated primary care, mental health and substance use services with increased access to high-quality community mental health and substance use care, including crisis care appropriate for individuals across the lifespan, targeted care management (TCM) for SPMI population and/or co-occurring MH/SUD/chronic conditions, and HRSN supports (Alternative Payment Model) •Mobile Response Stabilization Services (MRSS) for de-escalation of BH crisis, diversion from hospitalization, and provision of care in least restrictive setting (including strategies for ensuring statewide capacity and establishing appropriate access while not increasing cost) •SUD Waiver-Access to critical Levels of Care for OUD and other SUDs. Improving access to treatment for other SUDs and strategies for maintaining or increasing lower levels of care. Access to MOUD with initiation and continuity of pharmacotherapy and more research into addressing potential performance variation •Promotion of cross system coordination •Alternative Payment Models: Comprehensive Primary Care (CPC) and CPC Kids •State Directed Payments
	4.2 Increase 7-day follow-up after an ED visit for mental health among children and adolescents	
	4.3 Increase 7-day & 30-day follow-up after hospitalization for mental illness for children and adolescents	
	4.4 Increase initiation & engagement of substance use disorder treatment among adolescents	
	4.5 Increase the use of psychosocial care for children and adolescents on antipsychotics	
	4.6 Increase the use of age-appropriate standardized depression screening tools and follow-up among adolescents	
Subpopulation: Behavioral Health Adults **Goals:** •Increase Availability of Comprehensive & Coordinated BH Services •Reduce BH & SUD Related Mortality	5.1 Increase initiation & engagement of substance use disorder treatment among adults	
	5.2 Increase 7-day follow-up after emergency department (ED) visits for substance abuse among adults	
	5.3 Increase 7-day & 30-day follow-up after hospitalization for mental illness for adults	
	5.4 Increase 7-day follow-up after emergency department visit for mental illness for adults	
	5.5 Increase the use of pharmacotherapy for opioid use disorder for adults	
	5.6 Increase depression screening and follow-up for adults	

		•Medicaid in Schools Program (MSP) •New Care Coordination Model •Minium Performance Standards (MPS) for behavioral health measures •Utilization Management •MCO value added services including transportation •Promotion of the integration of physical and BH healthcare •Promotion of the use of health information technology and information exchange among physical and behavioral health providers, payers, and programs to optimize member outcomes **State** •Ohio Governor's expansion of School-Based Health Centers •The Outcomes Acceleration for Kids (OAK) Learning Network •Ohio Governor's Initiative: All MCO collaborative Performance Improvement Project – Improve Follow-Up After Mental Health (MH) Emergency Department (ED) Visit for Adults (EDM-A)
Goals	**Objectives**	**Prioritized Strategies**
Population: Chronic Physical & Developmental Conditions Children & Adults		
Subpopulation Chronic Physical & Developmental Conditions Children **Goal:** Increase Well Managed Chronic Conditions	6.1 Increase the percentage of children on Medicaid aged 5-11 years old who have an Asthma medication ratio greater than 50% 6.2 Increase the percentage of children on Medicaid aged 12-18 years old who have an Asthma Medication ratio greater than 50% 6.3 Increase the Transcranial Ultrasound completion rate of all children on Medicaid with sickle cell disease	**Policy** •Removal of prior authorization for continuous glucose monitors (CGM) in pharmacy benefit •Healthchek: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program **Contractual Requirements** •ODM Provider Agreement: MCO Service Coverage / Managed Care Network for Primary Care Providers and Specialists •ODM Provider Agreement: MCO Population Health Management Strategy for Chronic Physical & Developmental Conditions Children & Adults **Program** •Promote preventive screenings, treatment, services, and supports to achieve well managed chronic conditions •Alternative Payment Models: Comprehensive Primary Care (CPC) and CPC Kids •State Directed Payments •Medicaid in Schools Program (MSP) •Long-Term Services & Supports (LTSS) •New Care Coordination Model •School-Based Asthma Pharmacy program collaboration with Nationwide Children's Hospital to supply additional inhaler at school for children with asthma •Minium Performance Standards (MPS) for asthma and diabetes measures •Utilization Management •Monitor member access to pharmacies •MCO value added services including transportation **State**
Subpopulation Chronic Physical & Developmental Conditions Adults **Goal:** Increase Well Managed Chronic Conditions	7.1 Increase the number of adults with well-managed asthma 7.2 Increase the number of adults with well-managed, controlled high blood pressure 7.3 Decrease the number of adults with poorly controlled diabetes 7.4 Increase the number of adults receiving statin therapy for cardiovascular disease	

		•Ohio Governor's expansion of School-Based Health Centers •The Outcomes Acceleration for Kids (OAK) Learning Network
Goals	**Objectives**	**Prioritized Strategies**
Population: Older Adults		
Goal: Promote Maximal Choice & Independence	Note: Due to the Next Generation MyCare redesign, procurement, and implementation starting January 1, 2026, ODM will define Quality Strategy goals and objectives for the Older Adults population in 2026 for 2027	**Policy** •Increase Reimbursement for In-Home Health Care **Contractual Requirements** •ODM Next Generation MyCare Ohio Provider Agreement service coverage requirements •Population health management strategy for covered populations •Population stream assignments •Risk stratification assessment of each member's risk level to determine individual member needs including level of Care Coordination needs •Quality Withhold Performance Improvement Projects **Program** •MCOP Care Coordination Model •Value-Based Payment •Utilization Management •MCOP value added services •Community Reinvestment •Transitions of care requirements •Quality metrics and performance evaluation •Long-Term Services & Supports (LTSS) •LTSS time & distance standards •Home-based LTSS service standards •MyCare Ohio HCBS Waiver Services

ODM Population-Specific Priority Quality Measures

ODM has designated population-specific priority performance quality measures to meet the population specific goals and objectives of the Quality Strategy as identified in Table 2 above. The development of a common set of population-specific priority performance quality measures will guide and align Ohio Medicaid's managed care entities (MCEs) population health management strategies and quality improvement projects for collective impact to improve performance related to the quality of, timeliness of, and access to positive healthcare and services provided by Ohio's MCEs. The QS priority performance measures monitor, trend, and assess member outcomes and MCE performance by population-specific health streams and by stratifying measures for the Overall population and the Black population to address population-specific performance gaps in healthcare and health outcomes.

ODM monitors a wide selection of quality measures and contractually requires MCEs to track and submit performance data. The selection process includes the identification of national quality organizational endorsed measures including the CMS Child, Adult and Behavioral Health Core Sets; the National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set (HEDIS); the Consumer Assessment of Healthcare Providers and Systems (CAHPS); Managed Long Term Services and Supports (LTSS); and CMS Quality Rating System (QRS). ODM has developed several ODM-specific measures to evaluate performance and monitor member outcomes. In addition, External Quality Review (EQR) Technical reports are also used to evaluate performance and to identify opportunities for improvement.

Table 4 depicts ODM's Population Health and Quality Strategy 2026-2028 Population-Specific Priority Quality Measures. For collective population health management, ODM aligns quality measures across it's several different types of contracted managed care entities (MCEs), including MCOs, the OhioRISE PIHP, the Single Pharmacy Benefit Manager (SPBM) PAHP, and MyCare Ohio Plans (MCOPs) as well as alignment across multiple ODM programs, including alternative payment models Comprehensive Primary Care (CPC) and Comprehensive Maternal Care (CMC), Performance Improvement Projects (PIPs), and State Directed Payments (SDP). Evidence of alignment of quality measures across MCEs and ODM programs is identified on the table in the column labeled Program Area(s) Performance Measure. Alignment across quality measures demonstrates one of the multiple strategies ODM employs for collaboration with MCEs, health systems and communities for collective impact on population-specific goals. The establishment of common program-specific quality metrics and definitions allows for meaningful collaboration across program areas and delivery systems and allows for reliable measurement, reporting, and meaningful comparisons across Medicaid managed care plans. For a complete list of the metrics ODM uses to monitor and evaluate MCE performance see Appendix A.

Table 4: ODM Population-Specific Priority Quality Measures

Objective	Quality Measure	Measure Steward	Program Area(s) Performance Measure	Statewide Baseline Performance MY 2023	Statewide Performance Target MY 2025	Statewide Performance Target MY 2026
The baseline performance rates and performance targets for the population health streams Healthy Children & Adults, Women & Infants, Behavioral Health Children & Adults, and Chronic Physical and Developmental Conditions Children & Adults are ODM's Medicaid contracted managed care organizations (MCOs) statewide average performance rates and performance targets except for four measures that have been identified on the table as regional population measures. ODM has established Quality Performance Measures and Standards to evaluate MCO performance in key program areas (e.g., access, clinical quality, consumer satisfaction). The selected measures align with specific priorities, goals, and focus areas of the ODM Quality Strategy. For a complete list of the metrics ODM uses to monitor MCO performance see Appendix A.						
Population: Healthy Children **Goals: Increase Well-Child Visits & Improve Academic Success**						
1.1 Increase infant well-care visits with a primary care provider	Infant Well-Care Visit with a Primary Care Provider	ODM	MCO CMC	Overall (All Children) 79.84%	Overall (All Children) Reporting Only	Overall (All Children) Reporting Only
1.2 Increase well-child visits among children 0-15 months of age	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 **QW-PIP**	NCQA/HEDIS Child Core QRS	MCO OhioRISE PIHP CPC SDP	Overall (All Children) 62.21%	Overall (All Children) ≥63.44%[STW] SAG	Overall (All Children) ≥66.32%[STW] SAG
				Population-Specific Goal (Black Children) 53.84%	Population-Specific Goal (Black Children) ≥53.04% SAG	Population-Specific Goal (Black Children) ≥54.70% SAG
1.3 Increase well-child visits among children 15-30 months of age	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 Child Core QRS	MCO OhioRISE PIHP	Overall (All Children) 67.40%	Overall (All Children) Reporting Only	Overall (All Children) Reporting Only
				Population-Specific Goal (Black Children) 61.99%	Population-Specific Goal (Black Children) Reporting Only	Population-Specific Goal (Black Children) Reporting Only
1.4 Increase well-care visits among children 3-11 years of age	Child and Adolescent Well-Care Visits, 3-11 Years	NCQA/HEDIS Child Core QRS	MCO OhioRISE PIHP CPC	Overall (All Children) 57.20%	Overall (All Children) Reporting Only	Overall (All Children) Reporting Only
				Population-Specific Goal (Black Children) 57.46%	Population-Specific Goal (Black Children) Reporting Only	Population-Specific Goal (Black Children) Reporting Only

Objective	Quality Measure	Measure Steward	Program Area(s) Performance Measure	Statewide Baseline Performance MY 2023	Statewide Performance Target MY 2025	Statewide Performance Target MY 2026
1.5 Increase well-care visits among adolescent children 12-17 years of age	Child and Adolescent Well-Care Visits, 12-17 Years **QW-PIP**	NCQA/HEDIS Child Core QRS	MCO OhioRISE PIHP CPC SDP	Overall (All Children) 50.86%	Overall (All Children) ≥53.10%[STW] SAG	Overall (All Children) ≥54.76%[STW] SAG
				Population-Specific Goal (Black Children) 52.86%	Population-Specific Goal (Black Children) ≥54.81% SAG	Population-Specific Goal (Black Children) ≥55.97% SAG
1.6 Increase well-care visits among adolescent children 18-21 years of age	Child and Adolescent Well-Care Visits, 18-21 Years	NCQA/HEDIS Child Core QRS	MCO OhioRISE PIHP CPC	Overall (All Children) 26.32%	Overall (All Children) Reporting Only	Overall (All Children) Reporting Only
				Population-Specific Goal (Black Children) 26.81%	Population-Specific Goal (Black Children) Reporting Only	Population-Specific Goal (Black Children) Reporting Only
1.7 Increase screening for depression and follow-up plan, ages 12-17	Screening for Depression and Follow-Up Plan (Ages 12-17)	NCQA/HEDIS Child Core QRS	MCO	Overall (All Children) N/A	Overall (All Children) Reporting Only	Overall (All Children) Reporting Only
				Population-Specific Goal (Black Children) N/A	Population-Specific Goal (Black Children) Reporting Only	Population-Specific Goal (Black Children) Reporting Only
1.8 Increase oral evaluation, dental services (ages 0-20)	Oral Evaluation, Dental Services	NCQA/HEDIS Child Core QRS	MCO	Overall (All Children) 33.71%	Overall (All Children) Reporting Only	Overall (All Children) Reporting Only
				Population-Specific Goal (Black Children) 32.33%	Population-Specific Goal (Black Children) Reporting Only	Population-Specific Goal (Black Children) Reporting Only
1.9 Increase general child rating of their health plan	General Child - Rating of Health Plan (CAHPS Health Plan Survey)	NCQA/HEDIS Child Core QRS	MCO OhioRISE PIHP	Overall (All Children) 82.16%	Overall (All Children) ≥85.23%	Overall (All Children) MPS TBD Fall 2025
				Population-Specific Goal (Black Children) N/A	Population-Specific Goal (Black Children) Reporting Only	Population-Specific Goal (Black Children) MPS TBD Fall 2025

Objective	Quality Measure	Measure Steward	Program Area(s) Performance Measure	Statewide Baseline Performance MY 2023	Statewide Performance Target MY 2025	Statewide Performance Target MY 2026
1.10 Increase general child rating of their health plan's customer service	General Child - Customer Service Composite (CAHPS Health Plan Survey)	NCQA/HEDIS Child Core QRS	MCO	Overall (All Children) 87.95%	Overall (All Children) ≥89.87%	Overall (All Children) MPS TBD Fall 2025
				Population-Specific Goal (Black Children) N/A	Population-Specific Goal (Black Children) Reporting Only	Population-Specific Goal (Black Children) MPS TBD Fall 2025
1.11 Increase general child rating of getting care quickly	General Child - Getting Care Quickly (CAHPS Health Plan Survey)	NCQA/HEDIS Child Core QRS	MCO	Overall (All Children) 89.06%	Overall (All Children) Reporting Only	Overall (All Children) Reporting Only
				Population-Specific Goal (Black Children) N/A	Population-Specific Goal (Black Children) Reporting Only	Population-Specific Goal (Black Children) Reporting Only
1.12 Increase general child rating of getting needed care	General Child - Getting Needed Care (CAHPS Health Plan Survey)	NCQA/HEDIS Child Core QRS	MCO	Overall (All Children) 86.39%	Overall (All Children) Reporting Only	Overall (All Children) Reporting Only
				Population-Specific Goal (Black Children) N/A	Population-Specific Goal (Black Children) Reporting Only	Population-Specific Goal (Black Children) Reporting Only
1.13 Increase general child rating of how well doctors communicate	General Child - How Well Doctors Communicate (CAHPS Health Plan Survey)	NCQA/HEDIS Child Core QRS	MCO	Overall (All Children) 95.35%	Overall (All Children) Reporting Only	Overall (All Children) Reporting Only
				Population-Specific Goal (Black Children) N/A	Population-Specific Goal (Black Children) Reporting Only	Population-Specific Goal (Black Children) Reporting Only
Academic Measures for Children						
1.14 Increase kindergarten readiness	Kindergarten Readiness	ODM	MCO OhioRISE PIHP	Medicaid 20.5% (SY2023)	Medicaid Reporting Only	Medicaid Reporting Only
				Population-Specific Goal (Black Children) Medicaid 18.2% (SY2023)	Population-Specific Goal (Black Children) Medicaid Reporting Only	Population-Specific Goal (Black Children) Medicaid Reporting Only
				Non-Medicaid	Non-Medicaid	Non-Medicaid

				47.4% (SY2023)	Reporting Only	Reporting Only
Objective	**Quality Measure**	**Measure Steward**	**Program Area(s) Performance Measure**	**Statewide Baseline Performance MY 2023**	**Statewide Performance Target MY 2025**	**Statewide Performance Target MY 2026**
1.15 Reduce chronic absenteeism	Chronic Absenteeism	ODM	MCO OhioRISE PIHP	Medicaid Grades K-8 34.6% (SY2023)	Medicaid Grades K-8 Reporting Only	Medicaid Grades K-8 MPS TBD Fall 2025
				Population-Specific Goal (Black Children) Medicaid Grades K-8 43.7% (SY2023)	Population-Specific Goal (Black Children) Medicaid Grades K-8 Reporting Only	Population-Specific Goal (Black Children) Medicaid Grades K-8 MPS TBD Fall 2025
				Non-Medicaid Grades K-8 N/A	Non-Medicaid Grades K-8 Reporting Only	Non-Medicaid Grades K-8 Reporting Only
				Medicaid Grades 9-12 49.6% (SY2023)	Medicaid Grades 9-12 Reporting Only	Medicaid Grades 9-12 MPS TBD Fall 2025
				Population-Specific Goal (Black Children) Medicaid Grades 9-12 61.3% (SY2023)	Population-Specific Goal (Black Children) Medicaid Grades 9-12 Reporting Only	Population-Specific Goal (Black Children) Medicaid Grades 9-12 MPS TBD Fall 2025
				Non-Medicaid Grades 9-12 N/A	Non-Medicaid Grades 9-12 Reporting Only	Non-Medicaid Grades 9-12 Reporting Only
Population: Healthy Adults **Goals: Increase Preventative Screenings & Improve Member Experience**						
2.1 Increase adults' access to preventive / ambulatory health services	Adults' Access to Preventive / Ambulatory Health Services – Total	NCQA/HEDIS	MCO MyCare	Overall (All Adults) 78.37%	Overall (All Adults) ≥78.37% MPS	Overall (All Adults) MPS TBD Fall 2025
				Population-Specific Goal (Black Adults) 74.96%	Population-Specific Goal (Black Adults) Reporting Only	Population-Specific Goal (Black Adults) MPS TBD Fall 2025

Objective	Quality Measure	Measure Steward	Program Area(s) Performance Measure	Statewide Baseline Performance MY 2023	Statewide Performance Target MY 2025	Statewide Performance Target MY 2026
2.2 Increase breast cancer screening among adults	Breast Cancer Screening (BCS-E)	NCQA/HEDIS Adult Core QRS	MCO MyCare CPC	Overall (All Adults) 51.09%	Overall (All Adults) ≥52.68% MPS	Overall (All Adults) MPS TBD Fall 2025
				Population-Specific Goal (Black Adults) 53.73%	Population-Specific Goal (Black Adults) Reporting Only	Population-Specific Goal (Black Adults) MPS TBD Fall 2025
2.3 Increase colorectal cancer screening among adults	Colorectal Cancer Screening (COL-E), Ages 45-75	NCQA/HEDIS Adult Core QRS	MCO	Overall (All Adults) N/A	Overall (All Adults) Reporting Only	Overall (All Adults) Reporting Only
				Population-Specific Goal (Black Adults) N/A	Population-Specific Goal (Black Adults) Reporting Only	Population-Specific Goal (Black Adults) Reporting Only
2.4 Increase adults' rating of their health plan	Adult Rating of Health Plan (CAHPS Health Plan Survey)	NCQA/HEDIS CAHPS Adult Core QRS	MCO MyCare	Overall (All Adults) 76.46%	Overall (All Adults) ≥79.53% MPS	Overall (All Adults) MPS TBD Fall 2025
				Population-Specific Goal (Black Adults) N/A	Population-Specific Goal (Black Adults) Reporting Only	Population-Specific Goal (Black Adults) MPS TBD Fall 2025
2.5 Increase adults' rating of their health plan's customer service	Adult Customer Service Composite (CAHPS Health Plan Survey)	NCQA/HEDIS CAHPS Adult Core QRS	MCO MyCare	Overall (All Adults) 89.38%	Overall (All Adults) ≥90.20% MPS	Overall (All Adults) MPS TBD Fall 2025
				Population-Specific Goal (Black Adults) N/A	Population-Specific Goal (Black Adults) Reporting Only	Population-Specific Goal (Black Adults) MPS TBD Fall 2025
2.6 Increase adults' rating of getting care quickly	Getting Care Quickly (CAHPS Health Plan Survey)	NCQA/HEDIS CAHPS Adult Core QRS	MCO	Overall (All Adults) 82.47%	Overall (All Adults) Reporting Only	Overall (All Adults) Reporting Only
				Population-Specific Goal (Black Adults) N/A	Population-Specific Goal (Black Adults) Reporting Only	Population-Specific Goal (Black Adults) Reporting Only

