

**THE OHIO DEPARTMENT OF MEDICAID
MYCARE OHIO PROVIDER AGREEMENT
FOR MYCARE OHIO PLAN**

This Provider Agreement (herein Provider Agreement or Agreement) is entered into between the State of Ohio, The Ohio Department of Medicaid, (hereinafter referred to as ODM) whose principal offices are located in the City of Columbus, County of Franklin, State of Ohio, and INSERT CORPORATE NAME, MyCare Ohio Plan (hereinafter referred to as MCOP), an Ohio corporation, whose principal office is located in the city of INSERT CITY, County of INSERT COUNTY, State of Ohio.

The MCOP is licensed as a Health Insuring Corporation by the State of Ohio, Department of Insurance (hereinafter referred to as ODI), pursuant to Chapter 1751 of the Ohio Revised Code (ORC) and is organized and agrees to operate as prescribed by Chapter 5160-58 of the Ohio Administrative Code (OAC), and other applicable portions of the OAC as amended from time to time.

The MCOP is an entity eligible to enter into a provider agreement in accordance with 42 CFR (Code of Federal Regulations) 438.6 and is engaged in the business of providing comprehensive health care services as defined in 42 CFR 438.2 through the managed care program for the Medicaid-Medicare eligible population described in OAC rule 5160-58-02(A) and any other Medicaid eligible populations authorized by the Centers for Medicare and Medicaid Services (CMS).

The goal of MyCare Ohio is for MCOPs to manage the full continuum of Medicare and Medicaid benefits for their members, providing coordination of long-term care services, behavioral health services, and physical health services. Each MCOP has entered into a Three-Way Contract (Three-Way) with the United States Department of Health and Human Services Centers for Medicare & Medicaid Services and ODM. The Three-Way, which is incorporated as if rewritten herein sets forth comprehensive requirements for MCOPs regarding program operation, enforcement, monitoring and oversight. If an express conflict exists between the Three-Way and this Agreement, the Three-Way controls

Dual benefits members, also known as opt-in members, are defined in Ohio Adm. Code 5160-58-01 as individuals enrolled in an MCOP for whom the MCOP is responsible for the coordination and payment of both Medicare and Medicaid benefits. Medicaid-only members, also known as opt-out members, are defined in Ohio Adm. Code 5160-58-01 to include individuals enrolled in an MCOP for whom the MCOP is responsible for coordination and payment of only Medicaid benefits. This Agreement applies to both dual benefits members and Medicaid-only members, unless otherwise specified herein.

ODM, as the single state agency designated to administer the Medicaid program under Section 5162.03 of the ORC and Title XIX of the Social Security Act, desires to obtain MCOP services for the benefit of certain Medicaid recipients. In so doing, the MCOP has provided and will

continue to provide proof of the MCOP's capability to provide quality services, efficiently, effectively and economically during the term of this Agreement.

This Provider Agreement is a contract between ODM and the undersigned MCOP, provider of medical assistance, pursuant to the federal contracting provisions of 42 CFR 434.6 and 438.6 in which the MCOP agrees to provide comprehensive Medicaid services through the managed care program as provided in Chapter 5160-58 of the OAC, assuming the risk of loss, and at all times complying with federal and state laws and regulations, federal and state Medicaid program requirements, and other requirements as specified by ODM. This includes without limitation Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

ARTICLE I - GENERAL

- A. ODM enters into this Agreement in reliance upon the MCOP's representations that it has the necessary expertise and experience to perform its obligations hereunder, and the MCOP represents and warrants that it does possess such necessary expertise and experience.
- B. The MCOP agrees to communicate with the Chief of the Bureau of Managed Care (BMC) (hereinafter referred to as BMC) or his or her designee as necessary in order for the MCOP to assure its understanding of the responsibilities and satisfactory compliance with this Provider Agreement.
- C. The MCOP agrees to furnish its staff and services as necessary for the satisfactory performance of the services as enumerated in this Provider Agreement.
- D. ODM may, from time to time as it deems appropriate, communicate specific instructions and requests to the MCOP concerning the performance of the services described in this Provider Agreement. Upon such notice and within the designated time frame after receipt of instructions, the MCOP shall comply with such instructions and fulfill such requests to the satisfaction of the department. It is expressly understood by the parties that these instructions and requests are for the sole purpose of performing the specific tasks requested to ensure satisfactory completion of the services described in this Provider Agreement, and are not intended to amend or alter this Provider Agreement or any part thereof.