Objective	Quality Measure	Measure Steward	Program Area(s) Performance Measure	Statewide Baseline Performance MY 2023	Statewide Performance Target MY 2025	Statewide Performance Target MY 2026
2.7 Increase adults' rating of getting needed care	Getting Needed Care (CAHPS Health Plan Survey)	NCQA/HEDIS CAHPS Adult Core QRS	MCO	Overall (All Adults) 83.99%	Overall (All Adults) Reporting Only	Overall (All Adults) Reporting Only
				Population-Specific Goal (Black Adults) N/A	Population-Specific Goal (Black Adults) Reporting Only	Population-Specific Goal (Black Adults) Reporting Only
2.8 Increase adults' rating of how well doctors communicate	How Well Doctors Communicate (CAHPS Health Plan Survey)	NCQA/HEDIS CAHPS Adult Core QRS	MCO	Overall (All Adults) 93.57%	Overall (All Adults) Reporting Only	Overall (All Adults) Reporting Only
				Population-Specific Goal (Black Adults) N/A	Population-Specific Goal (Black Adults) Reporting Only	Population-Specific Goal (Black Adults) Reporting Only
Population: Women & Infants **Goals: Timely & Accessible Care and Decrease Maternal & Infant Mortality**						
3.1 Increase the timeliness of prenatal care	Prenatal and Postpartum Care-Timeliness of Prenatal Care	NCQA/HEDIS Adult/Child Core QRS	MCO CPC SDP	Overall (All Adults) 83.29%	Overall (All Adults) ≥84.55% MPS	Overall (All Adults) MPS TBD Fall 2025
				Population-Specific Goal (Black Adults) 80.24%	Population-Specific Goal (Black Adults) Reporting Only	Population-Specific Goal (Black Adults) MPS TBD Fall 2025
3.2 Increase the number of women who have a prenatal visit by nine weeks gestation	Prenatal Visit by Nine Weeks Gestation	ODM	MCO CMC SDP	Overall (All Adults) 52.96%	Overall (All Adults) Reporting Only	Overall (All Adults) Reporting Only
				Population-Specific Goal (Black Adults) N/A	Population-Specific Goal (Black Adults) Reporting Only	Population-Specific Goal (Black Adults) Reporting Only
3.3 Reduce Preterm Births	Preterm Birth (PTB)	ODM	MCO CMC SDP	Overall (All Adults) 10.6%	Overall (All Adults) Reporting Only	Overall (All Adults) MPS TBD Fall 2025
				Population-Specific Goal (Black Adults) 12.3%	Population-Specific Goal (Black Adults) Reporting Only	Population-Specific Goal (Black Adults) MPS TBD Fall 2025

Objective	Quality Measure	Measure Steward	Program Area(s) Performance Measure	Statewide Baseline Performance MY 2023	Statewide Performance Target MY 2025	Statewide Performance Target MY 2026
3.4 Increase postpartum care	Prenatal and Postpartum Care-Postpartum Care	NCQA/HEDIS Child Core QRS	MCO CPC CMC SDP	Overall (All Adults) 75.83%	Overall (All Adults) ≥80.23% MPS	Overall (All Adults) MPS TBD Fall 2025
				Population-Specific Goal (Black Adults) 72.47%	Population-Specific Goal (Black Adults) Reporting Only	Population-Specific Goal (Black Adults) MPS TBD Fall 2025
3.5 Increase contraceptive care for postpartum women	Contraceptive Care – Postpartum Women (CCP), Ages 15-44	OPA Child Core QRS	MCO	Overall (All Adults) N/A	Overall (All Adults) Reporting Only	Overall (All Adults) Reporting Only
				Population-Specific Goal (Black Adults) N/A	Population-Specific Goal (Black Adults) Reporting Only	Population-Specific Goal (Black Adults) Reporting Only
3.6 Increase primary care visits for mother	Primary Care Visits for Mother	ODM	MCO CMC SDP	Overall (All Adults) 39.47%	Overall (All Adults) Reporting Only	Overall (All Adults) Reporting Only
				Population-Specific Goal (Black Adults) 37.73%	Population-Specific Goal (Black Adults) Reporting Only	Population-Specific Goal (Black Adults) Reporting Only
3.7 Increase primary care visits for women of reproductive age	Primary Care Visits for Women of Reproductive Age	ODM	MCO SDP	Overall (All Adults) 75.96%	Overall (All Adults) Reporting Only	Overall (All Adults) Reporting Only
				Population-Specific Goal (Black Adults) 74.01%	Population-Specific Goal (Black Adults) Reporting Only	Population-Specific Goal (Black Adults) Reporting Only
3.8 Increase chlamydia screening among women ages 21 to 24	Chlamydia Screening in Women (Chlamydia Screening, eff. MY 2025) Ages 21 to 24	NCQA/HEDIS Adult Core	MCO SDP	Overall (All Adults) 61.66%	Overall (All Adults) ≥ 62.63% MPS	Overall (All Adults) MPS TBD Fall 2025
				Population-Specific Goal (Black Adults) N/A	Population-Specific Goal (Black Adults) Reporting Only	Population-Specific Goal (Black Adults) MPS TBD Fall 2025

Objective	Quality Measure	Measure Steward	Program Area(s) Performance Measure	Statewide Baseline Performance MY 2023	Statewide Performance Target MY 2025	Statewide Performance Target MY 2026
3.9 Increase cervical cancer screening among women	Cervical Cancer Screening	NCQA/HEDIS Adult Core QRS	MCO CPC SDP	Overall (All Adults) 56.79%	Overall (All Adults) ≥ 57.18% MPS	Overall (All Adults) MPS TBD Fall 2025
				Population-Specific Goal (Black Adults) N/A	Population-Specific Goal (Black Adults) Reporting Only	Population-Specific Goal (Black Adults) MPS TBD Fall 2025
Population: Behavioral Health Children **Goals: Increase Availability of Comprehensive & Coordinated BH Services and Reduce BH & SUD Related Mortality**						
4.1 Increase 7-day follow-up after emergency department (ED) visits for substance abuse among children & adolescents	Follow-Up After Emergency Department (ED) for Substance Use, 7-day, Ages 13-17	NCQA/HEDIS Child Core BH Core	MCO OhioRISE PIHP CCHBC	Overall (All Children) 30.20%	Overall (All Children) Reporting Only	Overall (All Children) Reporting Only
	1-7 Day Follow-Up Visit After ED Encounter for Substance Use, Ages 10 – 17 **QW-PIP**	ODM	MCO OhioRISE PIHP SDP	Overall (All Children) 34.70% (MY2022)	Overall (All Children) ≥38.17%[STW] SAG	Overall[STW] (All Children) ≥39.91%[STW] SAG
				Population-Specific Goal (Black Children) 28.34% (MY2022)	Population-Specific Goal (Black Children) ≥30.23% SAG	Population-Specific Goal (Black Children) ≥31.18% SAG
4.2 Increase 7-day follow-up after an ED visit for mental health among children and adolescents	Follow-Up After Emergency Department Visit for Mental Illness, 7-day, Ages 6-17	NCQA/HEDIS Child Core BH Core	MCO OhioRISE PIHP CCHBC	Overall (All Children) 68.43%	Overall (All Children) Reporting Only	Overall (All Children) Reporting Only
	1-7 Day Follow-Up Visit After ED Encounter for Mental Illness, Ages 0 -17 **QW-PIP**	ODM	MCO OhioRISE PIHP SDP	Overall (All Children) 49.13% (MY2022)	Overall (All Children) ≥54.05%[STW] SAG	Overall[STW] (All Children) ≥56.50%[STW] SAG
				Population-Specific Goal (Black Children) 44.23% (MY2022)	Population-Specific Goal (Black Children) ≥47.18% SAG	Population-Specific Goal (Black Children) ≥48.65% SAG

Objective	Quality Measure	Measure Steward	Program Area(s) Performance Measure	Statewide Baseline Performance MY 2023	Statewide Performance Target MY 2025	Statewide Performance Target MY 2026
4.3 Increase 7-day & 30-day follow-up after hospitalization for mental illness for children and adolescents	Follow-Up After Hospitalization for Mental Illness, 7 -day Follow-Up, Ages 6- 17	NCQA/HEDIS Child Core BH Core QRS	MCO CPC OhioRISE PIHP CCHBC	Overall (All Children) 48.90%	Overall (All Children) Reporting Only	Overall (All Children) Reporting Only
				Population-Specific Goal (Black Children) 45.94%	Population-Specific Goal (Black Children) Reporting Only	Population-Specific Goal (Black Children) Reporting Only
	Follow-Up After Hospitalization for Mental Illness, 30 -day Follow-Up, Ages 6- 17	NCQA/HEDIS Child Core BH Core QRS	MCO CCHBC	Overall (All Children) 77.78%	Overall (All Children) Reporting Only	Overall (All Children) Reporting Only
				Population-Specific Goal (Black Children) 71.26%	Population-Specific Goal (Black Children) Reporting Only	Population-Specific Goal (Black Children) Reporting Only
4.4 Increase initiation & engagement of substance use disorder treatment among adolescents	Initiation and Engagement of Substance Use Disorder Treatment, Initiation, Ages 13-17	NCQA/HEDIS QRS	MCO CPC OhioRISE PIHP	Overall (All Children) 44.73%	Overall (All Children) Reporting Only	Overall (All Children) Reporting Only
				Population-Specific Goal (Black Children) N/A	Population-Specific Goal (Black Children) Reporting Only	Population-Specific Goal (Black Children) Reporting Only
	Initiation and Engagement of Substance Use Disorder Treatment, Engagement, Ages 13-17	NCQA/HEDIS QRS	MCO OhioRISE PIHP	Overall (All Children) 22.83%	Overall (All Children) Reporting Only	Overall (All Children) Reporting Only
				Population-Specific Goal (Black Children) N/A	Population-Specific Goal (Black Children) Reporting Only	Population-Specific Goal (Black Children) Reporting Only
4.5 Increase the use of psychosocial care for children and adolescents on antipsychotics	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics, Ages 1-17	NCQA/HEDIS Child Core BH Core QRS	MCO OhioRISE PIHP CCHBC	Overall (All Children) 76.10%	Overall (All Children) Reporting Only	Overall (All Children) Reporting Only
				Population-Specific Goal (Black Children) N/A	Population-Specific Goal (Black Children) Reporting Only	Population-Specific Goal (Black Children) Reporting Only

Objective	Quality Measure	Measure Steward	Program Area(s) Performance Measure	Statewide Baseline Performance MY 2023	Statewide Performance Target MY 2025	Statewide Performance Target MY 2026
4.6 Increase the use of age-appropriate standardized depression screening tools and follow-up among adolescents	Preventive Care and Screening: Screening for Depression and Follow-Up Plan, Ages 12-17 (CDF-CH) Three Rates: •Overall (Screening=Yes) •Positive for Depression (Screening=Yes, Result= Positive, Follow up plan in place) •Negative for Depression (Screening=Yes, Result= Negative, no Follow up plan required)	CMS QRS	MCO	Overall (All Children) N/A	Overall (All Children) Reporting Only	Overall (All Children) Reporting Only
				Population-Specific Goal (Black Children) N/A	Population-Specific Goal (Black Children) Reporting Only	Population-Specific Goal (Black Children) Reporting Only
Population: Behavioral Health Adults **Goals: Increase Availability of Comprehensive & Coordinated BH Services and Reduce BH & SUD Related Mortality**						
5.1 Increase initiation & engagement of substance use disorder treatment among adults	Initiation and Engagement of Substance Use Disorder Treatment, Initiation, Ages 18-64	NCQA/HEDIS Adult Core BH Core QRS	MCO MyCare SDP	Overall (All Adults) 56.09%	Overall (All Adults) ≥ 52.23% MPS	Overall (All Adults) MPS TBD Fall 2025
				Population-Specific Goal (Black Adults) N/A	Population-Specific Goal (Black Adults) Reporting Only	Population-Specific Goal (Black Adults) MPS TBD Fall 2025
	Initiation and Engagement of Substance Use Disorder Treatment, Engagement, Ages 18-64	NCQA/HEDIS Adult Core BH Core QRS	MCO MyCare SDP	Overall (All Adults) 31.99%	Overall (All Adults) ≥ 30.31% MPS	Overall (All Adults) MPS TBD Fall 2025
				Population-Specific Goal (Black Adults) N/A	Population-Specific Goal (Black Adults) Reporting Only	Population-Specific Goal (Black Adults) MPS TBD Fall 2025

Objective	Quality Measure	Measure Steward	Program Area(s) Performance Measure	Statewide Baseline Performance MY 2023	Statewide Performance Target MY 2025	Statewide Performance Target MY 2026
5.2 Increase 7-day follow-up after emergency department (ED) visits for substance abuse among adults	Follow-Up After Emergency Department Visit for Substance Use, 7-day, Ages 18 and older	NCQA/HEDIS Adult Core BH Core	MCO MyCare CCHBC SDP	Overall (All Adults) 28.87%	Overall (All Adults) Reporting Only	Overall (All Adults) TBD Fall 2025
				Population-Specific Goal (Black Adults) 21.93%	Population-Specific Goal (Black Adults) Reporting Only	Population-Specific Goal (Black Adults) TBD Fall 2025
	Central Region: Follow-Up After Emergency Department Visit for Substance Use, 7-day, Ages 18 and older **QW-PIP**	NCQA/HEDIS Adult Core BH Core	MCO	Overall (All Adults) 32.21%	Overall (All Adults) ≥39.04% SAG	Overall (All Adults) TBD Fall 2025
				Population-Specific Goal (Black Adults) 23.35%	Population-Specific Goal (Black Adults) ≥39.04% SAG	Population-Specific Goal (Black Adults) TBD Fall 2025
	Northwest Region: Follow-Up After Emergency Department Visit for Substance Use, 7-day, Ages 18 and older **QW-PIP**	NCQA/HEDIS Adult Core BH Core	MCO	Overall (All Adults) 31.24%	Overall (All Adults) ≥39.04% SAG	Overall (All Adults) TBD Fall 2025
				Population-Specific Goal (Black Adults) 31.24%	Population-Specific Goal (Black Adults) ≥39.04% SAG	Population-Specific Goal (Black Adults) TBD Fall 2025
5.3 Increase 7-day & 30-day follow-up after hospitalization for mental illness for adults	Follow-Up After Hospitalization for Mental Illness, 7 -day Follow-Up, Ages 18-64	NCQA/HEDIS Adult Core BH Core QRS	MCO MyCare CPC CCHBC	Overall (All Adults) 40.39%	Overall (All Adults) Reporting Only	Overall (All Adults) Reporting Only
				Population-Specific Goal (Black Adults) 35.80%	Population-Specific Goal (Black Adults) Reporting Only	Population-Specific Goal (Black Adults) Reporting Only
	Follow-Up After Hospitalization for Mental Illness, 30-day, Ages 18-64	NCQA/HEDIS Adult Core BH Core QRS	MCO MyCare CPC SDP CCHBC	Overall (All Adults) 62.78%	Overall (All Adults) Reporting Only	Overall (All Adults) Reporting Only
				Population-Specific Goal (Black Adults) 56.69%	Population-Specific Goal (Black Adults) Reporting Only	Population-Specific Goal (Black Adults) Reporting Only

Objective	Quality Measure	Measure Steward	Program Area(s) Performance Measure	Statewide Baseline Performance MY 2023	Statewide Performance Target MY 2025	Statewide Performance Target MY 2026
5.4 Increase 7-day follow-up after emergency department visit for mental illness for adults	Follow-Up After Emergency Department Visit for Mental Illness, 7-day, Ages 18-64	NCQA/HEDIS Adult Core BH Core	MCO MyCare SDP CCBHC	Overall (All Adults) 36.94%	Overall (All Adults) Reporting Only	Overall (All Adults) Reporting Only
				Population-Specific Goal (Black Adults) 35.96%	Population-Specific Goal (Black Adults) Reporting Only	Population-Specific Goal (Black Adults) Reporting Only
	Central Region: 1-7 Day Follow-Up After ED Encounter for Mental Illness, Ages 18 and older (EDM-A) **QW-PIP**	ODM	MCO	Overall (All Adults) 34.34%	Overall (All Adults) ≥39.01% SAG	Overall (All Adults) SAG TBD Fall 2025
				Population-Specific Goal (Black Adults) 29.76%	Population-Specific Goal (Black Adults) ≥39.01% SAG	Population-Specific Goal (Black Adults) SAG TBD Fall 2025
	Northwest Region: 1-7 Day Follow-Up After ED Encounter for Mental Illness, Ages 18 and older (EDM-A) **QW-PIP**	ODM	MCO	Overall (All Adults) 35.55%	Overall (All Adults) ≥39.01% SAG	Overall (All Adults) SAG TBD Fall 2025
				Population-Specific Goal (Black Adults) 33.95%	Population-Specific Goal (Black Adults) ≥39.01% SAG	Population-Specific Goal (Black Adults) SAG TBD Fall 2025
5.5 Increase the use of pharmacotherapy for opioid use disorder for adults	Pharmacotherapy for Opioid Use Disorder	NCQA/HEDIS Adult Core BH Core	MCO SPBM-PAHP CCHBC	Overall (All Adults) 17.92%	Overall (All Adults) Reporting Only	Overall (All Adults) Reporting Only
				Population-Specific Goal (Black Adults) 12.92%	Population-Specific Goal (Black Adults) Reporting Only	Population-Specific Goal (Black Adults) Reporting Only
5.6 Increase depression screening and follow-up for adults	Screening for Depression and Follow-Up Plan: Age 18 and Older	NCQA/HEDIS Adult Core BH Core QRS	MCO SDP	Overall (All Adults) N/A	Overall (All Adults) Reporting Only	Overall (All Adults) MPS TBD Fall 2025
				Population-Specific Goal (Black Adults) N/A	Population-Specific Goal (Black Adults) Reporting Only	Population-Specific Goal (Black Adults) MPS TBD Fall 2025

Objective	Quality Measure	Measure Steward	Program Area(s) Performance Measure	Statewide Baseline Performance MY 2023	Statewide Performance Target MY 2025	Statewide Performance Target MY 2026
Population: Chronic Physical and Developmental Conditions Children **Goals: Increase Well Managed Chronic Conditions**						
6.1 Increase the percentage of children on Medicaid aged 5-11 years old who have an Asthma medication ratio greater than 50%	Asthma Medication Ratio, Ages 5 – 11 **QW-PIP**	NCQA/HEDIS Child Core QRS	MCO SPBM PAHP OhioRISE PIHP SDP	Overall (All Children) 72.02%	Overall (All Children) ≥79.70%[STW] SAG	Overall (All Children) ≥82.19%[STW] SAG
				Population-Specific Goal (Black Children) 67.43%	Population-Specific Goal (Black Children) ≥74.50%[STW] SAG	Population-Specific Goal (Black Children) ≥76.08%[STW] SAG
6.2 Increase the percentage of children on Medicaid aged 12-18 years old who have an Asthma Medication ratio greater than 50%	Asthma Medication Ratio, Ages 12 – 18 **QW-PIP**	NCQA/HEDIS Child Core QRS	MCO SPBM PAHP OhioRISE PIHP SDP	Overall (All Children) 67.73%	Overall (All Children) ≥73.37%[STW] SAG	Overall (All Children) ≥75.66%[STW] SAG
				Population-Specific Goal (Black Children) 65.98%	Population-Specific Goal (Black Children) ≥71.22%[STW] SAG	Population-Specific Goal (Black Children) ≥72.74%[STW] SAG
6.3 Increase the Transcranial Ultrasound completion rate of all children on Medicaid with sickle cell disease	Sickle Cell Disease: Transcranial Ultrasound **QW-PIP**	ODM	MCO SDP	Overall (All Children) 58.47%	Overall (All Children) ≥60.00%[STW] SAG	Overall (All Children) ≥70.00%[STW] SAG
Population: Chronic Physical and Developmental Conditions Adults **Goals: Increase Well Managed Chronic Conditions**						
7.1 Increase the number of adults with well-managed asthma	Asthma Medication Ratio – Ages 19 to 50 & 51-64	NCQA/HEDIS Adult Core QRS	MCO MyCare SPBM PAHP CPC SDP	Overall (All Adults) 58.95%	Overall (All Adults) Reporting Only	Overall (All Adults) Reporting Only
				Population-Specific Goal (Black Adults) 59.52%	Population-Specific Goal (Black Adults) Reporting Only	Population-Specific Goal (Black Adults) Reporting Only
7.2 Increase the number of adults with well-managed, controlled high blood pressure	Controlling High Blood Pressure	NCQA/HEDIS Adult Core QRS	MCO MyCare CPC SDP CCHBC	Overall (All Adults) 67.08%	Overall (All Adults) ≥67.40% MPS	Overall (All Adults) MPS TBD Fall 2025
				Population-Specific Goal (Black Adults) 61.44%	Population-Specific Goal (Black Adults) Reporting Only	Population-Specific Goal (Black Adults) MPS TBD Fall 2025

Objective	Quality Measure	Measure Steward	Program Area(s) Performance Measure	Statewide Baseline Performance MY 2023	Statewide Performance Target MY 2025	Statewide Performance Target MY 2026
7.3 Decrease the number of adults with poorly controlled diabetes	Glycemic Status Assessment for Patients with Diabetes – HbA1c Poor Control (>9.0%)	NCQA/HEDIS Adult Core QRS	MCO MyCare CPC SDP	Overall (All Adults) 35.06%	Overall (All Adults) Reporting Only	Overall (All Adults) MPS TBD Fall 2025
				Population-Specific Goal (Black Adults) 35.87%	Population-Specific Goal (Black Adults) Reporting Only	Population-Specific Goal (Black Adults) MPS TBD Fall 2025
7.4 Increase the number of adults receiving statin therapy for cardiovascular disease	Statin Therapy for Patients with Cardiovascular Disease, received Statin Therapy	NCQA/HEDIS	MCO MyCare CPC SDP	Overall (All Adults) 83.24%	Overall (All Adults) ≥83.00% MPS	Overall (All Adults) MPS TBD Fall 2025
				Population-Specific Goal (Black Adults) 81.50%	Population-Specific Goal (Black Adults) Reporting Only	Population-Specific Goal (Black Adults) MPS TBD Fall 2025

Adult Core= 2026 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)
BH Core=Core Set of Behavioral Health Measures for Medicaid and CHIP (Behavioral Health Core Set)
CAHPS=Consumer Assessment of Healthcare Providers and Systems
CCBHC=Certified Community Behavioral Health Centers (CCBHC)
Central Region=Ohio counties statistical area not a statewide measure for Quality Improvement Project (QIP)
Child Core=2026 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP
CMC=Comprehensive Maternal Care
CMS=Centers for Medicare & Medicaid Services
CPC=Comprehensive Primary Care
CPC Kids= Comprehensive Primary Care Kids
HEDIS=Healthcare Effectiveness Data and Information Set
MCO=Ohio Medicaid contracted Managed Care Organization
MPS=Minimum Performance Standard
MY=Measurement Year
MyCare=Dual program for Ohioans who receive both Medicaid and Medicare benefits
NCQA=National Committee for Quality Assurance
Northwest Region=Ohio Counties statistical area not a statewide measure for Quality Improvement Project (QIP)
ODM=Ohio Department of Medicaid Developed Measure
OhioRISE PIHP=OhioRISE Prepaid Inpatient Health Plan (PIHP)
OPA=US Office of Population Affairs
QW-PIP=MCO Quality Withhold Performance Improvement Project
QRS=CMS Quality Rating System (QRS) quality measures
SAG=SMART Aim Goal for a Quality Improvement Project including Performance Improvement Projects and Quality Withhold (QW) Projects

SDP=State Directed Payments
SPBM PAHP=Single Pharmacy Benefit Manager Prepaid Ambulatory Health Plan
STW=Overall managed care statewide rate
SY=School Year

Quality Improvement Projects (QIPs) including Performance Improvement Projects (PIPs) and Quality Withhold PIPs

Quality Improvement Projects (QIPs) encompass improvement projects that require managed care entities to work collaboratively with each other, academic partners, associations, hospitals, healthcare providers, Medicaid members, community-based organizations, ODM, and other external stakeholders to improve outcomes for the Medicaid population. ODM promotes the development of payer-best practices for supporting evidence-based practice through requirements that MCEs engage in QIPs that focus on improving the patient experience and removing provider barriers to evidence-based care. MCEs are required to obtain the perspective of members and providers in determining barriers to optimal care and in collaboratively designing interventions to address these barriers.

ODM Quality Improvement Projects include Performance Improvement Projects (PIPs), and Quality Withhold Performance Improvement Projects (QW-PIPs). PIPs, implemented in accordance with 438.330(d), are validated by Ohio's External Quality Review Organization (EQRO) as a CMS requirement for an annual validation of plan performance improvement projects.

Quality Withhold Performance Improvement Projects (QW-PIPs) are used by ODM to pursue broader quality improvement goals by using financial incentives linked to specific quality standards. Under federal managed care regulations (Government Publishing Office, 2024) ODM uses a withhold arrangement to withhold a certain percentage of MCO's full monthly capitation rate, with can be earned back by meeting predetermined targets on key quality measures or milestones throughout the year. Ohio bases the withhold on collective MCO collaboration and performance (e.g., all MCO performance rate on a particular quality measure). ODM embraced this collective MCO approach to better align MCO activity in priority areas. QW Projects operate on a 2-year cycle and after projects have finished the initial 2 – year cycle, ODM ties a modest part of the withhold in year 3 for the MCOs to maintain the performance level for measures from the previous withhold cycle.

Governor's Quality Improvement Project Priorities. Ohio Governor Mike DeWine worked closely with the ODM Director Maureen Corcoran, Medical Director Dr. Mary Applegate, and Leaders to continue his commitment of ensuring the health and success of Ohioans by prioritizing ODM quality improvement projects, including the following projects that focus on mothers and children and adult behavior health:

- **The Outcomes Acceleration for Kids (OAK) QW-PIP** project is a new learning collaborative focused on improving children's health. The OAK Learning Network is a first-of-its-kind collaboration to achieve accelerated improvements in the health and wellbeing of Ohio's youth. The goal of OAK is to deliver the highest quality care by connecting regional partners to identify opportunities to close performance gaps for Ohio's pediatric population, achieve superior outcomes by transforming care delivery to meet patient's needs and ensure whole child health. The collaboration is a partnership between families, MCOs', Children's Hospitals, and ODM. OAK is designed to improve outcomes in four areas of care, including improving controller medication use for children with asthma; improving ED follow-up care for mental health and substance use visits; improving transcranial ultrasound, a routine screening for sickle cell disease (SCD); and increasing well-child visits and preventive care.

- **The Preterm Birth and Related Population Health Build Work QW-PIP** will create a framework for MCOs, providers, and community partners to work together to develop person-centered, customized interventions to support women and families who've historically lacked ready access to high-quality responsive care before and after pregnancy to improve birth outcomes for the Medicaid population. MCOs must also identify gaps in their own services and supports to improve the healthcare system as well as consider and link patients to resources that address broader factors of health, such as housing, food instability, and transportation.

- **The Follow-Up After Emergency Department Visit for Substance Use (FUA) and Follow-Up After Mental Health (MH) Emergency Department (ED) Visit (EDM-A) QW-PIP** focuses on MCOs working collaboratively with providers and community mental health partners to connect Medicaid members to long-term treatment services and supports after experiencing an emergency department visit for substance abuse and/or mental health.

Table 5 depicts ODM's Population Health and Quality Strategy 2026-2028 Population-Specific Quality Improvement Projects (PIPs & QW-PIPs) and Quality Measure SMART Aim Goals for Managed Care Entities including Medicaid Managed Care Organizations (MCOs), MyCare Ohio Plan (MCOP), Single Pharmacy Benefit Manager (SPBM-PAHP), and OhioRISE PIHP.

Table 5: ODM Population-Specific Quality Improvement Projects

Population	Quality Measure SMART Aim	Measure Source	Managed Care Entity (MCE) & QIP Type	SFY 2024	SFY 2025	SFY 2026
Project: Maintaining or Surpassing QW2022-2023 SMART Aim Performance Levels for Diabetes Continuous Glucose Monitors (CGM) and Diabetes Self-Management Education (DSME)						
Chronic Physical & Developmental Conditions Adults	**Maintenance SMART Aim Carried Over from 2022-2023 QW:** Maintain or surpass 17.7% of the members with diabetes who acquire or have evidence of use of a CGM for the measurement period ending December 31, 2024	ODM	MCO QW-PIP	✓	X	X
	Maintenance SMART Aim Carried Over from 2022-2023 QW: Maintain or surpass 1.45% of the members who attend DSME for the measurement period ending December 31, 2024	ODM	MCO QW-PIP	✓	X	X
Project: MyCare Diabetes PIP – Maintaining or Surpassing SMART Aim Performance Levels for Continuous Glucose Monitors (CGM)						
Chronic Physical & Developmental Conditions Older Adults	**Maintenance SMART Aim Carried Over from 2023-2024 PIP:** Maintain or surpass 15.87% of the members with diabetes who acquire or have evidence of use of a CGM for the measurement period ending December 31, 2025.	ODM	MyCare PIP	✓	✓	MyCare PIP Topic TBD Fall 2025
Project: Maintaining or Surpassing QW2022-2023 SMART Aim Performance Levels for Pregnancy Risk Assessment Form (PRAF)						
Women & Infants	**Maintenance SMART Aim Carried Over from 2022-2023 QW:** Maintain or surpass the weekly count of 840 ODM	ODM	MCO QW-PIP	✓	✓	X

	managed care organization members (members) with an electronically submitted pregnancy risk assessment form (PRAF 2.0) for the weeks ending December 31, 2024, June 30, 2025, and December 31, 2025.					
***Project: Preterm Birth and Related Population Health Build Work**						
Women & Infants	**Quality Measure:** Population health build work to understand the population, the healthcare system, and identify gaps in MCO services and supports to inform and develop a system that improves birth outcomes for the Medicaid population. Performance will be evaluated based on the monitoring of key measures: •Percent of pregnant women with prenatal care during first nine weeks of pregnancy. •Women of reproductive age (WRA) with a PCP visit in the last 12 months. •Percent of WRA with screening for depression or substance use disorder. •Percent of postpartum women who receive postpartum visit.	ODM	MCO QW-PIP	X	✓	✓ Preterm Birth SMART Aim TBD Fall 2025
***Project: Follow-Up After Emergency Department Visit for Substance Use (FUA) and Follow-Up After Mental Health (MH) Emergency Department (ED) Visit (EDM-A)**						
Behavioral Health Adults	**SMART Aim:** Of the members not included in the Black population aged 18+ of the **Central region** with an emergency department visit for substance use (2,937), increase the percentage of emergency department visits that have evidence of a 7 day follow up from (32.21%) to (39.04%) as of December 31, 2025.	NCQA / HEDIS	MCO QW-PIP	✓	✓	✓ Statewide SMART Aim TBD Fall 2025
	Population-Specific SMART Aim: Of the members included in the Black population aged 18+ of the **Central region** with an emergency department visit for substance use (1,270), increase the percentage of emergency department visits that have evidence of a 7 day follow up from (23.35%) to (39.04%) as of December 31, 2025.	NCQA / HEDIS	MCO QW-PIP	✓	✓	✓ Statewide SMART Aim TBD Fall 2025
	SMART Aim: Of the members not included in the Black population aged 18+ of the **Northwest region** with an emergency department visit for substance use (1,394), increase the percentage of emergency department visits that have evidence of a 7 day follow up from (31.24%) to (39.04%) as of December 31, 2025.	NCQA / HEDIS	MCO QW-PIP	✓	✓	✓ Statewide SMART Aim TBD Fall 2025
	Population-Specific SMART Aim: Of the members in the Black population aged 18+ of the **Northwest region** with an emergency department visit for	NCQA / HEDIS	MCO QW-PIP	✓	✓	✓ Statewide SMART Aim

	substance use (341), increase the percentage of emergency department visits that have evidence of a 7 day follow up from (19.71%) to (39.04%) as of December 31, 2025.					TBD Fall 2025
	SMART Aim: Of the members not included in the Black population aged 18+ of the **Central region** with an emergency department visit for mental health (3,061), increase the percentage of emergency department visits that have evidence of a 7 day follow up from (34.34%) to (39.01%) as of December 31, 2025.	ODM	MCO QW-PIP	✓	✓	✓ Statewide SMART Aim TBD Fall 2025
	Population-Specific SMART Aim: Of the members included in the Black population aged 18+ of the **Central region** with an emergency department visit for mental health (1,328), increase the percentage of emergency department visits that have evidence of a 7 day follow up from (29.76%) to (39.01%) as of December 31, 2025.	ODM	MCO QW-PIP	✓	✓	✓ Statewide SMART Aim TBD Fall 2025
	SMART Aim: Of the members not included in the Black population aged 18+ of the **Northwest region** with an emergency department visit for mental health (2,409), increase the percentage of emergency department visits that have evidence of a 7 day follow up from (35.55%) to (39.01%) as of December 31, 2025.	ODM	MCO QW-PIP	✓	✓	✓ Statewide SMART Aim TBD Fall 2025
	Population-Specific SMART Aim: Of the members included in the Black population aged 18+ of the **Northwest region** with an emergency department visit for mental health (573), increase the percentage of emergency department visits that have evidence of a 7 day follow up from (33.95%) to (39.01%) as of December 31, 2025.	ODM	MCO QW-PIP	✓	✓	✓ Statewide SMART Aim TBD Fall 2025
Project: The Outcomes Acceleration for Kids (OAK) Learning Network						
All Children	**Quality Measure:** Design and build a Learning Network in partnership with ODM and Ohio's Children's Hospitals between January 1, 2024 – December 31, 2024.	ODM	MCO QW-PIP	✓	X	X
Healthy Children	**SMART Aim: Well-Care Visits: Children 0-15 Months:** Increase the well-child visit rate for all children on Medicaid aged 0 – 15 months from 57.67% to 63.44% by December 31, 2025.	NCQA / HEDIS	MCO QW-PIP	✓	✓	✓ Maintenance SMART Aim TBD Fall 2025
	Population-Specific SMART Aim: Well-Care Visits: Children 0-15 Months: Increase the well-child visit rate for Black children on Medicaid	NCQA / HEDIS	MCO QW-PIP	✓	✓	✓ Maintenance SMART Aim TBD Fall 2025

	aged 0 – 15 months from 49.73% to 53.04%: by December 31, 2025.					
	SMART Aim: Well-Child Visits: Children 12-17 Years: Increase the Well-Child visit rate for all children on Medicaid aged 12-17 years from 49.78% to 53.10% by December 31, 2025.	NCQA / HEDIS	MCO QW-PIP	✓	✓	✓ Maintenance SMART Aim TBD Fall 2025
	Population-Specific SMART Aim: Well-Child Visits: Children 12-17 Years: Increase the Well-Child visit rate for Black children on Medicaid aged 12-17 years from 52.47% to 54.81% by December 31, 2025.	NCQA / HEDIS	MCO QW-PIP	✓	✓	✓ Maintenance SMART Aim TBD Fall 2025
Behavioral Health Children	**SMART Aim: 1-7 Day Follow-Up After ED Visit for Substance Use (EDS): 1-7 day, Ages 10-17:** Increase the rate of follow-up visits within 1-7 days of an ED visit for substance use for all children on Medicaid aged 10-17 years from 34.70% to 38.17% by December 31, 2025.	ODM	MCO QW-PIP OhioRISE PIHP PIP	✓	✓	✓ Maintenance SMART Aim TBD Fall 2025
	Population-Specific SMART Aim: 1-7 Day Follow-Up After ED Visit for Substance Use (EDS): 1-7 day, Ages 10-17: Increase the rate of follow-up visits within 1-7 days of an ED visit for substance use for Black children on Medicaid aged 10-17 years from 28.34% to 30.23% by December 31, 2025.	ODM	MCO QW-PIP OhioRISE PIHP PIP	✓	✓	✓ Maintenance SMART Aim TBD Fall 2025
	SMART Aim: 1-7 Day Follow-Up After ED Visit for Mental Health (EDM), 7 days, Ages 0-17: Increase the rate of follow-up visits within 7 days of an ED visit for mental health for all children on Medicaid ages 0-17 years from 49.13% to 54.05%% by December 31, 2025.	ODM	MCO QW-PIP OhioRISE PIHP PIP	✓	✓	✓ Maintenance SMART Aim TBD Fall 2025
	Population-Specific SMART Aim: 1-7 Day Follow-Up After ED Visit for Mental Health (EDM), 7 days, Ages 0-17: Increase the rate of follow-up visits within 1-7 days of an ED visit for mental health for all Black children on Medicaid aged 0-17 years from 44.23% to 47.18% by December 31, 2025.	ODM	MCO QW-PIP OhioRISE PIHP PIP	✓	✓	✓ Maintenance SMART Aim TBD Fall 2025
Chronic Physical & Developmental Conditions Children	**SMART Aim: Asthma Medication Ratio: Ages 5-11:** Increase the percentage of children on Medicaid aged 5-11 years old who have an Asthma medication ratio greater than 50% from 74.71% to 79.70% by December 31, 2025.	NCQA / HEDIS	MCO QW-PIP SPBM PAHP PIP	✓	✓	✓ Maintenance SMART Aim TBD Fall 2025
	Population-Specific SMART Aim: Asthma Medication Ratio: Ages 5-11: Increase the percentage of Black children on Medicaid aged 5-11 who	NCQA / HEDIS	MCO QW-PIP SPBM PAHP PIP	✓	✓	✓ Maintenance SMART Aim

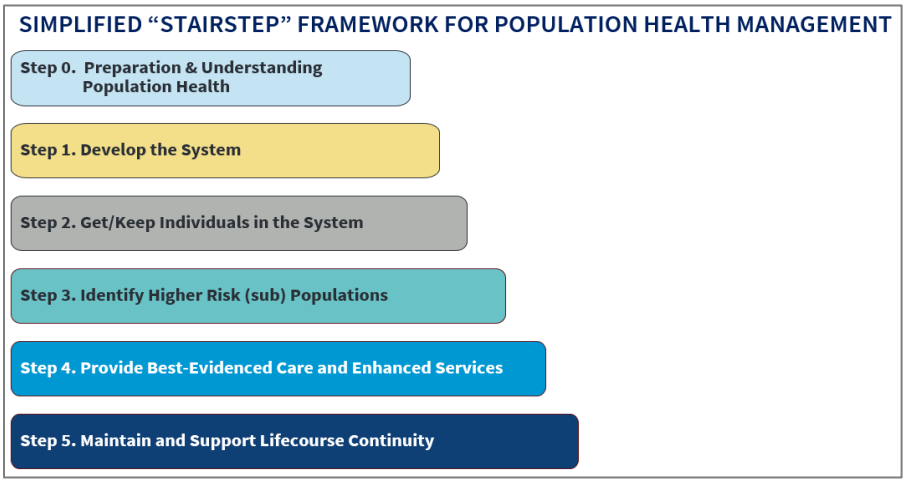
	have an Asthma medication ratio greater than 50% from 71.33% to 74.50% by December 31, 2025.					TBD Fall 2025
	SMART Aim: Asthma Medication Ratio: Ages 12-18: Increase the percentage of children on Medicaid aged 12-18 years old who have an Asthma Medication ratio greater than 50% from 68.78% to 73.37% by December 31, 2025.	NCQA / HEDIS	MCO QW-PIP SPBM PAHP PIP	✓	✓	✓ Maintenance SMART Aim TBD Fall 2025
	Population-Specific SMART Aim: Asthma Medication Ratio: Ages 12-18: Increase the percentage of Black children on Medicaid aged 12-18 who have an Asthma medication ratio greater than 50% from 68.19% to 71.22% by December 31, 2025.	NCQA / HEDIS	MCO QW-PIP SPBM PAHP PIP	✓	✓	✓ Maintenance SMART Aim TBD Fall 2025
	SMART Aim: Sickle Cell Disease: Transcranial Ultrasound: Increase the Transcranial Ultrasound completion rate of all children on Medicaid with sickle cell disease, after medical record review applying clinical exclusion criteria, from 58.47% to 60.00% by December 31, 2025.	ODM	MCO QW-PIP	✓	✓	✓ Maintenance SMART Aim TBD Fall 2025
	SMART Aim: Reduce the percentage of chronic absenteeism among Medicaid school-aged children in Ohio's public schools from (x%) to (y%) by December 31, 2026. (Improvement percentage TBD Fall 2025).	ODM	MCO QW-PIP	X	X	✓ SMART Aim TBD Fall 2025

QIP=Quality Improvement Project
PIP=Performance Improvement Project
QW-PIP=Quality Withhold Performance Improvement Project
OhioRISE PIHP=OhioRISE Prepaid Inpatient Health Plan
SPBM PAHP=Single Pharmacy Benefit Manager Prepaid Ambulatory Health Plan
*Ohio Governor Priority Quality Improvement Projects
✓ Active QIP Year
X Inactive Year

ODM Population Health Management Framework

For each MCE and population-specific health stream, ODM employs a population health management framework to improve healthcare quality, member and provider experience, and health outcomes while reducing cost for each of its population streams.

Figure 2. Stairstep Framework for Population Health Management



Underlying this framework is an understanding of each population and the related improvement opportunities for each population stream (Step 0). Based on this understanding, there must then be a focus on developing the system of care (e.g., ensuring an adequate provider network). Individuals, then, must have access to this system (Step 2). Segmenting individuals by risk (Step 3) facilitates prioritization of needs and ensuring that individuals get the services and supports they need in Step 4 of providing best evidence care and enhanced services and supports according to these needs. Step 5 in the model below focuses on continuity of care and support throughout the life course by partnering with communities.

Within each "Stairstep", ODM and the MCEs employ strategies to improve population health as shown below.

Figure 3. Strategies for Moving through the Population Health Management Framework

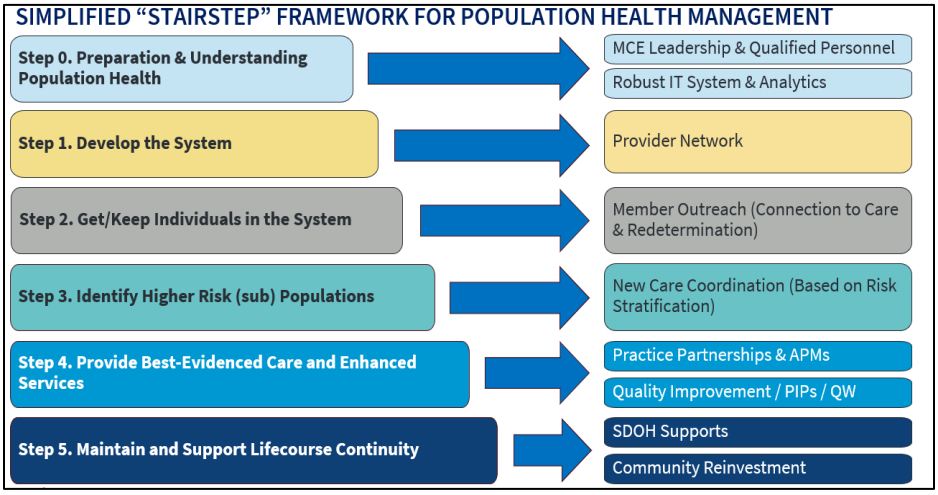


Table 6 below illustrates which population streams are impacted by these strategies and how each of these strategies contributes to moving the broader programmatic goals.