ARTICLE II - TIME OF PERFORMANCE

- A. Upon approval by the Director of ODM this Provider Agreement shall be in effect from the date executed and shall run concurrently with the Three-Way, including any permissible renewals pursuant to Section 5.7 of the Three-Way, unless this Provider Agreement is suspended or terminated pursuant to Article VIII prior to the termination date.

ARTICLE III - REIMBURSEMENT

- A. ODM will reimburse the MCOP in accordance with the terms of this Agreement or OAC, as applicable.

ARTICLE IV - RELATIONSHIP OF PARTIES

- A. ODM and the MCOP agree that, during the term of this Agreement, the MCOP shall be engaged with ODM solely on an independent contractor basis, and neither the MCOP nor its personnel shall, at any time or for any purpose, be considered as agents, servants or employees of ODM or the state of Ohio. The MCOP shall therefore be responsible for all the MCOP's business expenses, including, but not limited to, employee's wages and salaries, insurance of every type and description, and all business and personal taxes, including income and Social Security taxes and contributions for Workers' Compensation and Unemployment Compensation coverage, if any.
- B. The MCOP agrees to comply with all applicable federal, state, and local laws in the conduct of the work hereunder.
- C. ODM retains the right to ensure that the MCOP's work is in conformity with the terms and conditions of this Agreement.
- D. Except as expressly provided herein, neither party shall have the right to bind or obligate the other party in any manner without the other party's prior written consent.

ARTICLE V - CONFLICT OF INTEREST; ETHICS LAWS

- A. In accordance with the safeguards specified in section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423) and other applicable federal requirements, no officer, member or employee of the MCOP, the Chief of BMC, or other ODM employee who exercises any functions or responsibilities in connection with the review or approval of this Provider Agreement or provision of services under this Provider Agreement shall, prior to the completion of such services or reimbursement, acquire any interest, personal or otherwise, direct or indirect, which is incompatible or in conflict with, or would compromise in any manner or degree the discharge and fulfillment of his or her functions and responsibilities with respect to the carrying out of such services. For purposes of this article, "members" does not include individuals whose sole connection with the MCOP is the receipt of services through a health care program offered by the MCOP.
- B. The MCOP represents, warrants, and certifies that it and its employees engaged in the administration or performance of this Agreement are knowledgeable of and understand the Ohio Ethics and Conflicts of Interest laws. The MCOP further represents, warrants, and certifies that neither the MCOP nor any of its employees will do any act or omit any action that is inconsistent with such laws.

- C. The MCOP hereby covenants that the MCOP, its officers, members and employees of the MCOP, shall not, prior to the completion of the work under this Agreement, voluntarily acquire any interest, personal or otherwise, direct or indirect, which is incompatible or in conflict with or would compromise in any manner of degree the discharge and fulfillment of his or her functions and responsibilities under this Provider Agreement. The MCOP shall periodically inquire of its officers, members and employees concerning such interests.
- D. Any such person who acquires an incompatible, compromising or conflicting personal or business interest, on or after the effective date of this Agreement, or who involuntarily acquires any such incompatible or conflicting personal interest, shall immediately disclose his or her interest to ODM in writing. Thereafter, he or she shall not participate in any action affecting the services under this Provider Agreement, unless ODM shall determine in its sole discretion that, in the light of the personal interest disclosed, his or her participation in any such action would not be contrary to the public interest. The written disclosure of such interest shall be made to: Chief, BMC, ODM.
- E. No officer, member or employee of the MCOP shall promise or give to any ODM employee anything of value that is of such a character as to manifest a substantial and improper influence upon the employee with respect to his or her duties. The MCOP, along with its officers, members and employees, understand and agree to take no action, or cause ODM or its employees to take any action, which is inconsistent with the applicable Ohio ethics and conflict of interest laws including without limitation those provisions found in Chapter 102 and Chapter 2921 of the ORC.
- F. The MCOP hereby covenants that the MCOP, its officers, members and employees are in compliance with section 102.04 of the ORC and that if MCOP is required to file a statement pursuant to 102.04(D)(2) of the ORC, such statement has been filed with the ODM in addition to any other required filings.