Table 6: Population Health Management Framework Broad Strategies and Programmatic Goals

Population Health Management Step	Broad Strategies (examples)	Population Streams Impacted	Programmatic Goals Impacted
Step 0. Preparation and Understanding Population Health	MCE Leadership and Qualified Personnel (Executive Sponsorship at CEO-level, Medical Director involvement in clinical initiatives, dedicated analysts) Robust IT systems & analytics (ODM Population Health Dashboards)	All	Increased Program Transparency and Accountability
Step 1. Develop the System	Network Access (Appendix F Requirements, Expanding Covered Provider Types-Doulas)	All* *Specific Network Access Requirements can be found in Appendix F	Improve Individual and Population Wellness and Health Outcomes
Step 2. Get/Keep Individuals in the System	Connection to Care coordination and Reductions in Avoidable Redeterminations	All	
Step 3. Identify Higher-risk (sub) Populations	New Care Coordination based on Unified Approach to Risk Stratification		• Emphasize a Personalized Care Experience • Improve Care for Individuals with Complex Needs to Promote Independence in the Community

Population Health Management Step	Broad Strategies (examples)	Population Streams Impacted	Programmatic Goals Impacted
Step 4. Provide Best-Evidenced Care and Enhanced Services	Practice Partnerships & APMs (Regional QI Hubs, Care Innovation and Community Improvement Program-CICIP) Quality Improvement Projects (QIPs), Performance Improvement Projects (PIPs), and Quality Withhold Incentivized Collaborative Improvement Initiatives (QW)	Healthy Children and Adults Women and Infants Behavioral Health (Children and Adults) Chronic Developmental and Physical Conditions (Children and Adults) Older Adults	• Improve Individual and Population Wellness and Health Outcomes • Emphasize a Personalized Care Experience • Support Providers in Better Patient Care • Improve Care for Individuals with Complex Needs to Promote Independence in the Community Increase program Transparency and Accountability
Step 5. Maintain and Support Lifecourse Continuity	Health-Related Social Needs (HRSN) Supports Community Reinvestment	All	• Improve Individual and Population Wellness and Health Outcomes • Emphasize a Personalized Care Experience • Support Providers in Better Patient Care • Improve Care for Individuals with Complex Needs to Promote Independence in the Community

The paragraphs below provide more detail about the specific programs, improvement initiatives and initiatives that support these strategies for each step of the population health management framework.

Population Health Management Framework Stairstep Strategies

Step 0. Preparation and Understanding Population Health.

An understanding of the population of focus and the context in which population health

improvement work will occur is the preparatory work necessary for determining where improvements are needed and how success will be measured.

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, qualified staffing, and maintenance of a robust information system and related analytics to support strategic population health improvement activities (identifying performance variations in subpopulations through data analytics, care coordination, and quality improvement).

MCE Leadership Support and Qualified Personnel Leadership Support. ODM requires MCE senior leaders to create and foster an ongoing dynamic culture of innovation and healthcare excellence by supporting collaborative, cross-system population health management efforts that promote population-specific goals to achieve full health potential. MCE engagement in high impact leadership activities as described in *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*7F7F (Swenson, et al., 2013) 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, 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.

ODM has specific leadership requirements for quality improvement. 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.

MCE senior leadership must also ensure that the results of improvement activities 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 population-specific health outcomes.

Qualified Personnel. MCEs must allocate sufficient qualified staff to support all population health activities. Staffing must be adequate to support each strategic initiative and respond comprehensively to the needs of internal and external stakeholders. ODM specifically requires that the MCEs ensure that qualified staffing is sufficient in the following areas: data analytics, population health management, quality improvement, and care coordination.

QI Capacity Development. MCEs must ensure that staff at all levels of the organization are fully equipped and committed to improving health outcomes, by:

- 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) (Institute for Healthcare Improvement, 2024a);
- 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 (Institute for Healthcare Improvement, 2024b);
- 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 their annual 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.

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.

MCE Population Health Information System and Analytics. Each MCE 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, ODM requires that MCE information systems 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 PIHP 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; and
- 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 PIHP 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.

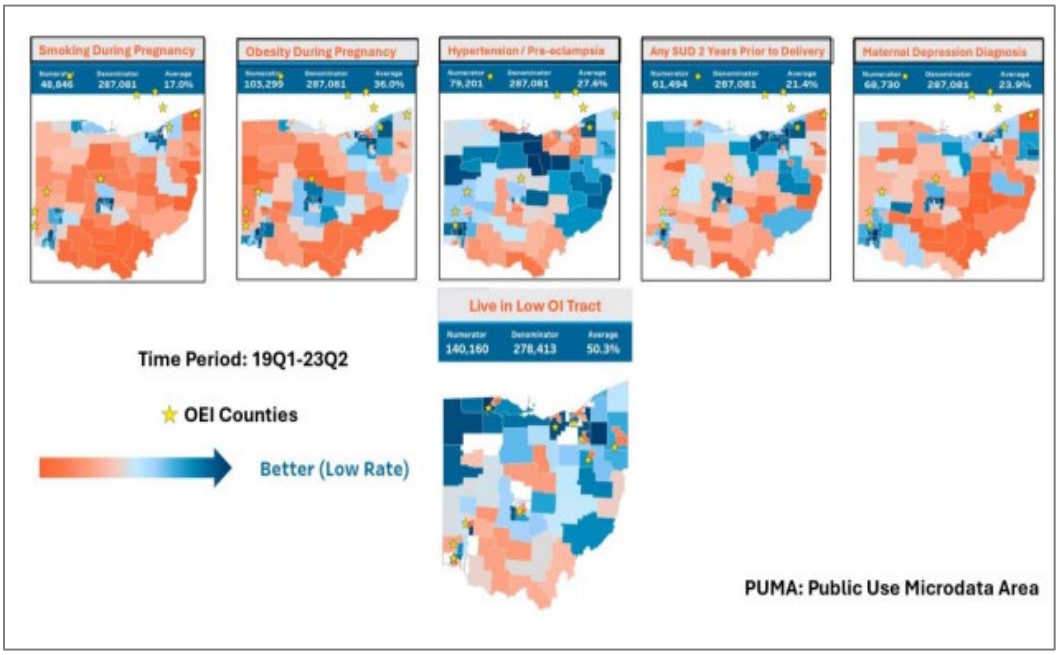
MCE health information systems must support population-specific efforts by allowing for the identification of performance variations in areas such as service access, utilization, health outcomes, intervention effectiveness, social risk factors, and survey (e.g., CAHPS) results, while

also allowing for the monitoring and comparison of process and outcome measures over time to inform efforts to reduce performance gaps.

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 health-related social needs (HRSN), 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.

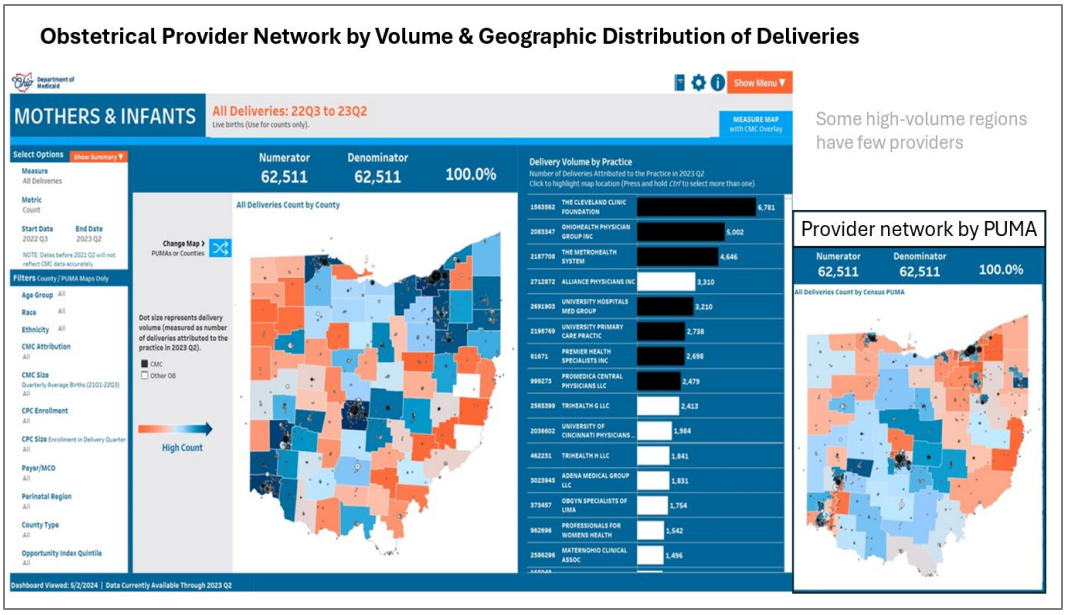
For care coordination activities specifically, the MCE's information system must be able to identify the type of care coordination (i.e., Care Manager, Care Manager Plus, Care Guide, and Care Guide Plus); the primary entity providing care management and/or coordination; the person-centered care plan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

ODM-led Population Health Data Analysis. ODM has created population health dashboards to help the MCEs understand the geographic distribution of health outcomes and health related opportunities, as well as the existing provider network for a particular population stream. An example below for the Women and Infant population stream, displays the geographic distribution of risk factors such as smoking during pregnancy, obesity and maternal depression. It also shows how the population is distributed by the Ohio Opportunity Index (2024) and Ohio Equity Institute Counties.



The example below shows delivery volume by county and by Public Use Microdata Areas (PUMAs) which partition each state into geographic areas containing no fewer than 100,000 people each. These visualizations give ODM and the MCEs a better understanding of the health of a population,

as well as insight into geographical areas where needs may be greater than other areas of the state.



Understanding the population is a significant part of the preparatory work needed 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), 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).

Step 1. Develop the System.

Developing the system refers to creating a system that allows people to access the healthcare they need to improve their wellness and health outcomes. The main strategic approaches that are employed by the Ohio Department of Medicaid and its managed care plans to develop the system are focused on network capacity and access to healthcare.

General Network Adequacy and Availability Standards. 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.

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.

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.

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, 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.

ODM network adequacy and service availability standards are published in the MCE provider agreements and are publicly available on Medicaid's website. As required by 42 CFR 438.340, detailed requirements can be found in Appendix F

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.

MCOs must provide member access to medical advice and direction through a centralized 24-hour per day, seven days a week (24/7) toll-free call-in system that is available nationwide. The medical advice line must be available every day of the year and must be staffed with physicians, physician assistants, licensed practical nurses, or registered nurses. The MCO must comply with any changes or updates to Utilization Review Accreditation Commission call center standards.

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 (The Ohio Department of Medicaid Ohio Medicaid Provider Agreement for Managed Care Organization (2024a). 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).

Data and Analytical Supports for Network Adequacy. ODM and its managed care entities use population health dashboards (such as those described in Step 0) to understand the distribution of the provider network in relation to populations with specific health needs, including health related social needs.

This information, along with measures of timely access (e.g., timeliness of prenatal care), grievances and appeals, and utilization management data help Medicaid and its MCEs to determine where there are gaps in the current provider network that need to be addressed to develop a system that addresses all needs.

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.

Step 2. Get/Keep Individuals in the System.

Individuals must have health insurance to access the care they need to stay well and improve health outcomes. ODM is committed to making it easier to enroll in Medicaid and to maintain

Medicaid coverage so that those who are eligible for Medicaid have access to care and has thus employed several policy changes at the macro level to facilitate enrollment and maintenance of coverage for eligible individuals. ODM also recognizes the connection that members have with their MCE care coordinators. This relationship is built on trust resulting from the MCE's timely and comprehensive identification of needs, connection with needed resources and supports, and follow-up to ensure that needs are met. Thus, member outreach by their care coordinator is a key strategy for connecting individuals to care and facilitating maintenance of eligibility through notification of upcoming redetermination dates.

Member Outreach. Ohio's managed care entities use care coordination and related outreach to keep people connected to the care delivery system. 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 connects individuals to resources that address their physical, behavioral, and psychosocial needs. Care coordination also supports member goals and choices through a person-centered, trauma-informed, and culturally attuned approach, and provides care continuity while honoring member experience. This person-centered responsiveness allows care coordinators to build a solid relationship with the members they serve.

Member services staff are responsible for reminding members who call the member services telephone system of upcoming Medicaid redetermination dates when the redetermination date is within 90 calendar days.

Transition of Care Policy. ODM and its MCEs are committed to keeping eligible members connected to a system of care by ensuring that members can transition smoothly between FFS and managed care, between managed care entities, and upon disenrollment from an MCE.

> 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.
>
> More detail can be found in ODM's contracts (provider agreements) with MCOs, the PIHP, and PAHP publicly available at Medicaid.ohio.gov

Transitions of Care for New MCO Members. 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. 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 New Members. 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.

In addition, MCOs must allow a new member to receive services from network and out-of-network providers when Group VIII Expansion members are receiving nursing facility care, when a new member is in the third trimester of pregnancy, and when a prior authorization has been approved prior to the member's transition.

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.

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.

Transitions Between MCOs

Member initiated. The following groups may transition between plans on a month-to-month basis any time during the year: dual-benefits member enrolled in a MyCare participating county, individuals enrolled in DODD waivers, and children in custody. The switch to a new plan will be effective the beginning of the next effective month.

For all other membership groups, individuals may request a plan change during the first three months of plan membership or during the 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.

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.

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.

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 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.

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

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. Transition of care activities include 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.

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 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 is quality concerns identified with the previously authorized provider.

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 encompass: 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 also ensure that the 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 within five business days when there is a transition between CMEs or between care coordinators within a CME.

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, OhioRISE Plan (if applicable) and CCE, as assigned;
- Ensuring the member's care coordinator, or other designated care coordination staff if the member does not have a Care Manager or Care Guide, communicates with the discharging facility and informs 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;
- Ensuring notifications, admission dates, discharge dates, and clinical information is communicated in a timely manner between MCEs departments, CME, the OhioRISE plan and behavioral health providers (if applicable), 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 MCO, CCE, OhioRISE plan or CME, as assigned;

- Obtaining (either directly or through the CME, if one is assigned) a copy of the discharge/transition plan and sharing the plan with the members' care team;
- Arranging for and confirming that 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.

State Policy Changes. As the state Medicaid agency, many of the changes related to facilitating enrollment and maintenance of eligibility when appropriate come from Ohio Department of Medicaid. Changes to facilitate enrollment and maintenance of coverage while eligible, have included: presumptive eligibility for pregnant women, expanding Medicaid eligibility to 12 months postpartum.

Data and Analytical Supports for Keeping Eligible Members Connected to Medicaid. Ohio's Medicaid Managed Care Organizations are committed to increasing the use of tools such as the Pregnancy Risk Assessment Form (PRAF) and Report of Pregnancy which alert Ohio's eligibility system of pregnancy, preventing unnecessary redetermination during pregnancy and postpartum.

In addition to linking to the eligibility system, the PRAF and the ROP, also notify the MCOs of medical, mental health, and health related social needs, as well as serving as referrals to the Supplemental Nutritional Program for Women, Infants, and Children (WIC) and Ohio's home visiting services. These connections are key to improving wellness and health outcomes for pregnant women.

Ohio's Medicaid Managed Care Organizations increased the use of the PRAF form in calendar year 2023 and receive a portion of the quality withhold for maintaining or surpassing the 2023 usage in calendar years 2024 and 2025. These efforts, and others, to get and keep individuals enrolled in Medicaid, as appropriate, ensure that they have an insurance source to cover needed preventive care, sick visits, and visits to treat chronic conditions, developmental conditions, or mental health conditions.

Step 3. Identify Higher Risk (sub)Populations.

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, behavioral health children & adults , chronic physical & developmental 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).

To best prioritize resources for improving wellness and health outcomes, the MCOs must identify which members are at higher risk of adverse events and/or poor outcomes. This includes the identification of individuals who need long-term services and supports and those who have special healthcare needs. To facilitate this effort, ODM shares seven-years of claims history with the MCOs, as well as information such as the Ohio Opportunity Index (OOI), a tool used by ODM to identify and understand the interplay of complex health-related social needs (HRSN) at the census tract level that influences the ability for individuals and communities to achieve optimal health. The Ohio Opportunity Index synthesizes over 34 variables measuring neighborhood conditions and opportunities, known to be associated with health and well-being, across a variety of domains into a single index score that can be used to assess overall neighborhood conditions, target interventions, and adjust evaluations for neighborhood-level risk. The OOI helps inform mitigation strategies and interventions that can address population performance gaps in targeted geographical areas in Ohio for vulnerable communities due to the ability to identify communities in greater need of vigorous responses. ODM also shares population-specific information such as the Enhanced Maternal Care file which links claims history, eligibility, and vital statistics files to provide MCOs with indicators of pregnancy risk for women of reproductive age.

> As required by 42 CFR 438.340, ODM has defined mechanisms for identifying persons who need long-term services and supports (LTSS) and special healthcare needs. ODM has enlisted Aging and Disability Resource Network (ADRN) serves as the "Front Door" to long-term services and supports. Members with special healthcare needs are identified based upon the need for health and related services of a type or amount beyond that required by individuals generally.

The MCOs and OhioRISE PIHP use this information as well as information from their care coordination systems, utilization management data, information from their grievances and complaints systems, and needs assessments such as the Health Risk Assessment (HRA) and Child and Adolescent Needs and Strengths (CANS) assessment to identify individuals who are at higher risk of poor outcomes so that efforts to improve wellness and health outcomes can be prioritized for these individuals.

Risk Stratification. Each MCO and the OhioRISE PIHP 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 PIHP must both include health-related social needs, 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 PIHP'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.

Timing of Risk Tier Assignment. 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 the change in stratification.

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.

MCEs re-evaluate member risk tiers whenever there is a significant change in member needs or circumstances.

The MCO must submit a file to ODM that contains a risk stratification level for all members (MCO Risk Stratification Data Submission File), in a file format as required in the Medicaid Managed Care: Risk Stratification Data Submission Specifications and as specified in Appendix P - Chart of Deliverables of the Ohio Department of Medicaid Ohio Medicaid Provider Agreement for Managed Care Organization (2024b).

Step 4. Provide Best-Evidenced Care and Enhanced Services.

ODM has identified two main strategies for providing best-evidenced care and enhanced services to the populations it serves: 1.) Practice partnerships and Alternative Payment Models (APMs) and 2.) Quality Improvement Projects, including Performance Improvement Projects (PIPs) and Quality Withhold Incentivized Collaborative Improvement Initiatives.

The work occurring through practice partnerships, APMs, and QIPs overlap to advance best-evidenced care and enhanced services. Practice partnerships enable MCEs and ODM to learn how managed care is experienced by the providers of healthcare. Quality Improvement Projects provide an avenue for improving the managed care experience, and alternative payment models incentivize the application of best evidence care.

Practice Partnerships and Alternative Payment Models

Practice Partnerships. ODM and the Medicaid MCOs are currently partnering with Ohio's Colleges of Medicine to improve outcomes for patients diagnosed with diabetes and hypertension through a Regional QI Hub model. In this effort, Ohio's Colleges of Medicine act as "hubs" who facilitate the dissemination of best practices to "spoke" sites within their region. This initiative uses a learning

network model in which spokes test interventions aimed at applying best evidence care and then present their learning to other spoke sites to allow learning to occur at a more rapid pace. The Chief Medical Officers at each MCO support this effort, providing a bridge between the clinical and managed care experience and actively identifying enhanced service delivery options to facilitate application of evidence-based best practice at the clinical sites. For example, in 2024, the regional QI hubs identified the difficulties involved in obtaining home blood pressure cuffs for their patients. In response, the MCO's chief medical officers came together, along with ODM's Medical Director, to identify and implement innovative approaches to reducing the identified barriers and allow the colleges of medicine to more easily comply with known best practice.

Value-based Purchasing and Alternative Payment Models. 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.

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

Ohio's Comprehensive Primary Care Program (CPC) and CPC for Kids. The Ohio CPC program, which began in 2016, is a patient-centered medical home program designed to improve population health through the use a primary care practice led team-based care delivery model 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.

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. Practices that meet three types of requirements: activity requirements, clinical quality metrics, and efficiency metrics. 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 is an optional add-on program specific to pediatric practices that includes additional quality metrics and bonus incentives. Incentives are based on performance on additional metrics related to pediatrics, as well as additional CPC for Kids activities.

The Comprehensive Maternal Care (CMC) Program provides support for obstetrical practices to develop community connections and culturally aligned supports for women with Medicaid as they and their families navigate pre- and post-natal care. It uses an innovative payment structure, creating financial opportunities for maternal care providers to address patient and family needs across the entire cycle of childbearing – prenatal, birth, and postnatal. Additionally, the design leverages a flexible prospective per-member-per-month value-based payment centered around the risk level of enrolled Medicaid members. The CMC model builds on ODM's commitment to personalized care experience by encouraging providers and communities to partner on building a trustworthy, comprehensive, and equitable system of care for members. Investing in the health of our mothers and infants is the first step in creating long healthy lives for all Ohioans.

The Care Innovation and Community Improvement Program (CICIP) is a collaboration between the Ohio Department of Medicaid (ODM), the Centers for Medicare and Medicaid Services (CMS), and four participating Ohio hospital systems including University of Toledo Medical Center/Physicians Practice (UTMC), MetroHealth, University of Cincinnati Health(UC Health), and the Ohio State University Wexner Medical Center(OSU). CICIP aims to drive innovation in healthcare for Medicaid beneficiaries. CICIP addresses gaps in care for: pregnant women and newborns; patients with an opioid use disorder; patients admitted to the emergency department(ED) or hospital for mental healthcare; and patients using the ED who can be treated in non-urgent settings. The CICIP evaluation examines:

- hospital systems' progress in designing, implementing, and continuously advancing initiatives to improve quality of care and health outcomes at their institutions for Medicaid beneficiaries;
- hospital systems' adoption of QI science (QIS) and data analysis strategies, inclusion of patients' perspectives, community partnerships, engaged leadership, and targeted use of funding for CICIP priorities; and
- collaboration among systems to leverage the expertise and initiatives of the four hospital systems.