ARTICLE VI - NONDISCRIMINATION OF EMPLOYMENT

- A. The MCOP agrees that in the performance of this Provider Agreement or in the hiring of any employees for the performance of services under this Provider Agreement, the MCOP shall not by reason of race, color, religion, gender, sexual orientation, age, disability, national origin, military status, health status, genetic information or ancestry, discriminate against any individual in the employment of an individual who is qualified and available to perform the services to which the Provider Agreement relates.
- B. The MCOP agrees that it shall not, in any manner, discriminate against, intimidate, or retaliate against any employee hired for the performance or services under the Provider Agreement on account of race, color, religion, gender, sexual orientation, age, disability, national origin, military status, health status, genetic information or ancestry.
- C. In addition to requirements imposed upon subcontractors in accordance with OAC Chapter 5160-58, the MCOP agrees to hold all subcontractors and persons acting on behalf of the

MCOP in the performance of services under this Provider Agreement responsible for adhering to the requirements of paragraphs (A) and (B) above and shall include the requirements of paragraphs (A) and (B) above in all subcontracts for services performed under this Provider Agreement, in accordance with OAC rules 5160-58-01.1 and 5160-26-05.

ARTICLE VII - RECORDS, DOCUMENTS AND INFORMATION

- A. The MCOP agrees that all records, documents, writings or other information produced by the MCOP under this Provider Agreement and all records, documents, writings or other information used by the MCOP in the performance of this Provider Agreement shall be treated in accordance with OAC rules 5160-58-01.1 and 5160-26-06 and must be provided to ODM, or its designee, if requested. The MCOP must maintain an appropriate record system for services provided to members. The MCOP must retain all records in accordance with 45 CFR 74.53.
- B. All information provided by the MCOP to ODM that is proprietary shall be held to be strictly confidential by ODM. Proprietary information is information which, if made public, would put the MCOP at a disadvantage in the market place and trade of which the MCOP is a part [see ORC Section 1333.61(D)]. The MCOP agrees to expressly indicate by marking the top or bottom of each individual record containing information the MCOP deems proprietary or trade secret, regardless of media type (CD-ROM, Excel file etc.) prior to its release to ODM. Upon request from ODM, the MCOP agrees to promptly notify ODM in writing of the nature of the proprietary information including all reasonable evidence regarding the nature of the proprietary information in records submitted to ODM. The MCOP also agrees to provide for the legal defense of all proprietary information submitted to ODM. ODM shall promptly notify the MCOP in writing or via email of the need to legally defend the proprietary information such that the MCOP is afforded the opportunity to adequately defend such information. Failure to provide such prior notification or failure to legally defend the proprietary nature of such information is deemed to be a waiver of the proprietary nature of the information, and a waiver of any right of the MCOP to proceed against ODM for violation of this Provider Agreement or of any proprietary or trade secret laws. Such failure shall also be deemed a waiver of trade secret protection in that the MCOP will have failed to make efforts that are reasonable under the circumstances to maintain the information's secrecy. ODM will make the final determination of whether any or all of the information identified by the MCOP is proprietary or a trade secret. The provisions of this Article are not self-executing.
- C. The MCOP shall not use any information, systems, or records made available to it for any purpose other than to fulfill the duties specified in this Provider Agreement. The MCOP agrees to be bound by the same standards of confidentiality that apply to the employees of ODM and the State of Ohio, including without limitation the confidentiality requirements found in 42 CFR Part 431 Subpart F and ORC 5160.45, as well as 42 C.F.R. 2.12 and ORC 5119.27, as applicable. The terms of this section shall be included in any subcontracts executed by the MCOP for services under this Provider Agreement. The MCOP must

implement procedures to ensure that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164.

- D. The MCOP agrees, certifies and affirms that HHS, US Comptroller General or representatives will have access to books, documents, and other business records of the MCOP.
- E. All records relating to performance, under or pertaining to this Provider Agreement will be retained by the MCOP in accordance to the appropriate records retention schedule. The appropriate records retention schedule for this Provider Agreement is for a total period of eight (8) years. For the initial three (3) years of the retention period, the records must be stored in a manner and place that provides readily available access. If any records are destroyed prior to the date as determined by the appropriate records retention schedule, the MCOP agrees to pay to ODM all damages, costs, and expenses incurred by ODM associated with any cause, action or litigation arising from such destruction.
- F. The MCOP agrees to retain all records in accordance with any litigation holds that are provided to them by ODM, and actively participate in the discovery process if required to do so, at no additional charge. Litigation holds may require the MCOP to keep the records longer than the approved records retention schedule. The MCOP will be notified by ODM when the litigation hold ends and retention can resume based on the approved records retention schedule. If the MCOP fails to retain the pertinent records after receiving a litigation hold from ODM, the MCOP agrees to pay to ODM all damages, costs and expenses incurred by ODM associated with any cause, action or litigation arising from such destruction.
- G. The MCOP shall promptly notify ODM of any legal matters and administrative proceedings including, but not limited to, litigation and arbitration, which involve or otherwise pertain to the activities performed pursuant to this Provider Agreement and any third party. In the event that the MCOP possesses or has access to information and/or documentation needed by ODM with regard to the above, the MCOP agrees to cooperate with ODM in gathering and providing such information and/or documentation to the extent permissible under applicable law.

ARTICLE VIII - NONRENEWAL AND TERMINATION

- A. This Provider Agreement may be terminated, pursuant to Section 5.5 of the Three-Way or by ODM or the MCOP upon written notice in accordance with the applicable rule(s) of the OAC, with termination to occur at the end of the last day of the termination month. If the Three-Way is terminated, and ODM decides to enter into a new Provider Agreement with the MCOP, MCOP shall be required to enter into a new Provider Agreement with ODM that shall begin the day after the termination of the Three-Way. By executing this Agreement, MCOP expressly agrees to be bound by this provision of the Agreement. If the option to enter into a new Provider Agreement per this Section is exercised, the MCOP

will be provided a copy of the proposed new Provider Agreement for review prior to execution. The terms of the new Provider Agreement will not be unconscionable or capricious and the parties agree to negotiate in good faith.

- B. Subsequent to receiving a notice of termination from ODM, the MCOP beginning on the effective date of the termination, shall cease provision of services on the terminated activities under this Provider Agreement; terminate all subcontracts relating to such terminated activities, take all necessary or appropriate steps to limit disbursements and minimize costs, and comply with the requirements specified in this Provider Agreement, as of the date of receipt of notice of termination describing the status of all services under this Provider Agreement.
- C. In the event of termination under this Article, the MCOP shall be entitled to request reconciliation of reimbursements through the final month for which services were provided under this Provider Agreement, in accordance with the reimbursement provisions of this Provider Agreement. The MCOP agrees to waive any right to, and shall make no claim for, additional compensation against ODM by reason of such suspension or termination.
- D. In the event of termination under this Article, MCOP shall return all records in their native format relating to cost, work performed, supporting documentation for invoices submitted to ODM, and copies of all materials produced under or pertaining to this Provider Agreement.
- E. ODM may, in its sole discretion, terminate or fail to renew this Provider Agreement if the MCOP or MCOP's subcontractors violate or fail to comply with the provisions of this Agreement or other provisions of law or regulation governing the Medicaid program. Where ODM proposes to terminate or refuse to enter into a provider agreement, the provisions of applicable sections of the OAC with respect to ODM's suspension, termination or refusal to enter into a provider agreement may apply Pursuant to ORC 5164.38, the MCOP does not have the right to request an adjudication hearing under Chapter 119 of the ORC to challenge any action taken or decision made by ODM with respect to entering into or refusing to enter into a provider agreement with the MCOP pursuant to section 5167.10 of the Revised Code.
- F. The MCOP understands that availability of funds to fulfill the terms of this Provider Agreement is contingent on appropriations made by the Ohio General Assembly and the United States government for funding the Medicaid program. If sufficient funds are not available from the Ohio General Assembly or the United States government to make payments on behalf of a specific population (Aged, Blind, Disabled, Covered Families and Children, or Adult Extension) to fulfill the terms of this Provider Agreement, the obligations, duties and responsibilities of the parties with respect to that population will be terminated except as specified in Appendix P as of the date funding expires. If the Ohio General Assembly or the United States government fails at any time to provide

sufficient funding for ODM or the State of Ohio to make payments due under this Provider Agreement, this Provider Agreement will terminate as of the date funding expires without further obligation of ODM or the State of Ohio.

ARTICLE IX - AMENDMENT AND RENEWAL

- A. This Provider Agreement may be amended only by a writing signed by both parties. Any written amendments to this Provider Agreement shall be prospective in nature.
- B. In the event that changes in state or federal law, regulations, an applicable waiver or state plan amendment, or the terms and conditions of any applicable federal waiver or state plan amendment, require ODM to modify this Agreement, ODM shall notify the MCOP regarding such changes and this Agreement shall be automatically amended to conform to such changes without the necessity for executing written amendments pursuant to this Article of this Agreement.