Evidence-Based Practice Guidelines

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. Each MCE is required to follow the guidance of national associations in establishing federally required practice guidelines for improving wellness and health outcomes. Furthermore, as part of their value-based purchasing programs, they must design payments to encourage adherence to clinical guidelines.

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.

Guidance from organizations such as the American Medical Association, the American Academy of Pediatrics, American Colleges of Obstetrics and Gynecology, the American Heart Association, and the National Association of Chronic Disease Directors are reviewed and updated as needed by the MCEs on a quarterly basis.

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 care of women with mental health needs prenatally and postpartum.

Examples of evidence-based practice guidelines:

- 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

Payer Best Practices

Payer best practices are policies and procedures that support health systems in providing 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.

Quality Improvement Projects (QIPs) Including Performance Improvement Projects (PIPs) and Quality Withhold (QW) Projects

Quality Improvement Projects (QIPs) encompass improvement projects that require managed care entities to work collaboratively with each other, academic partners, associations, hospitals, healthcare providers, Medicaid members, community-based organizations, ODM, and other external stakeholders to improve outcomes for the Medicaid population. ODM promotes the development of payer-best practices for supporting evidence-based practice through requirements that MCEs engage in QIPs that focus on improving the patient experience and removing provider barriers to evidence-based care. MCEs are required to obtain the perspective of members and providers in determining barriers to optimal care and in collaboratively designing interventions to address these barriers.

ODM Quality Improvement Projects include Performance Improvement Projects (PIPs), and Quality Withhold Performance Improvement Projects (QW-PIPs). PIPs, implemented in accordance with 438.330(d), are validated by Ohio's External Quality Review Organization (EQRO) as a CMS requirement for an annual validation of plan performance improvement projects.

Quality Withold Performance Improvement Projects (QW-PIPs) are used by ODM to pursue broader quality improvement goals by using financial incentives linked to specific quality standards. Under federal managed care regulations (Government Publishing Office, 2024) ODM uses a withhold arrangement to withhold a certain percentage of MCO's full monthly capitation rate, with can be earned back by meeting predetermined targets on key quality measures or milestones throughout the year. Ohio bases the withhold on collective MCO collaboration and performance (e.g., all MCO performance rate on a particular quality measure). ODM embraced this collective MCO approach to better align MCO activity in priority areas.

QW projects operate on a 2- year cycle, using a quality improvement science framework, starting with milestones to understand the current state, develop a theory for improvement, and test interventions that are evaluated for success that can be implemented, sustained, and spread. After projects have finished the initial 2 – year cycle, ODM ties a modest part of the withhold in year 3 for the MCOs to maintain the performance level for quality measures from the previous withhold cycle. Each QW project consists of cross-MCO teams with executive sponsor(s) (MCO chief executive). The teams meet weekly with a steering committee comprised of all MCO quality

improvement directors and ODM staff. A QW Executive Committee consisting of all MCO chief executives and ODM leadership meets and reports on project progress.

ODM quality improvement projects to ensure timely access to high quality care, eliminate population performance gaps, and advance evidence-based practice for improved healthcare outcomes include:

- **Ohio Governor's Quality Improvement Project Priorities.** Ohio Governor Mike DeWine worked closely with the ODM Director Maureen Corcoran, Medical Director Dr. Mary Applegate, and Leaders to continue his commitment of ensuring the health and success of Ohioans by prioritizing ODM quality improvement projects, including the following projects that focus on mothers and children and adult behavior health:

    - **The Outcomes Acceleration for Kids (OAK) QW-PIP** project is a new learning collaborative focused on improving children's health. The OAK Learning Network is a first-of-its-kind collaboration to achieve accelerated improvements in the health and wellbeing of Ohio's youth. The goal of OAK is to deliver the highest quality care by connecting regional partners to identify opportunities to close performance gaps for Ohio's pediatric population, achieve superior outcomes by transforming care delivery to meet patient's needs and ensure whole child health. The collaboration is a partnership between families, MCOs', Children's Hospitals, and ODM. OAK is designed to improve outcomes in four areas of care, including improving controller medication use for asthma; improving ED follow-up care for mental health and substance use visits; improving transcranial ultrasound, a routine screening for sickle cell disease (SCD); and increasing well-child visits and preventive care. (The asthma medication ratio component of OAK is serving as a PIP for the MCOs and the SPBM PAHP while the follow-up after ED visits for substance abuse and mental health components are serving as a PIP for the MCOs and the OhioRISE PIHP).

    - **The Preterm Birth and Related Population Health Build Work QW-PIP** will create a framework for MCOs, providers, and community partners to work together to develop person-centered, customized interventions to support women and families who've historically lacked ready access to high-quality responsive care before and after pregnancy to improve birth outcomes for the Medicaid population. MCOs must also identify gaps in their own services and supports to improve the healthcare system as well as consider and link patients to resources that address broader factors of health, such as housing, food instability, and transportation.

    - **The Follow-Up After Emergency Department Visit for Substance Use (FUA) and Follow-Up After Mental Health (MH) Emergency Department (ED) Visit (EDM-A) QW-PIP** focuses on MCOs working collaboratively with providers and community mental health partners to connect Medicaid members to long-term treatment services and supports after experiencing an emergency department visit for substance abuse and/or mental health.

- **The MyCare Managed Care Diabetes PIP** to improve Diabetes self-management among the dually eligible Medicare-Medicaid population.

- **Regional QI Hub Partnership** between Ohio's Colleges of Medicine and Ohio's Medicaid

Managed Care Organizations to spread of best-evidence clinical practice related to hypertension control and diabetes management.

- **Maintaining or Surpassing QW2022-2023 SMART Aim Performance Levels for Pregnancy Risk Assessment Form (PRAF)** to maintain or surpass the weekly count of ODM MCO members with an electronically submitted pregnancy risk assessment form (PRAF 2.0).

For more information regarding ODM Quality Improvement Projects, including information on project SMART Aim goals please see Table 4: ODM Population-Specific Quality Improvement Projects.

Performance Improvement Projects to be implemented in accordance with 438.330(d)

- Asthma Medication Ratio Improvement Project: MCO and the SPBM PAHP PIP
- Improving follow-up after ED visits for substance abuse and mental health: MCO and the OhioRISE PIHP PIP
- Improving Diabetes self-management among members who are dually eligible for Medicare and Medicaid: MyCare PIP

Step 5. Maintain and Support Lifecourse Continuity.

ODM has identified two main strategies for maintaining and supporting population health across the lifecourse: 1.) addressing health-related social needs supports and 2.) reinvesting in the communities where Medicaid members live, work, and play.

Health-Related Social Needs Supports. Identification of individual and population health-related social 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 subpopulation 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.

Community Reinvestment. The social and environmental factors that create or mitigate risks of poor health also require ODM and the MCEs to collaborate with communities while leveraging past collective impact work. In 2023, ODM began community reinvestment work with the MCEs. This work requires the MCEs to reinvest a percentage of their profits back into the community. Efforts to date have included statewide efforts to expand access to doulas to augment the provider network, partnerships with school-based health, efforts to address homelessness, and efforts to address food insecurity. Future efforts will be designed to focus on building capacity within communities. By working with community partners, ODM and its MCEs can address the upstream factors that impact wellness and health outcomes.

ODM Plan for Reducing Performance Gaps and Increasing Health Opportunities

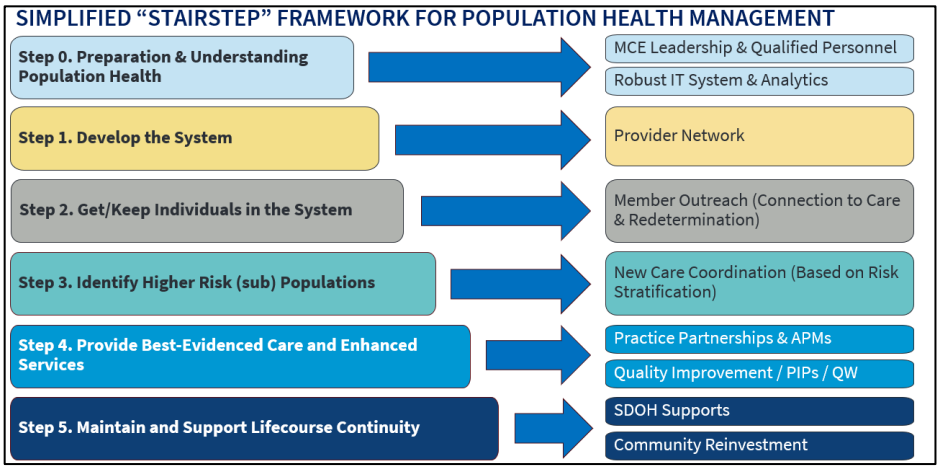
As required by 42 CFR 438.340, ODM has a plan for identifying, evaluating, and reducing, to the extent practicable, population-specific performance gaps in health outcomes.

ODM requires all MCEs to identify and address population performance gaps and ensure equitable access and delivery of services for all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

> As required by 42 CFR 438.340, ODM defines disability status as a qualifier for Medicaid based on disability. This information is included in the Medicaid enrollee files.

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

Population performance gap reduction and improvement of health opportunities permeate all population health improvement efforts. ODM's population performance gap reduction plan therefore incorporates all steps of the population health management framework but applies the strategies with cultural humility and through a lens specific to the needs of subpopulations with the greatest performance gaps.



ODM Population Management Framework to Reduce Population Performance Gaps

Step 1. Preparing for Understanding the Health of the Population. ODM requires the MCEs to have adequate population health infrastructure to fully support population-specific performance gap reduction efforts. MCE infrastructure (i.e., leadership, qualified staffing, information technology systems) must provide the necessary resources and support for identifying, understanding the distribution of, and preparing for addressing and reducing performance gaps. This requires more than looking at distribution of service utilization. It requires digging in to understand why under-utilization (such as not attending regular well visits) or over-utilization (such as several monthly visits to the ER) are occurring. It also involves examining grievances and appeals data and calls to member services to understand how well the MCE is providing services and supports.

Leadership to Support Population-Specific Performance Gap Reduction and Increase Health Opportunities. The MCOs are required to employ a full-time, Ohio-based, Director of Community Initiatives with demonstrated experience with community and stakeholder engagement and in the application of science-based quality improvement methods to reduce population-specific performance gaps. The director of community initiatives works in close coordination with the MCO's population health director to oversee the strategic design, implementation, and evaluation of population-specific efforts in the context of the MCO's population health initiatives. The director of community initiatives also coordinates and collaborates with members, providers, local and state government, community-based organizations, ODM, and other MCEs to reduce population-specific performance gaps.

Each MCO's director of community initiatives is responsible for ensuring a population-specific approach remains at the forefront of all the MCE's quality improvement and population health management work. This includes providing resources and research around population-specific

performance gap closure and health-related social needs to other MCO leadership and programmatic areas; ensuring that the perspectives of members with gaps in health outcomes are incorporated into the tailoring of intervention strategies.

All efforts to reduce population-specific performance gaps 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 population-specific performance improvement initiatives.

The director of community initiatives at each MCO must ensure that efforts to reduce population-specific performance gaps 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.

Quality Improvement Staff. MCO and the OhioRISE plan quality improvement staff must be of sufficient number to actively contribute to quality improvement projects within each of the ODM identified population health streams, attend ODM-led meetings and make connections quality improvement staff from ODM and other ODM-contracted managed care entities, coordinate population-specific work with other ODM-contracted managed care entities, and establish relationships with communities and community-based entities to inform and address local health issues.

Information Technology (IT). MCEs are required to have the necessary IT infrastructure to identify gaps in performance among populations, support the efficient launching of coordinated efforts for collective 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, health information exchange, risk assessment forms) to inform focused population health improvement efforts (care coordination, value-based initiatives, quality improvement, community reinvestment) and the prioritization of these efforts for populations experiencing the greatest gaps in outcomes.

ODM requires that the MCO's data system allow for the identification of population-specific performance gaps in areas such as service access, utilization, health outcomes, intervention effectiveness, health related social needs, and service access and satisfaction (e.g., CAHPS) so that efforts can be focused and tailored to better meet needs. Each MCO's IT system must also support monitoring and comparison of process and outcome measures over time to inform performance gap 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 support population-specific improvement efforts, as well as coordinated efforts for collective impact by allowing for efficient and secure data sharing with ODM and other MCEs.

Step 2. Efforts to get and keep eligible individuals enrolled, as appropriate. MCEs are required to examine how their policies and procedures may impact subpopulations in member connection to the health system. This includes analyzing any population-specific disenrollment from the MCE,

as well as any population-specific grievances and complaints about healthcare operations and then adjusting processes and policies to address identified needs. As the establishment and maintenance of trusting relationships are built on integrity of responsiveness and cultural humility, plans must evaluate how closely each of their members is tied to the MCE, who accepts or declines MCE connections through care coordination, how well they are demonstrating integrity and building trust by satisfactorily meeting health related social needs.

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

Step 3. Identification of higher-risk sub(populations). ODM 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 subpopulation performance variation and improved allocation of resources for subpopulation specific efforts.

Members with Disabilities or Special Healthcare Needs

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.

> 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. ODM uses eligibility, diagnosis, and utilization data to identify individuals with special healthcare needs (CFR 438.340).

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 those provided to individuals with special healthcare needs and individuals needing long term services and supports. 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 assess the quality and appropriateness of the services they receive. This information is provided as part of MCE's annual QAPI submission to ODM, as is the MCE's approach to identifying and reducing gaps in performance among populations.

Step 4. Evidence-based practices and enhanced services incorporate cultural humility by engaging individuals, their families, their Medicaid providers, and their communities in the co-design of the services themselves and how they are accessed and delivered.

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 policies and processes.

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

Evidence-based practice clinical guidelines must be reviewed at least quarterly to ensure that the newest research has been considered. A subpopulation specific perspective requires that MCEs specifically examine the literature to determine how clinical guidelines may vary for different segments of their population.

Each MCO's member services area is charged with assisting members in accessing sign language, oral interpretation, and auxiliary aids and services. The MCO must ensure these services are provided at no cost to the eligible individual or member. The MCO must designate a staff person to coordinate and document the provision of these services.

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

Value-Based Purchasing and Performance Gap Reduction

VBP emphasizes reduction of subpopulation performance gaps alongside improvements in overall population health. ODM requires the MCOs to design and implement value-based care and payment reform initiatives that reward innovation and results over the volume of services provided to transform the healthcare delivery system to improve individual and population health outcomes and member experience, while containing the cost of healthcare.

ODM through its provider agreements with managed care entities has laid the foundation for using VBP models to support population-specific 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 performance gap reduction goals for these populations and monitor progress over time.

Each MCO must work collaboratively with CPC and CMC practices 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., health-related social needs, data sharing).

When developing alternative payment model (APM) strategies, the MCOs must balance what is necessary for network adequacy and reasonable non-hospital access, as well as carefully considering which providers can take on risk to ensure that the MCO maintains network adequacy standards across its entire service area.

MCOs must support provider-led innovation sponsoring provider cultural transformation and workforce development, develop Alternative payment Model funding arrangements to retain and train providers, especially related to certification to advance their technical skills, and build capacity for value-based arrangements in underserved and at-risk regions.

Quality Improvement and Performance Gap Reduction

Subpopulation performance gap reduction is an essential component of all ODM managed care quality improvement efforts. ODM therefore prioritizes improvement projects targeting health outcomes in which there are large subpopulation performance gaps. Examples have included:

- The APMM PIP which targeted subpopulation performance gaps in metabolic monitoring after antipsychotic prescribing between children enrolled in the OhioRISE program for children with complex behavioral health needs and other Medicaid-insured children.

- Improvement projects aimed at increasing well-child visits, improving asthma medication ratios, and increasing follow-up after emergency department visits for mental health or substance use, which require working with Ohio's Black pediatric population, their families, and providers to co-design interventions to address unique barriers they identify.

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. Understanding the experience from the perspective of individuals insured by Medicaid allows equity to be incorporated into the understanding of root causes of disparate health access, experience and outcomes, allowing for increased intervention effectiveness.

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

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 services meet community expectations, members' 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 variation in performance by race and ethnicity 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 HRSN 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). These agencies built on the state's collaborative work to reclassify Medicaid benefits, as appropriate, at the time of admission or release from a correctional facility.

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 seven available MCOs. 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 to provide necessary information to facilitate eligibility and enrollment in Medicaid and select an MCO. 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.

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" (McPherson, et al., 1998). 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 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.

The OhioRISE Program. The OhioRISE Program was designed to improve outcomes for children and youth with complex behavioral health and multisystem needs. OhioRISE aims to shift the system of care and keep more kids and families together by creating new access to in-home and community-based services for children with the most complex behavioral health challenges. The OhioRISE program's child and family-centric delivery system recognizes the need to provide specialized services and support for this unique group of children and families. Aetna Better Health of Ohio (the OhioRISE plan) is partnering with Ohio Department of Medicaid (ODM), partner state agencies, providers, families, and other stakeholders to develop and implement new and enhanced services such as improved intensive home-based treatment, psychiatric treatment facilities, mobile response and stabilization services, and behavioral health respite.

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 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.

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.

Step 5. Maintain and Support LifeCourse Continuity. ODM's two main strategies for maintaining and supporting population health across the lifecourse: 1.) addressing health-related social needs

and 2.) reinvesting in the communities where Medicaid members live, work, and play are central to reducing gaps in population-specific performance.

Health-Related Social Needs (HRSN). ODM requires its managed care plans to employ mechanisms for identifying and responding to health-related social needs. HRAs and PRAFs allow MCOs to identify patient needs. MCOs may also find out about these needs from other sources, such as value-based payment partnerships with providers.

Each MCO must participate with both of Ohio's health information exchanges (HIEs) and be capable of exchanging protected health information, connecting to inpatient and ambulatory electronic health records, connecting to care coordination information technology system records, and supporting secure messaging or electronic querying between providers, patients, and the MCO. This must include but is not limited to using HIEs for admission, discharge, and transfer (ADT) data and closing referral loops for health-related social needs (HRSN).

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. The Community Reinvestment program will be extended to the MyCare Duals population when the next generation MyCare program launches in 2026.

Each MCE must commit to improving health outcomes in local communities in which it operates by contributing up to 5% of its annual profits to community reinvestment to support population health strategies within the region(s) it serves. ODM encourages the MCEs to maximize the collective impact of community reinvestment by actively collaborating with other MCOs and other organizations serving the Medicaid population. Over the next few years, ODM will be strategically working with the MCEs to determine how to build the capacity of community-based organizations within local communities.

Promotion of Cultural Humility. All MCEs and MCE subcontractors are prohibited from discrimination in the delivery of services. This includes proactively identifying population-specific performance gaps 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, gender, age, sexual orientation, disability, language, national origin, or need for health services.

MCEs must actively participate in and support ODM's efforts to reduce subpopulation performance gaps, address health-related social needs, and improve health outcomes 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 on policy and processes. MCEs are contractually required to obtain and incorporate ongoing input from members and families in the creation of initiatives to reduce population-specific performance gaps, 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 take 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, 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 needs, 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.

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.

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 eliminate performance gaps for all subpopulations. 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.

MCE QI Strategy and Evaluation

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.

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 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 population performance gaps, 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 performance gaps 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 EQR 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 2020-2024, PIPs for both Medicaid MCOs and MyCare Ohio Plans focused on well-managed diabetes control.

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.

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.

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 health-related social needs, 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.

Infant Mortality Community Partnership. The Infant Mortality Community Partnership is a collaboration among state agencies, such as ODM and the Ohio Department of Health (ODH), and the MCOs which are working with local community-based organizations (CBO) in Ohio Equity Institute (OEI) communities disproportionately experiencing higher rates in infant mortality. The partnership's purpose is to use population data to target areas for outreach and services, as well as coordinate the work of programs in each community. Initiatives include community health workers, doula services, prenatal care coordination, breastfeeding support, peer-to-peer support, women's neighborhood advisory boards, centralized intake/care connectors, fatherhood encouragement, health and parenting education, and community engagement. Taken together, these interventions were focused on improving the health of pregnant women, infants, and their families within the OEI communities.

In January 2025, MCOs extended funding that had awarded $25 million for extra care coordination resources to 120 CBOs for a 2022-2024 project period in the OEI communities which include areas in the ten counties with the largest infant mortality burden: Butler County, Cuyahoga County, Franklin County, Hamilton County, Lorain County, Lucas County, Mahoning County, Montgomery County, Stark County, and Summit County.

Concurrent with the funding of these CBOs, ODM sponsored an evaluation grounded in the collection of participant-level data with the goal of determining the extent to which the selected interventions serve high-risk pregnant women and to assess the effect of these interventions on healthcare utilization and birth outcomes. Service provision began in August 2018 and 155 CBOs have participated in the partnership. Between August 2018 and June 2024, CBOs have served 64,130 total participants.

Value-Oriented Payment Innovation

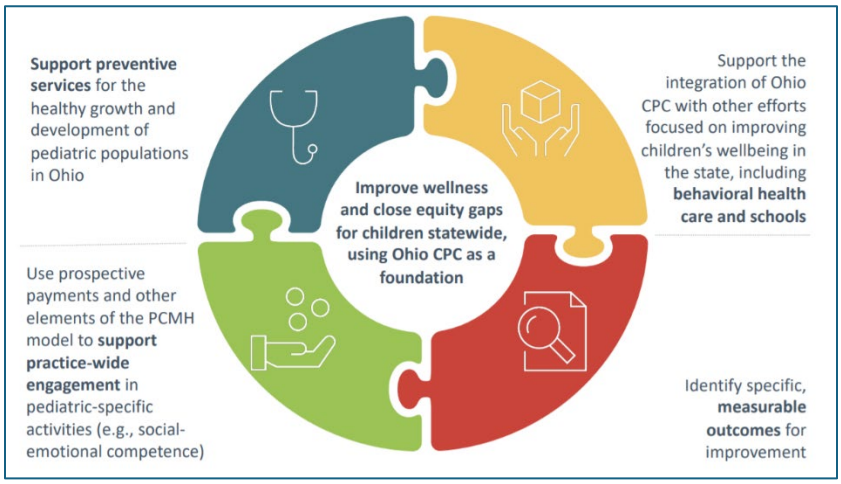
Comprehensive Primary Care (CPC). MCOs play a key role in supporting network Comprehensive Primary Care (CPC) practices with achieving optimal population health outcomes. ODM requires that each MCO establish a relationship with each network CPC practice and work collaboratively with the CPC to determine 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 health-related social needs, 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 performance gaps and improving outcomes and member experience.

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 (Combo 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 (Combo 2). 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.



Comprehensive Maternal Care (CMC). Ohio ranks near the bottom of the nation for its rate of infant mortality and faces significant population-specific gaps in neonatal outcomes. As Ohio's largest source of payment for Ohio births, the Ohio Department of Medicaid aims to reduce and eliminate gaps 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 population performance gaps.

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. 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.

MCE-initiated Payment Reforms. Due to the length of their 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 health-related social needs (HRSN), (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.

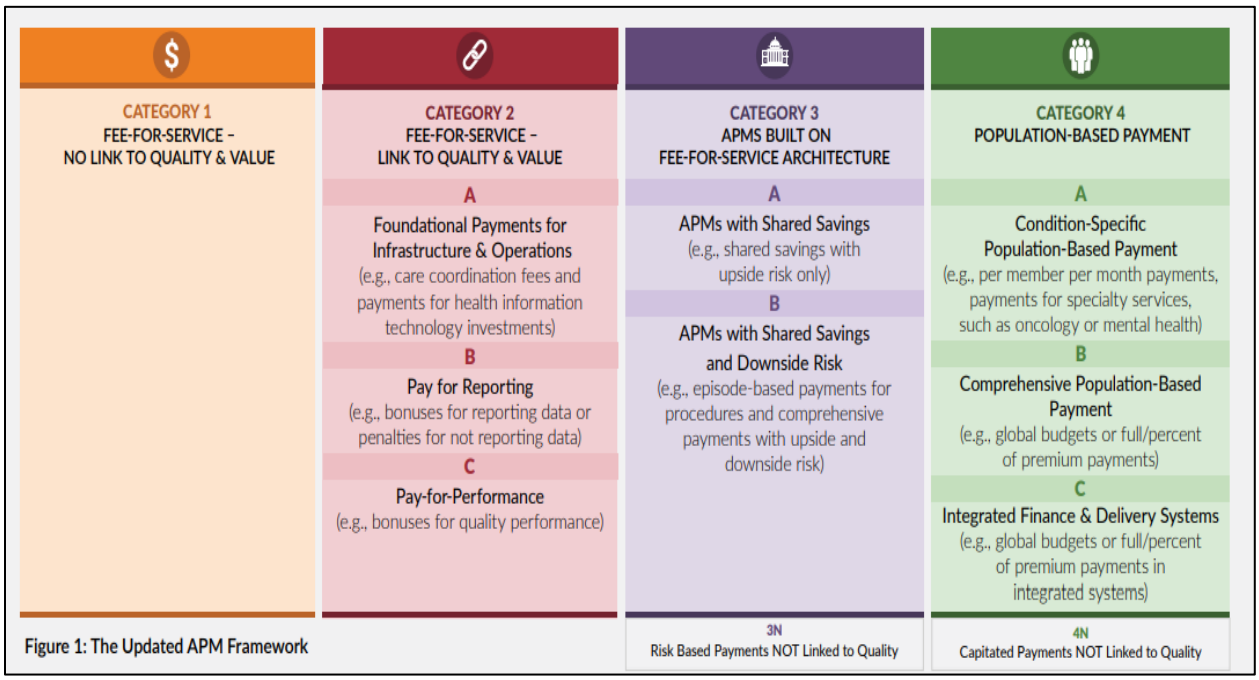


Figure 1: The Updated APM Framework

Table 7 below illustrates the APM payment goals for CY 2023-2030 shown in the table below. These may be added for the OhioRISE plan as the program matures.

Table 7: MCE APM Targets 2023-2030

Measurement Year	Small Providers		Large Providers	
	APM LAN Categories 3A/3B/4A/4B/ 4C	APM LAN Categories 3B/4A/4B/4C	APM LAN Categories 3A/3B/4A/4B/4C	APM LAN Categories 3B/4A/4B/4C
CY 2023	Reporting Only	Reporting Only	Reporting Only	Reporting Only
CY 2024	Reporting Only	Reporting Only	Reporting Only	Reporting Only
CY 2025	30%	0%	75%	10%
CY 2026	40%	0%	80%	15%
CY 2027	50%	0%	90%	20%
CY 2028	60%	0%	100%	30%
CY 2029	75%	0%	100%	40%
CY 2030	90%	0%	100%	50%

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.

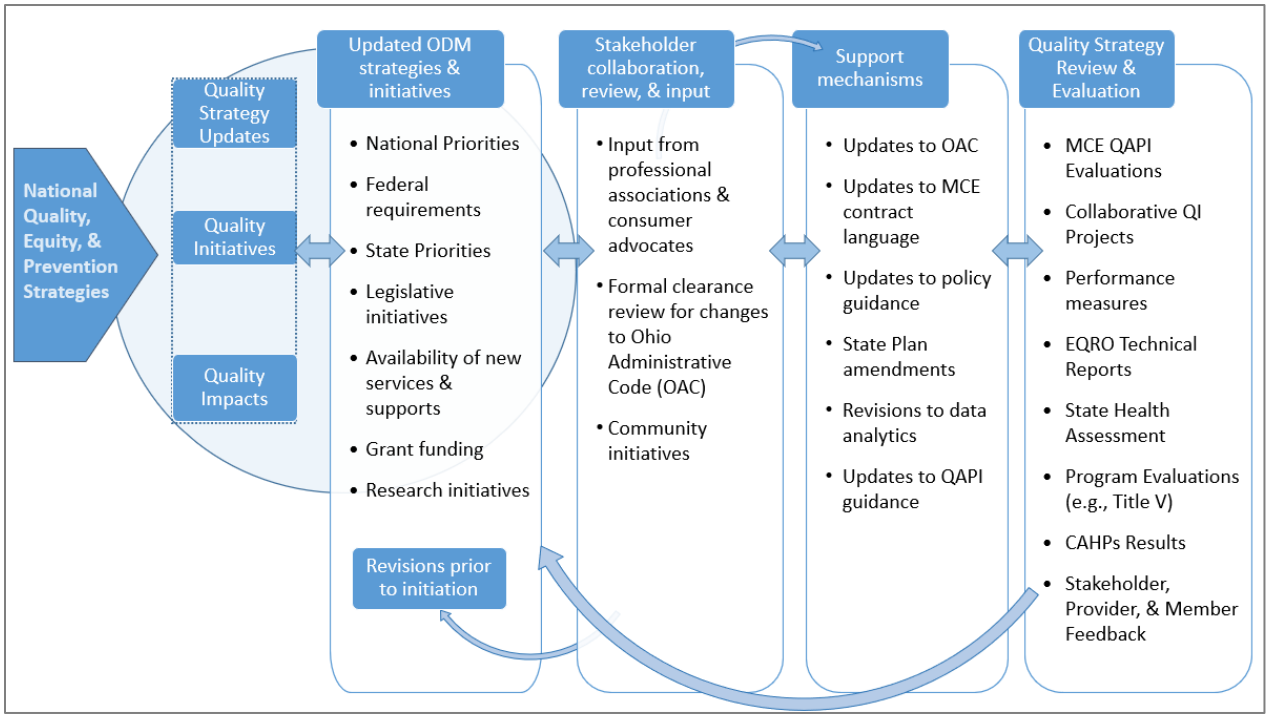
Quality Measures. ODM-developed measures are used to measure the MCO's performance specific to the Ohio Medicaid managed care program's service delivery system. For those measures, the MCO must collect and report valid and reliable data in accordance with associated measure specifications, as well as 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 Health Plan HEDIS Report. A subset of measures is also published annually on ODM's website in the form of a Report Card. The Report Card and full methodology are available on the Ohio Department of Medicaid website (2024 MCO Report Card, 2024).

Quality Strategy Review, Evaluation, and Updates

As illustrated by Figure 4 below, review of *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 4. Ongoing Development, Review, and Refinement of the Managed Care Quality Strategy



The ongoing nature of review and modification shown in Figure 4 above 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.

Formal Quality Strategy Evaluation

ODM contracted with its External Quality Review Organization (EQRO) to evaluate the 2022 Quality Strategy. In conducting the evaluation, the Island Peer Review Organization (IPRO) reviewed 42 CFR 438.340, the Centers for Medicare and Medicaid Services (CMS) QS Toolkit, the 2022 Quality Strategy, the most current MCO, OhioRISE, MyCare Ohio, and SPBM contractual agreements (i.e., provider agreements), the MCEs' Quality Assurance and Performance Improvement (QAPI) programs, and the MCO population health management strategies.

IPRO found that ODM's Quality Strategy, written during the procurement period for Next Generation Managed Care, meets the federal guidelines outlined in 42 CFR and contains detailed explanations regarding the state's development of the next generation managed care to improve population health outcomes.

Recommendations included augmenting the five programmatic goals with shorter intermediate objectives aligning with the three-year quality strategy and suggestions for presenting more clearly

indicating prioritized measures, and clearly linking quality initiatives to the prioritized measures, shorter term objectives, and broad programmatic goals.

Table 8 below shows IPROs recommendations, and the location of updates made to the Quality Strategy in response.

Table 8: ODM Quality Strategy Recommendations

Evaluation Recommendation	Resulting Update
Demonstrate how population health management principles will be operationalized to improve health outcomes.	ODM has reorganized the population health and quality strategy to demonstrate the specific strategies that are being operationalized within each step of the population health management stairstep framework to improve population health outcomes.
Shorten the Section Documenting the History of Ohio's Managed Care Program	The History Section of the Quality Strategy was included to comply with recommendations in the prior CMS Quality Strategy Toolkit. ODM has moved this information to Appendix B for historical purposes.
Carrying the population health management framework through the goals sections could help the agency operationalize the goals within this framework and align program execution at each step of this approach.	The organization of the ODM Quality Strategy identifies Overarching Programmatic Goals, Population-Specific Goals & Objectives (with baselines and targets for select metrics), and Prioritized Strategies ODM employs to achieve the Quality Strategy Goals & Objectives. These Goals, Objectives, strategies provide a clear roadmap of how ODM will operationalize its Population Health Management Framework and align the population health management strategies of its contracted Managed Care Entities (MCEs) for collective impact and focused population-specific improvement targets to achieve desired outcomes.
Be consistent in use of population stream terminology across ODM documents (i.e., QS, QS visual, PHMS, QAPI, Quality Withhold)	Some of the differences in naming conventions result from spacing constraints (e.g., labeling of tabs in the QAPI Excel document for example; need for font size to be readable in graphics). ODM will work to align terminology where possible. Crosswalks will be created when character constraints prevent the full name of a population stream from being used. ODM has also added descriptive language to differentiate between the main population

Evaluation Recommendation	Resulting Update
	stream and the subpopulations that are contained within it (e.g., Women and Infants population stream contains the subpopulations of Women of Reproductive Age, High Risk (Women), and Infants)
Consider adding a demographics and enrollment section to more clearly describe the population served and then detail how population health approaches were tailored to meet the needs of Ohioans.	ODM has developed and distributes monthly to MCEs a Population Health Stream Specifications file (Appendix E) identifying criteria for the population streams Healthy Children & Adults, Women & Infants, Behavioral Health Children & Adults, Chronic Physical & Development Conditions Children & Adults, and Older Adults to assist in the Population Health Management efforts of each population-specific stream.
Goals in the 2022 QS are overly broad, performance benchmarks are not specific, and a measurement strategy is not in place to assess the effectiveness of a goal or impact of an intervention.	ODM has reorganized its Population Health and Quality Strategy to more clearly delineate the difference between Programmatic Goals and Population Health and Quality Goals and has outlined specific strategies to .
Focus on a smaller number of measures (i.e., one to three measures per goal)	ODM has trimmed the number of Population-Specific measures and aligned measures across MCEs and programs for targeted improvement. See Table 3: ODM Population-Specific Priority Quality Measures.
• Tie in how current programs were identified and adapted to address gaps in population-specific health performance measures specific to Ohioans.	ODM has made a programmatic change to report quality measures identified as Priority Measures in the Quality Strategy by the Overall population and the Black population to monitor and track quality measures by race to understand the needs of our members, including health-related social needs and changes in communities' needs over time. Reporting metrics by the Overall population and the Black population will allow ODM and its MCEs to further identify population-specific gaps in outcomes and promote evidence-informed approaches to reduce gaps. See Table 3: ODM Population-Specific Priority Quality Measures.

Evaluation Recommendation	Resulting Update
• Highlight additional programs designed to improve outcomes for chronic conditions such as case management, CPC, PIPs, etc., that are ongoing at the state level.	The Outcomes Acceleration for Kids (OAK) QW-PIP project is a new learning collaborative focused on improving children's health. The OAK Learning Network is a first-of-its-kind collaboration to achieve accelerated improvements in the health and wellbeing of Ohio's youth. The goal of OAK is to deliver the highest quality care by connecting regional partners to identify opportunities to close subpopulation performance gaps for Ohio's pediatric population, achieve superior outcomes by transforming care delivery to meet patient's needs and ensure whole child health. The collaboration is a partnership between families, MCOs', Children's Hospitals, and ODM. OAK is designed to improve outcomes in four areas of care, including improving controller medication use for asthma; improving ED follow-up care for mental health and substance use visits; improving transcranial ultrasound, a routine screening for sickle cell disease (SCD); and increasing well-child visits and preventive care.

As required by 42 CFR 438.340 the evaluation of the 2022-2024 Population Health and Quality Strategy is posted on ODM's website at External Quality Review Tech Report

In the Population Health and Quality Strategy 2026-2028, ODM considered the results of the EQRO's Evaluation, as well as 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 Plan HEDIS 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); and progress towards improvement project goals.

Other sources of information that were used to inform the Population Health and Quality Strategy 2026-2028 include ad hoc data analysis, reviews of quarterly performance metrics; the Ohio Pregnancy Assessment Survey (OPAS), the Ohio Medicaid Assessment Survey (OMAS), program evaluations (e.g., 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.

Annual, External Independent Reviews

As required by 42 CFR Part 438.350, states contracting with MCOs, PIHPs and PAHPs are required to arrange for an independent annual external quality review of the timeliness, accessibility and quality of healthcare services provided to Medicaid managed care members. ODM contracts with a qualified external review organization to perform mandatory and optional external quality review activities specified at 43 CFR 438.358 including the following:

- Validation of performance improvement projects
- Validation and calculation of performance measures
- Comprehensive administrative reviews
- Validation of network adequacy
- Validation of encounter data
- Validation of consumer and provider surveys
- Evaluation of state directed payments and the Quality Strategy

In addition, the EQRO performs information systems reviews in support of performing measure reporting and network adequacy validation, produces an MCO score card, conducts program evaluations, and provides technical assistance to improve the effectiveness and efficiency of ODM's managed care programs.

In accordance with 42 CFR 438.364, ODM's EQRO, produces an annual technical report which summarizes results on mandatory and optional EQR activities. For each EQR activity, the report includes 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.

The SFY 2023-2024 External Quality Review Annual Technical Report assessed MCE performance improvement projects (PIPs), included the results of comprehensive administrative reviews, performance measures, network adequacy validations, encounter data validations studies (EDV), and a consumer satisfaction survey.

As required by 42 CFR 438.340, 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://medicaid.ohio.gov/wps/portal/gov/medicaid/about-

us/qs/odm-quality-reports/external-quality-review-tech-report.

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.

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.

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

Sanctions for Noncompliance

ODM has created a robust accountability system to ensure that MCEs are working within the framework of the *Population Health 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 2025 can be found in Appendix G.

A. General Monitoring

NCQA Accreditation

ODM requires that MCOs and MCOPs maintain National Committee for Quality Assurance (NCQA) accreditation for the Ohio Medicaid line of business. The plans must achieve 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. 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.

B. Monitoring MCO 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 reduce subpopulation performance gaps; 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; 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 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, population-specific performance gaps, 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 performance gap 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 system;
- 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 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 Health Strategic Approaches

ODM requires certain population health strategic approaches (optimal delivery systems, care coordination, quality improvement, reducing subpopulation performance gaps 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 Population-Specific Efforts. Each MCE must contribute to ODM's quality strategy and must describe their efforts to reduce subpopulation performance gaps 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 to close subpopulation performance gaps, 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 the Overall population and the Black population, allowing for increased monitoring of any population-specific performance gaps over time at the MCE and state level. Measure performance also allows ODM to prioritize improvement initiatives to reduce performance gaps.

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 its 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 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 (The Ohio Department of Medicaid Ohio Medicaid Provider Agreement for Managed Care Organization, 2024c). 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 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. (The Ohio Department of Medicaid Ohio Medicaid Provider Agreement for Managed Care Organization, 2024a).

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 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, 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:

- Quality Improvement 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 population-specific performance gaps and Cultural Considerations
- Quality Improvement Strategy
- Quality Improvement 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), performance improvement projects initiated to regain a portion of the annual quality withhold amount (QW-PIPs), 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 D) using ODM's QI Template. This information is 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 D), 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 Overarching Programmatic 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-specific streams (e.g., Women and Infant Health, Healthy Children, Healthy Adults) to monitor progress at the population level. ODM also requires the MCEs to stratify these measures by various demographic factors to assist in identifying subpopulation performance gaps, prioritizing initiatives, and monitoring progress towards equalizing performance among subpopulations.

As required by 42 CFR 438.340, several of the quality measures and performance outcomes are published on the ODM website which provides a longitudinal summary and comparison of MCO performance. (Health Plan HEDIS Report, 2019).

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 population-specific performance gaps in healthcare access, service provision, satisfaction, and outcomes. These comparisons are used to identify quality improvement opportunities related to member satisfaction and reducing subpopulation performance gaps.

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;
- Sum of total medical spends; and
- Sum of total net payments.

Monitoring as a Tool for Continued Improvement. The monitoring of each population health approach, along with the EQR 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 MCE impact lends itself to continuous refinement of the overall Population Health and Quality Strategy which in turn leads to adjustments in the approaches of each MCE.

Conclusions and Opportunities

The Next Generation Ohio Medicaid Managed Care, Next Generation MyCare, and the ODM Population Health and Quality Strategy 2026-2028 provides managed care entities and ODM a comprehensive roadmap for structured population health management and targeted improvement to ensure beneficiaries experience appropriate, timely, equitable, and positive healthcare and services. Prioritized strategies emphasize strong cross-agency coordination and partnership among managed care entities (MCEs), ODM program areas, health systems, providers, vendors, partner agencies, communities, and ODM.

ODM's population health and quality strategy structure calls for a strong commitment to collective impact among ODM's contracted managed care entities. Established requirements include administrative practices, building population health infrastructure, access and availability, coverage and benefits, performance improvement projects, quality performance metrics & monitoring (e.g., HEDIS), utilization, compliance, and collaborative MCO quality withhold performance improvement projects tied to financial incentives, quality assessment, and EQR review processes. To date, contracted MCEs have demonstrated success, meeting and succeeding

ODM established requirements, however continuous quality improvement will provide MCEs with opportunities 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 to achieve population health and quality strategy goals. ODM's opportunities for improvement are framed by a commitment to collective impact supported by 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 (5.) a 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.

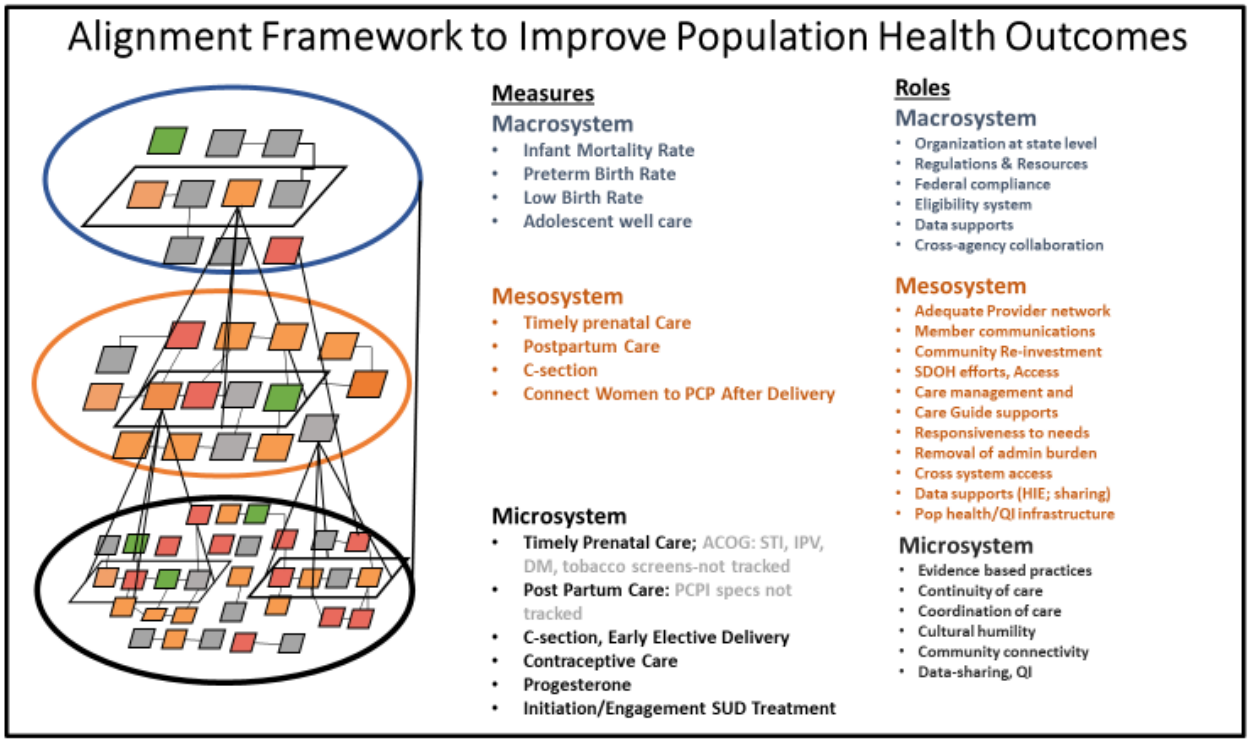
Alignment includes consistent requirements for population health and quality leadership and infrastructure, the use of the science-based quality improvement tools and methods, and quality improvement project content and reporting requirements.

ODM-initiated quality improvement projects, including performance improvement projects (PIPs) and quality withhold performance improvement projects (QW-PIPs), 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 the "Framework of Nested Systems" within *The Improvement Guide* (Langley, et al. (2009) and the Applegate Alignment Framework (Olin S.S., et al. 2021). These frameworks, used conjointly, outline the roles and responsibilities of each "level" of

the health 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.

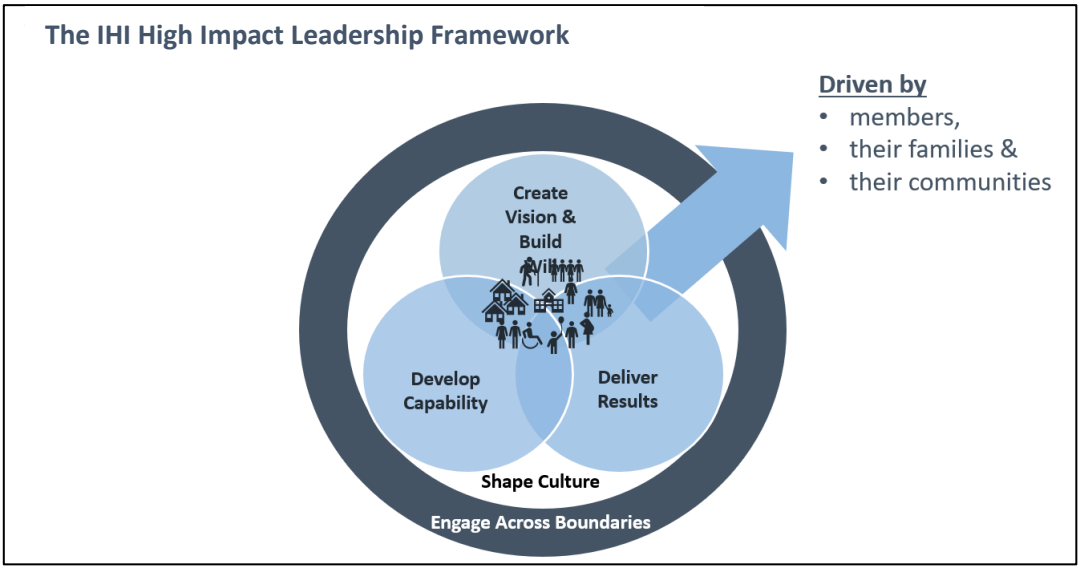
For population health improvement efforts to succeed, ODM, MCEs, health systems, individual clinical providers, and communities must collaborate and coordinate efforts towards achieving well defined improvement goals, and Medicaid members must be partners in their own care. The establishment and maintenance 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. 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 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 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 (Swenson, et al. 2013). 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 of community partners.



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., subpopulation performance variation, 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.

Summary

The Population Health and Quality Strategy 2026-2028 reveals the Population-Specific Goals, Objectives, Priority Quality Measures, and Prioritized Strategies identified to produce needed improvements and reach intended health outcomes by:

- Ensuring high quality and high levels of access to timely; appropriate; and equitable healthcare
- Focusing on the individual by creating personalized care experiences
- Improving individual and population wellness and health outcomes
    - Well-Child Visits & Academic Success
    - Preventative Adult Screenings
    - Timely & Accessible Maternal Care
    - Decrease in Infant Mortality
    - Comprehensive & Coordinated Behavioral Health Services
    - Reduced Behavioral Health & Substance Use Disorder Related Mortality
    - Well Managed Chronic Conditions
- Supporting providers in continuously improving care
- Improving care for individuals with complex needs to promote independence in the community
- Reducing population-specific gaps in performance in healthcare and health outcomes
- Leveraging quality measures to improve health outcomes and set benchmarks to track progress (e.g., HEDIS & ODM developed measures)

- Monitoring and tracking quality measures by subpopulations to understand the needs of members, including health-related social needs and changes in communities' needs over time
- Improving quality outcomes and reducing gaps in performance through structured performance improvement projects, alternative payment models, and state directed payments
- Increasing program transparency and accountability

Measure Alignment, Subpopulation Specific Data Collection and Reporting. ODM aligns quality performance measures across it's several different types of contracted managed care entities (MCEs), including MCOs, the OhioRISE PIHP, the Single Pharmacy Benefit Manager (SPBM) PAHP, and MyCare Ohio Plans (MCOP) as well as alignment across multiple ODM programs, including alternative payment models Comprehensive Primary Care (CPC) and Comprehensive Maternal Care (CMC), Performance Improvement Projects (PIPs), and State Directed Payments (SDP) for collective population health management and targeted improvement. Alignment across targeted quality measures demonstrates one of the multiple strategies ODM employs for collaboration with MCEs, health systems and communities for collective impact on population-specific goals. The establishment of common program-specific quality metrics and definitions allows for meaningful collaboration across program areas and delivery systems and allows for reliable measurement, reporting, and meaningful comparisons across Medicaid managed care entities. In addition to measure alignment, ODM has implemented population-specific reporting by stratifying the Priority Quality Measures by the Overall population and the Black population to understand the needs of our members, including health-related social needs and changes in communities' needs over time to continuously promote evidence-informed approaches and quality improvement initiatives to reduce performance gaps in healthcare and health outcomes.

ODM contractual requirements for data collection and reporting to support the reduction population-specific performance gaps and develop approaches for improvement include but are not limited to:

- Requiring MCOs to collect member level Health Risk Assessments, including health-related social needs (HRSN) data
- Collecting member, provider, and community voice of the customer to ensure beneficiaries are engaged in intervention design and implementation of performance improvement projects
- Establishing SMART Aim Goals related to reducing subpopulation performance gaps for Quality Withhold Performance Improvement Projects (QW-PIPs) tied to financial incentives
- Using data driven approaches to identify any gaps in care among subpopulations

The Ohio Department of Medicaid (ODM) is committed to population health and quality with measurement, monitoring, and continuous improvement being fundamental to improving the health and well-being of Ohio Medicaid members. The ODM Population Health and Quality Strategy 2026-2028 provides a comprehensive plan for ODM and its Medicaid managed care programs to (1.) have a shared vision of population-specific health management with aligned goals and objectives among MCEs and ODM programs to drive improvement in health outcomes, (2.) a set of population-specific priority quality measures and definitions for targeted improvement across program areas with reliable measurement and reporting, (3.) mutually reinforcing activities

requiring MCEs to collaborate and coordinate with each other, providers, health systems, community-based organizations, and ODM to build sustainable partnerships centered around delivering optimal member care, (4.) build trust with members and providers across all levels of the health system with open, transparent, communication and by actively incorporating the perspectives of members, families, providers, and community organizations into population health improvement efforts, and (5.) develop a supportive MCO population health infrastructure with analytic capabilities and cross-system collaboration with active engagement and maintenance of community partners.

During the implementation of the ODM Population Health and Quality Strategy 2026-2028, ODM will be committed to achieving the clinical and non-clinical intended population health outcomes outlined in the strategy to ensure the health and well-being of Ohio Medicaid members. ODM will be monitoring and tracking the outcomes of the Population-Specific Goals, Objectives, and Priority Quality Measures to look for opportunities for continuous quality improvement to meet the needs of our beneficiaries.

Glossary

Care Coordination – A team-based, person-centered approach designed to assist members and their support systems in managing medical conditions and health-related social needs more effectively. 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.

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 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.

Health-Related Social Needs (HRSN) – Social and economic needs that individuals experience that affect their ability to maintain their health and well-being. They put individuals at risk for worse health outcomes and increased healthcare use. HRSN refers to individual-level factors such as financial instability, lack of access to healthy food, lack of access to affordable and stable housing and utilities, lack of access to health care, and lack of access to transportation.

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, 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 – 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 and distribution thereof within a group of individuals (i.e., population). These population groups may be defined by demographics characteristics (e.g., age) healthcare service utilization, common diagnoses (e.g., chronic conditions), physical or behavioral health needs geography, or health-related social needs (e.g., housing insecurity or homelessness). ODM divides Its population into five Population Streams.

Population Health Management – An approach to maintain and improve physical and psychosocial wellbeing and address variances in population-specific health outcomes through cost-effective, person-centered health solutions that address members' health needs in multiple settings at all points along the continuum of care. ODM uses a five-step population health approach that encompasses developing the system, getting and keeping people in the system, identifying higher risk subpopulations, providing evidence-based care and enhanced services, and ensuring continuity across the lifecourse.

Population Streams—A categorization of populations into groups of Medicaid recipients based on demographics utilization of healthcare services, common diagnosis, and physical and behavioral health needs.

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.

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.

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, 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.

Population Health and Quality Strategy Appendices

Appendix A: ODM Managed Care Entities Provider Agreements

- Next Generation Managed Care Provider Agreement: Appendix I – Quality Measures Managed Care Agreements
- MyCare Ohio Provider Agreement: Appendix M – Quality & Waiver Performance Measures and Standards MyCare Ohio Agreements

Appendix B: Brief History of Ohio Managed Care – See Appendix B below

Appendix C: Ohio Medicaid's Managed Care Programs – See Appendix C Below

Appendix D: Quality Management Structure – See Appendix D Below

Appendix E: Population Health Stream Specifications – See Appendix E Below

Appendix F: ODM Next Generation Managed Care Provider Agreement (Amended effective 1/1/2025): Provider Network Adequacy and Availability of Service Standards – Appendix F – Provider Network - Available Online at Managed Care Agreements

Appendix G: ODM Next Generation Managed Care Provider Agreement (Amended effective 1/1/2025): Sanctions for Noncompliance – Appendix N – Compliance Actions– Available Online at Managed Care Agreements

Appendix H: References – See Appendix H Below

Appendix B-Brief History of Ohio Managed Care

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	**2013**	
	2014	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 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

Key Administrative Actions		Population Health & Quality Advancements
	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	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 population performance gaps
		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		ODM and MCOs began using a unified preferred drug list (UPDL)
	2020	Diabetes PIP collaborative begins (5/2020)
		QW based on MCO response to COVID-19 using science-based quality improvement methods (6/2020)

Key Administrative Actions		Population Health & Quality Advancements
Next Generation managed care entities procured • Gainwell Single Pharmacy Benefit Manager procured (01/2021) • Aetna OhioRISE procured (04/2021) • 7 new MCOs 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 Medicaid Managed Care launch
	2026	Next Generation Duals Program launch

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

- expanding 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 (Ohio Department of Medicaid, 2016).
- launching 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. 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. (The Scan Foundation, 2020).

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 (Iams JD, et al. 2017).
- ODM published the first Managed Care Report Card on ODM's website. 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 (Ohio Department of Medicaid, 2017).

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 supports community-based initiatives (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 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 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 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.

2023-Launch of Next Generation Managed Care Organizations

2024-The Next Generation MyCare Procurement - aiming to improve MyCare member and provider experience with the program. To do this, ODM is transitioning the current program and selecting Next Generation MyCare plans. Beginning in January 2026, the selected plans will cover the full Medicare and Medicaid benefit for those who qualify in the current 29 demonstration counties. Statewide expansion will follow as quickly as possible.

ODM designed its Next Generation MyCare program to:

- Focus on the individual.
- Improve individual and population wellness and health outcomes.
- Create a personalized care experience.
- Support providers in continuously improving care.
- Improve care for individuals with complex needs to promote independence in the community.
- Increase program transparency and accountability.

References

Iams JD, Applegate MS, Marcotte MP, et al. (2017). A Statewide Progestogen Promotion Program in Ohio. *Obstet Gynecol*;129(2):337-346.

Ohio Department of Medicaid (2016). *Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly*. Retrieved online from: http://medicaid.ohio.gov/portals/0/resources/reports/annual/group-viii-assessment.pdf

Ohio Department of Medicaid (2017). 2017 MCP Report Card. Retrieved online from: Manage Care Plan (MCP) Report Card | Medicaid

The Scan Foundation (2020). 2020 Effective Transitions Winner Ohio. Retrieved online from: 2020_PacesetterPrize_one-pager_OH_FINAL.pdf

Appendix C: Ohio Medicaid's Managed Care Programs

MCE Type	Managed Care Entity Name(s)	Managed Care Authority	Populations Served
MCO	•AmeriHealth Caritas of Ohio •Anthem •Buckeye Health Plan •CareSource •Humana Healthy Horizons in Ohio •Molina Healthcare •United Healthcare Community Plan	1915(b)	•Healthy Children and Adults •Women and Infants •Children and Adults with Behavioral Health Conditions •Children and Adults with Chronic Physical and Developmental Conditions
PIHP	Aetna OhioRISE	1915(b)	•Medicaid children with complex, multisystem behavioral health-related needs
PAHP	Gainwell Single Pharmacy Benefit Manager	1915(b)	•Healthy Children and Adults Women and Infants •Behavioral Health Children and Adults •Chronic Physical and Developmental Conditions •Older Adults
MyCare MCOs (ending Dec 2025)	•Aetna MyCare •Buckeye Health Plan •CareSource •Molina Healthcare •United Healthcare Community Plan	1115	•Individuals dually eligible for Medicaid and Medicare •Healthy Adults •Women's Health •Behavioral Health for Adults •Adults with Chronic Physical and Developmental Conditions •Older Adults
FIDE-SNP MCOs (Beginning January 2026)	FIDE-SNP Plans for Next Generation MyCare • Anthem • Buckeye Health Plan • CareSource • Molina Healthcare		

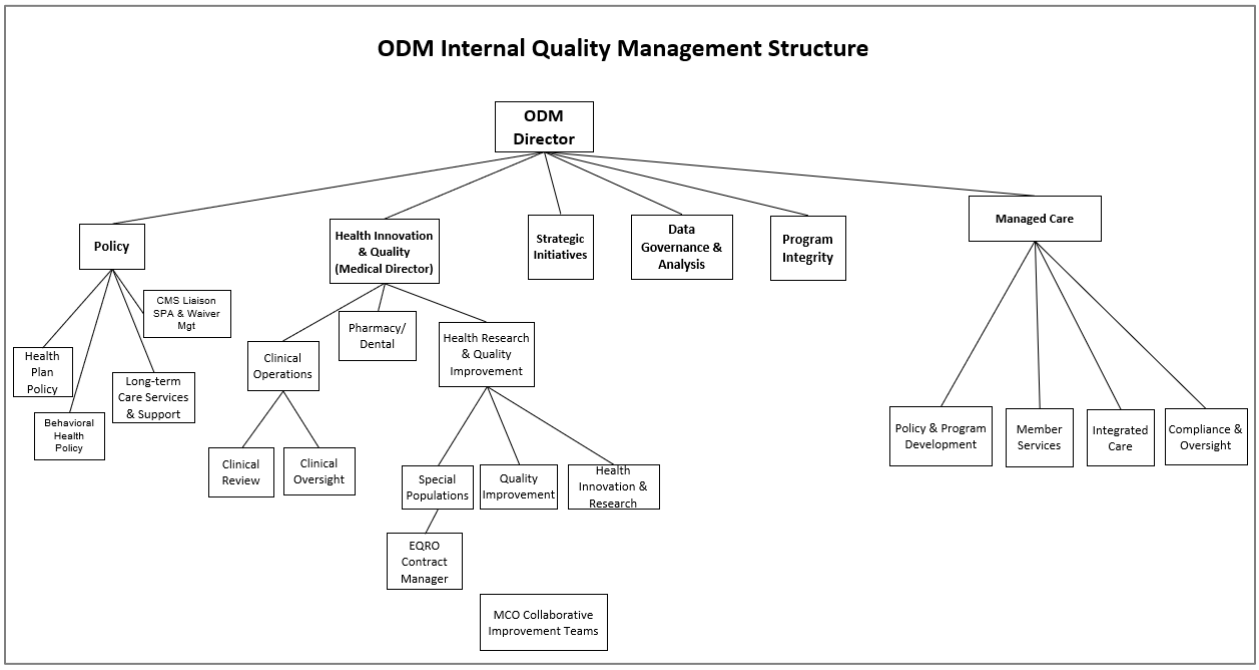
Appendix D: Quality Management Structure

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 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 members 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 • Quality Improvement (including adequate infrastructure, training, data, and metrics to support QAPI program emphasizing rapid cycle, continuous quality improvement methods) • Care Coordination • Specialized Services and Special Populations (e.g., members with special health care needs) • Health Equity and Health-related Social Needs • Community reinvestment • Optimized Delivery System (e.g., ensuring access to specialists, and promoting internal and external best practices) • 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 and sharing their experience & knowledge with ODM to maximize the quality of care available to low-income Ohioans The MCAC advises 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)

Medicaid Managed Care Population Stream Data Specifications

Issued: September 2024

Jonathan Lee

Office of Data and Integrated Systems

Jonathan.Lee@medicaid.ohio.gov

Table of Contents

List of Tables

Introduction

This document describes the file layout, data field definitions, and submission procedures for the reporting of the Managed Care Organization (MCO) population stream data. The Ohio Department of Medicaid (ODM) will produce a data file to be delivered by the end of each month via the ODM-MITS SFTP folder. The file(s) will contain all members enrolled by the MCO as of the prior month.

Below are the possible population stream subcategories a member may be assigned:

- Healthy Children
- Healthy Adults
- Infants
- Women of Reproductive Age – Non-High Risk
- Women of Reproductive Age – High-Risk
- Behavioral Health Children
- Behavioral Health Adults – Non-SUD
- Behavioral Health Adults – SUD
- Children with Chronic Conditions
- Children with Developmental Disabilities
- Adults with Chronic Conditions
- Older Adults

These subcategories are part of broader population streams as shown in the table below:

Population Stream	Population Stream Subcategory
Healthy Children & Adults	Healthy Children
	Healthy Adults
Women & Infant Health	Infants
	Women of Reproductive Age – Non-High Risk
	Women of Reproductive Age – High-Risk

Behavioral Health	Behavioral Health Children
	Behavioral Health Adults – Non-SUD
	Behavioral Health Adults – SUD
Chronic Physical & Development Conditions	Children with Chronic Conditions
	Children with Developmental Disabilities
	Adults with Chronic Conditions
Older Adults	Older Adults

A member can be part of more than 1 population stream, though some population streams can be mutually exclusive to each other.

File Name

The name for the population stream data file follows the naming convention below:

*PlanName*_Population_Stream_YYYY_MM.csv

The file will be transferred via the ODM-MITS SFTP as a comma separated value (CSV) file.

Data Field Definitions and Submission Specifications

The fields in **Table 1** must be reported on the full replacement file.

Table 1: Data Field Definitions and Submission Specifications

Data Field	Definition	Submission Specifications	Field Type
Medicaid ID	Member's 12-digit Medicaid ID number	12-digit character format: 999999999999	Character
Eligibility Year Month	The reporting year and month for the member's enrollment.	Six-digit numeric year and month: YYYYMM	Numeric
Healthy Children	**Healthy Children:** Members that are between the ages of 1 and 20 years old and do not have a primary diagnosis of a behavioral health condition, chronic condition, or developmental disability per Appendix A diagnosis codes during a 2 year look back period from the reporting month. Member must also not be present on the Enhanced Maternal Care file.	1 if the member meets the requirements for this population stream or a 0 if they do not.	Numeric
Healthy Adults	**Healthy Adults:** Members that are age 21-64 and do not have a primary diagnosis of a behavioral health condition, or chronic condition per Appendix A diagnosis codes during a 2 year look back period from the reporting month. Member must also not be present on the Enhanced Maternal Care file.	1 if the member meets the requirements for this population stream or a 0 if they do not.	Numeric
Infants	**Infants:** Members that are less than 1 year of age.	1 if the member meets the requirements for this population stream or a 0 if they do not.	Numeric
WRA Non-High Risk	**Women of Reproductive Age – Non-High Risk:** Members that are female, between the ages 15 – 45, and are not present on the Enhanced Maternal Care file.	1 if the member meets the requirements for this population stream or a 0 if they do not.	Numeric
WRA High Risk	**Women of Reproductive Age – High Risk:** Members that are female, between the ages 15 – 45, and are present on the Enhanced Maternal Care file.	1 if the member meets the requirements for this population stream or a 0 if they do not.	Numeric
BH	**Behavioral Health Children:**	1 if the member meets the	Numeric

Children	Members between the ages of 1 and 20 that have had a Behavioral Health primary diagnosis or one of the SUD Medication-Assisted Treatment (MAT) NDC/CPT codes per Appendices A and B during a 2 year look back period from the reporting month.	requirements for this population stream or a 0 if they do not.	
BH Adults Non-SUD	**Behavioral Health Adults – Non-SUD:** Members that are age 21-64 that have had a primary diagnosis of a behavioral health condition and no primary diagnosis of SUD and no Medication-Assisted Treatment (MAT) NDC/CPT codes per Appendices A and B diagnosis codes during a 2 year look back period from the reporting month.	1 if the member meets the requirements for this population stream or a 0 if they do not.	Numeric
BH Adults SUD	**Behavioral Health Adults – SUD:** Members that are aged 21-64 and have had a primary diagnosis of SUD or one of the SUD Medication-Assisted Treatment (MAT) NDC/CPT codes per Appendices A and B during a 2 year look back period from the reporting month.	1 if the member meets the requirements for this population stream or a 0 if they do not.	Numeric
Children with CC	**Children with Chronic Conditions:** Members between the ages of 1 and 20 that have had a primary diagnosis of a chronic condition diagnosis per Appendix C diagnosis codes during a 2 year look back period from the reporting month.	1 if the member meets the requirements for this population stream or a 0 if they do not.	Numeric
Children with DD	**Children with Developmental Disabilities:** Members between the ages of 1 and 20 and meet any of the following criteria: • Member was enrolled on a DD Waiver (Benefit Plan was IO, L1, or SELF) or • Member received Targeted Care Management (Procedure code Z9999) or • Member received service from an ICF/IID (Provider Type Code 88 or 89) or	1 if the member meets the requirements for this population stream or a 0 if they do not.	Numeric

	• Member had a primary diagnosis of a developmental disability condition per Appendix A diagnosis codes during a 2 year look back period from the reporting month.		
Adults with CC	**Adults with Chronic Conditions:** Members that are age 21-64 that have had a primary diagnosis of a chronic condition per Appendix C diagnosis codes during a 2 year look back period from the reporting month.	1 if the member meets the requirements for this population stream or a 0 if they do not.	Numeric
Older Adults	**Older Adults:** Members that are age 65 or older.	1 if the member meets the requirements for this population stream or a 0 if they do not.	Numeric
OI Septile	Opportunity Index Septile Ranking: Opportunity Index septile ranking based on their census tract for the reporting month.	The Opportunity Index septile (1 – 7) assigned to the member (or blank if this field is empty).	Numeric
COI Septile	Children's Opportunity Index Septile Ranking: Children's Opportunity Index septile ranking if they are under the age of 18. This septile ranking is determined based on their census tract for the reporting month.	The Children's Opportunity Index septile (1 – 7) assigned to the member (or blank if this field is missing).	Numeric
Member Race Code	Race code associated with the member.	Place the corresponding number that matches the member's race: 7 – Not Provided 8 – Not Applicable A – Asian or Pacific Islander B – Black C – Caucasian D – Subcontinental Asian American E – Other Race or Ethnicity F – Asian Pacific American G – Native American H – Hispanic I – American Indian or Alaska Native J – Native Hawaiian N – Black (Non-Hispanic) O – Caucasian (Non-Hispanic) P – Pacific Islander	Character

<table>
<tr><td></td><td></td><td>Z – Mutually Defined
~ – Missing</td><td></td></tr>
<tr><td>Member Race</td><td>Race descriptions that are assigned using the member's race code.</td><td>Possible entries:
Asian
American Indian or Alaskan Native
Black
Native Hawaiian
Other
Unknown
White</td><td>Character</td></tr>
<tr><td>Member ZIP Code</td><td>The ZIP code for the members' current address for the reporting month.</td><td>5-digit ZIP code of the member's address.</td><td>Numeric</td></tr>
<tr><td>Member Census Tract</td><td>Member's 12-digit FIPS census tract ID for the reporting month.</td><td>FIPS census tract ID.</td><td>Character</td></tr>
<tr><td>Member County</td><td>Member's county of residence for the reporting month.</td><td>The member's county code is based on their current county of residence for the reporting month.<table><tr><th>County Code</th><th>County Name</th></tr><tr><td>01</td><td>Adams</td></tr><tr><td>02</td><td>Allen</td></tr><tr><td>03</td><td>Ashland</td></tr><tr><td>04</td><td>Ashtabula</td></tr><tr><td>05</td><td>Athens</td></tr><tr><td>06</td><td>Auglaize</td></tr><tr><td>07</td><td>Belmont</td></tr><tr><td>08</td><td>Brown</td></tr><tr><td>09</td><td>Butler</td></tr><tr><td>10</td><td>Carroll</td></tr><tr><td>11</td><td>Champaign</td></tr><tr><td>12</td><td>Clark</td></tr></table></td><td>Character</td></tr>
</table>

		13	Clermont	
		14	Clinton	
		15	Columbiana	
		16	Coshocton	
		17	Crawford	
		18	Cuyahoga	
		19	Darke	
		20	Defiance	
		21	Delaware	
		22	Erie	
		23	Fairfield	
		24	Fayette	
		25	Franklin	
		26	Fulton	
		27	Gallia	
		28	Geauga	
		29	Greene	
		30	Guernsey	
		31	Hamilton	
		32	Hancock	
		33	Hardin	
		34	Harrison	
		35	Henry	
		36	Highland	
		37	Hocking	
		38	Holmes	
		39	Huron	
		40	Jackson	

		41	Jefferson	
		42	Knox	
		43	Lake	
		44	Lawrence	
		45	Licking	
		46	Logan	
		47	Lorain	
		48	Lucas	
		49	Madison	
		50	Mahoning	
		51	Marion	
		52	Medina	
		53	Meigs	
		54	Mercer	
		55	Miami	
		56	Monroe	
		57	Montgomery	
		58	Morgan	
		59	Morrow	
		60	Muskingum	
		61	Noble	
		62	Ottawa	
		63	Paulding	
		64	Perry	
		65	Pickaway	
		66	Pike	
		67	Portage	
		68	Preble	

		69	Putnam	
		70	Richland	
		71	Ross	
		72	Sandusky	
		73	Scioto	
		74	Seneca	
		75	Shelby	
		76	Stark	
		77	Summit	
		78	Trumbull	
		79	Tuscarawas	
		80	Union	
		81	Van Wert	
		82	Vinton	
		83	Warren	
		84	Washington	
		85	Wayne	
		86	Williams	
		87	Wood	
		88	Wyandot	
		99	Other/Out of State	

N/A = not applicable.

Appendix A: Population Stream Code Sets

Behavioral Health Diagnosis Codes:

Value Set Name	Code Type	Codes
Any Behavioral Health conditions* * Includes but it not limited to any of the behavioral health conditions listed below	ICD-10	**substr(ICDDiag1,1,2):** 'F0', 'F2', 'F3', 'F4', 'F5', 'F6', 'F9', 'X7', 'X8' **substr(ICDDiag1,1,3):** 'F10', 'F11', 'F12', 'F13', 'F14', 'F15', 'F16', 'F18', 'F19', 'F84', 'F88' **substr(ICDDiag1,1,4):** 'Z915', 'R468', 'R450', 'R451', 'R452', 'R453', 'R454', 'R455', 'R456', 'R457' **substr(ICDDiag1,1,5):** 'R4581', 'R4582', 'R4585', 'R4586', 'R4587', 'R4588', 'R4589', 'Z7281', 'T1491', 'Z7281' **substr(ICDDiag1,1,6):** 'T71112', 'T71122', 'T71132', 'T71152', 'T71162', 'T71192', 'T71222', 'T71232'
ADHD	ICD-10	substr(ICDDiag1,1,3): 'F90'
Adjustment Disorders	ICD-10	substr(ICDDiag1,1,4): 'F432'
Autism	ICD-10	substr(ICDDiag1,1,3): 'F84'
Bipolar Disorder	ICD-10	substr(ICDDiag1,1,3): 'F31'
Conduct Disorder	ICD-10	substr(ICDDiag1,1,3): 'F91'
Major Depression	ICD-10	'F321', 'F322', 'F323', 'F331', 'F332', 'F333', 'F3341'
Mood Disorders	ICD-10	'F063', 'F0630', 'F0631', 'F0632', 'F0633', 'F0634', 'F3010', 'F3011', 'F3012', 'F3013', 'F302', 'F303', 'F304', 'F308', 'F309', 'F349', 'R4586'
Other Depression	ICD-10	'F328', 'F3289', 'F338', 'F32', 'F320', 'F324', 'F325', 'F329', 'F330', 'F334', 'F3340', 'F3342', 'F339'
Other Psychological	ICD-10	'F88', 'F89'
Personality Disorders	ICD-10	substr(ICDDiag1,1,3): 'F60'
PTSD	ICD-10	substr(ICDDiag1,1,4): 'F431'
Schizophrenia	ICD-10	substr(ICDDiag1,1,2): 'F2'
Self-Harm	ICD-10	substr(ICDDiag1,1,6): 'T71112', 'T71122', 'T71132', 'T71152', 'T71162', 'T71192', 'T71222', 'T71232'; substr(ICDDiag1,1,5): 'R4585', 'T1491'
SUD	ICD-10	'F11', 'F111', 'F1110', 'F1111', 'F1112', 'F11120', 'F11121', 'F11122', 'F11129', 'F1114', 'F11150', 'F11151', 'F11159', 'F1118', 'F11181', 'F11182', 'F11188', 'F1119', 'F112', 'F1120', 'F1121', 'F1122', 'F11220', 'F11221', 'F11222', 'F11229', 'F1123', 'F1124', 'F11250', 'F11251', 'F11259', 'F11281', 'F11282', 'F11288', 'F1129', 'F119', 'F1190', 'F11920', 'F11921', 'F11922', 'F11929', 'F1193', 'F1194', 'F11950', 'F11951', 'F11959', 'F11981', 'F11982',

		'F11988', 'F1199', 'F1010', 'F1011', 'F1012', 'F10120', 'F10121', 'F10129', 'F1014', 'F10150', 'F10151', 'F10159', 'F10180', 'F10181', 'F10182', 'F10188', 'F1019', 'F102', 'F1020', 'F1021', 'F10220', 'F10221', 'F10229', 'F10230', 'F10231', 'F10232', 'F10239', 'F1024', 'F10250', 'F10251', 'F10259', 'F1026', 'F1027', 'F10280', 'F10281', 'F10282', 'F10288', 'F1029', 'F109', 'F10920', 'F10921', 'F10929', 'F1094', 'F10950', 'F10951', 'F10959', 'F1096', 'F1097', 'F10980', 'F10981', 'F10982', 'F10988', 'F1099', 'F121', 'F1210', 'F1211', 'F12120', 'F12121', 'F12122', 'F12129', 'F12150', 'F12151', 'F12159', 'F12180', 'F12188', 'F1219', 'F1220', 'F1221', 'F12220', 'F12221', 'F12222', 'F12229', 'F1223', 'F12250', 'F12251', 'F12259', 'F12280', 'F12288', 'F1229', 'F1290', 'F12920', 'F12921', 'F12922', 'F12929', 'F12950', 'F12951', 'F12959', 'F12980', 'F12988', 'F1299', 'F1310', 'F1311', 'F13120', 'F13121', 'F13129', 'F1314', 'F13150', 'F13151', 'F13159', 'F13180', 'F13182', 'F13188', 'F1319', 'F1320', 'F1321', 'F13220', 'F13221', 'F13229', 'F13230', 'F13231', 'F13232', 'F13239', 'F1324', 'F13250', 'F13251', 'F13259', 'F1326', 'F1327', 'F13280', 'F13282', 'F13288', 'F1329', 'F1390', 'F13920', 'F13921', 'F13929', 'F13930', 'F13931', 'F13932', 'F13939', 'F1394', 'F13950', 'F13951', 'F13959', 'F1396', 'F1397', 'F13980', 'F13981', 'F13982', 'F13988', 'F1399', 'F1410', 'F1411', 'F1412', 'F14120', 'F14121', 'F14122', 'F14129', 'F1414', 'F14150', 'F14151', 'F14159', 'F14180', 'F14181', 'F14182', 'F14188', 'F1419', 'F1420', 'F1421', 'F1422', 'F14220', 'F14221', 'F14222', 'F14229', 'F1423', 'F1424', 'F14250', 'F14251', 'F14259', 'F14280', 'F14281', 'F14282', 'F14288', 'F1429', 'F149', 'F1490', 'F14920', 'F14921', 'F14922', 'F14929', 'F1494', 'F14950', 'F14951', 'F14959', 'F14980', 'F14981', 'F14982', 'F14988', 'F1499', 'F1510', 'F1511', 'F15120', 'F15121', 'F15122', 'F15129', 'F1514', 'F15150', 'F15151', 'F15159', 'F15180', 'F15181', 'F15182', 'F15188', 'F1519', 'F152', 'F1520', 'F1521', 'F15220', 'F15221', 'F15222', 'F15229', 'F1523', 'F1524', 'F15250', 'F15251', 'F15259', 'F15280', 'F15282', 'F15288', 'F1529', 'F1590', 'F15920', 'F15921', 'F15922', 'F15929', 'F1593', 'F1594', 'F15950', 'F15951', 'F15959', 'F15980', 'F15982', 'F15988', 'F1599', 'F1610', 'F1611', 'F16120', 'F16121', 'F16122', 'F16129', 'F1614', 'F16150', 'F16151', 'F16159', 'F16180', 'F16183', 'F16188', 'F1619',

		'F1620', 'F1621', 'F16220', 'F16221', 'F16229', 'F1624', 'F16250', 'F16251', 'F16259', 'F16280', 'F16283', 'F16288', 'F1629', 'F1690', 'F16920', 'F16921', 'F16929', 'F1694', 'F16950', 'F16951', 'F16959', 'F16980', 'F16983', 'F16988', 'F1699', 'F1810', 'F18120', 'F18121', 'F18129', 'F1814', 'F18150', 'F18159', 'F1817', 'F18180', 'F1819', 'F1820', 'F1821', 'F18220', 'F18221', 'F18229', 'F1824', 'F18251', 'F1827', 'F18280', 'F18288', 'F1890', 'F18920', 'F18921', 'F18929', 'F1894', 'F18959', 'F18980', 'F18988', 'F1899', 'F1910', 'F1911', 'F19120', 'F19121', 'F19122', 'F19129', 'F1914', 'F19150', 'F19151', 'F19159', 'F1916', 'F1917', 'F19180', 'F19181', 'F19182', 'F19188', 'F1919', 'F1920', 'F1921', 'F19220', 'F19221', 'F19222', 'F19229', 'F19230', 'F19231', 'F19232', 'F19239', 'F1924', 'F19250', 'F19251', 'F19259', 'F1926', 'F1927', 'F19280', 'F19282', 'F19288', 'F1929', 'F1990', 'F19920', 'F19921', 'F19922', 'F19929', 'F19930', 'F19931', 'F19932', 'F19939', 'F1994', 'F19950', 'F19951', 'F19959', 'F1996', 'F1997', 'F19980', 'F19981', 'F19982', 'F19988', 'F1999', 'F1015', 'F1018', 'F1022', 'F1023', 'F1025', 'F1092', 'F12', 'F1212', 'F1215', 'F1218', 'F122', 'F1222', 'F1228', 'F129', 'F1298', 'F13', 'F131', 'F1312', 'F132', 'F1325', 'F139', 'F1398', 'F14', 'F141', 'F1418', 'F142', 'F1425', 'F1428', 'F1495', 'F1498', 'F15', 'F151', 'F1522', 'F1525', 'F159', 'F1595', 'F161', 'F1612', 'F1618', 'F1622', 'F169', 'F1692', 'F181', 'F19', 'F191', 'F1912', 'F1915', 'F1918', 'F192', 'F1923', 'F1925', 'F1928', 'F199', 'F1995', 'F1998'
MAT – Methadone, Buprenorphine, Naltrexone, Disulfiram, and Acamprosate	CPT	'H0020', 'H0033', 'J0571','J0572','J0573','J0574','J0575', 'J2315','S0109', 'Q9991', 'Q9992'

Developmental Disabilities (DD) Diagnosis Codes:

Value Set Name	Code Type	Codes
Cerebral Palsy	ICD-10	'G800', 'G801', 'G802', 'G803', 'G804', 'G808', 'G809'
Intellectual Disabilities	ICD-10	'E7871', 'E7872', 'F70', 'F71', 'F72', 'F73', 'F78', 'F78A1', 'F78A9', 'F79', 'P043', 'Q860', 'Q871', 'Q8711', 'Q8719', 'Q872', 'Q873', 'Q875', 'Q8781', 'Q8789', 'Q897', 'Q898', 'Q900', 'Q901', 'Q902', 'Q909', 'Q910', 'Q911', 'Q912', 'Q913', 'Q914', 'Q915', 'Q916', 'Q917', 'Q920', 'Q921', 'Q922',

		'Q925', 'Q9261', 'Q9262', 'Q927', 'Q928', 'Q929', 'Q930', 'Q931', 'Q932', 'Q933', 'Q934', 'Q935', 'Q9351', 'Q9359', 'Q937', 'Q9381', 'Q9388', 'Q9389', 'Q939', 'Q952', 'Q953', 'Q992'
Learning Disabilities	ICD-10	'F800', 'F801', 'F802', 'F804', 'F8081', 'F8082', 'F8089', 'F809', 'F810', 'F812', 'F8181', 'F8189', 'F819', 'F82', 'H9325', 'R480'
Other Developmental Delays	ICD-10	'F819', 'F82'

Medication-Assisted Treatment (MAT) NDC Codes:

See separate Appendix B Excel file for the NDC codes used for identifying members receiving MAT.

Chronic Conditions (CC) Diagnosis Codes:

See separate Appendix C Excel file for the code sets used for Chronic Conditions.

ODM followed the Center for Disease Control and Prevention (CDC)'s definition of chronic condition which defines chronic diseases as "conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both."

The list of chronic conditions includes codes from the Agency for Healthcare Research and Quality (AHRQ) grouper and select clinical conditions that were defined by Merative. ODM has removed codes from the Merative clinical conditions list based on the following logic:

1. Conditions that referenced "A history of…" were removed.
2. Conditions that were described as "unspecified", "not elsewhere specified/NEC", or "other" were removed.
3. Conditions that referenced an acute chronic condition were removed.

Appendix H: References

2024 MCO Report Card (2024). Available online at: MCO Report Card Released | Medicaid

Combo 2. 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).

Combo 3. Combination 3 includes the vaccines for Combination 2 along with four pneumococcal conjugates (PCV).

Government Publishing Office (August 2024). Special contract provision related to payment. 42 CFR 438.6. Available online at: eCFR :: 42 CFR 438.6 -- Special contract provisions related to payment.

Health Plan HEDIS Report (2019). Ohio Department of Medicaid Health Plan HEDIS Report. 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. Available online at: Health Plan HEDIS Report | Medicaid

Iams, J.D., Applegate, M.S., Marcotte, M.P., et al. (2017). A Statewide Progestogen Promotion Program in Ohio. *Obstet Gynecol*;129(2):337-34

Institute for Healthcare Improvement (IHI) (2024a). The Model for Improvement. Available online at: How to Improve: Model for Improvement | Institute for Healthcare Improvement

Institute for Healthcare Improvement (IHI) (2024b). Driver Diagram. Available online at: http://www.ihi.org/resources/Pages/Tools/Driver-Diagram.aspx

Langley, G.L., Moen, R., Nolan, K.M., Nolan, T.W., Norman, C.L., & Provost, L.P. (2009). The Improvement Guide: A Practical Approach to Enhancing Organizational Performance (2nd Edition). San Francisco: Jossey-Bass Publishers.

McPherson, M., Arango, P., Fox, H., Lauver, C., McManus, M., Newacheck, P.W., Perrin, J.M., Shonkoff, J.P., Strickland, B. (1998). 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.

Ohio Department of Medicaid (2016). *Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly*. 2016. Available online at: http://medicaid.ohio.gov/portals/0/resources/reports/annual/group-viii-assessment.pdf

Ohio Department of Medicaid Ohio Medicaid Provider Agreement for Managed Care Organization (2024a). Appendix B – Coverage and Services. Available online at: 2024_11_MCO_final_amendment.pdf

Ohio Department of Medicaid Ohio Medicaid Provider Agreement for Managed Care Organization (2024b). Appendix P – Chart of Deliverables. Available online at: 2024_11_MCO_final_amendment.pdf

Ohio Department of Medicaid Ohio Medicaid Provider Agreement for Managed Care Organization (2024c). Appendix G – Additional Reporting Requirements. Available online at: 2024_11_MCO_final_amendment.pdf

Ohio Opportunity Index (OOI) (2024). Ohio College of Medicine Government Resource Center. Available online at: Ohio Opportunity Index | Ohio Colleges of Medicine Government Resource Center

Olin, S.S., Freed, G.L., Scholle, S.H., & Applegate, M.S. (2021). Aligning To Improve Pediatric Healthcare Quality, Academic Pediatrics (2021), doi: https://doi.org/10.1016/j.acap.2021.08.021.

Pre-Release Enrollment Program (MPRE). 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.

Swensen, S., Pugh, M., McMullan, C., & Kabcenell, A. (2013). High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement. Available online at: ihi.org