ARTICLE X - LIMITATION OF LIABILITY

- A. The MCOP agrees to indemnify and to hold ODM and the state of Ohio harmless and immune from any and all claims for injury or damages resulting from the actions or omissions of the MCOP in the fulfillment of this Provider Agreement or arising from this Agreement which are attributable to the MCOP's own actions or omissions, or of those of its trustees, officers, employees, agents, subcontractors, suppliers, third parties utilized by the MCOP, or joint ventures'. Such claims shall include but are not limited to: any claims made under the Fair Labor Standards Act or under any other federal or state law involving wages, overtime, or employment matters and any claims involving patents, copyrights, trademarks and applicable public records laws. The MCOP shall bear all costs associated with defending ODM and the state of Ohio against these claims.
- B. The MCOP hereby agrees to be liable for any loss of federal funds suffered by ODM for enrollees resulting from specific, negligent acts or omissions of the MCOP or its subcontractors during the term of this Agreement, including but not limited to the nonperformance of the duties and obligations to which the MCOP has agreed under this Agreement.
- C. In the event that, due to circumstances not reasonably within the control of the MCOP or ODM, a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection occurs, neither ODM nor the MCOP will have any liability or obligation on account of reasonable delay in the provision or the arrangement of covered services; provided that so long as the MCOP's Certificate of Authority remains in full force and effect, the MCOP shall be liable for the covered services required to be provided or arranged for in accordance with this Agreement.
- D. In no event shall ODM be liable for indirect, consequential, incidental, special or punitive damages, or lost profits.

ARTICLE XI - ASSIGNMENT

- A. ODM will not allow the transfer of Medicaid members by one MCOP to another entity without the express prior written approval of ODM. Even with ODM's prior written approval, ODM reserves the right to offer such members the choice of MCOPs outside the normal open enrollment process and implement an assignment process as ODM determines is appropriate. MCOPs shall not assign any interest in this Provider Agreement and shall not transfer any interest in the same (whether by assignment or novation) without the prior written approval of ODM and subject to such conditions and provisions as ODM may deem necessary. No such approval by ODM of any assignment shall be deemed in any event or in any manner to provide for the incurrence of any obligation by ODM in addition to the total agreed-upon reimbursement in accordance with this Agreement. Any member transfer and/or assignments of interest shall be submitted for ODM's review 120 days prior to the desired effective date. ODM shall use reasonable efforts to respond to any such request for approval within the 120 day period. Failure of ODM to act on a request for approval within the 120 day period does not act as an approval of the request. ODM may require a receiving MCOP to successfully complete a readiness review process before the transfer of members or obligations under this Agreement.

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

ARTICLE XII - CERTIFICATION MADE BY THE MCOP

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

- B. The MCOP certifies that no federal funds paid to the MCOP through this or any other Agreement with ODM shall be or have been used to lobby Congress or any federal agency in connection with a particular contract, grant, cooperative agreement or loan. The MCOP further certifies its continuing compliance with applicable lobbying restrictions contained in 31 U.S.C. 1352 and 45 CFR Part 93. If this Agreement exceeds \$100,000, the MCOP has executed the Disclosure of Lobbying Activities, Standard Form LLL, if required by federal regulations. This certification is material representation of fact upon which reliance was placed when this Provider Agreement was entered into.

- C. The MCOP certifies that neither the MCOP nor any principals of the MCOP (i.e., a director, officer, partner, or person with beneficial ownership of more than 5% of the MCOP's equity) is presently debarred, suspended, proposed for debarment, declared ineligible, or otherwise excluded from participation in transactions by any Federal agency. The MCOP also certifies that it is not debarred from consideration for contract awards by the Director of the Department of Administrative Services, pursuant to either ORC Section 153.02 or ORC Section 125.25. The MCOP also certifies that the MCOP has no employment, consulting or any other arrangement with any such debarred or suspended person for the provision of items or services or services that are significant and material to the MCOP's contractual obligation with ODM. This certification is a material representation of fact upon which reliance was placed when this Provider Agreement was entered into. Federal financial participation (FFP) is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP, except for emergency services. If it is ever determined that the MCOP knowingly executed this certification erroneously, then in addition to any other remedies, this Provider Agreement shall be terminated pursuant to Article VIII, and ODM must advise the Secretary of the appropriate federal agency of the knowingly erroneous certification.
- D. The MCOP certifies that the MCOP is not on the most recent list established by the Secretary of State, pursuant to Section 121.23 of the ORC, which identifies the MCOP as having more than one unfair labor practice contempt of court finding. This certification is a material representation of fact upon which reliance was placed when this Provider Agreement was entered into.
- E. The MCOP agrees not to discriminate against individuals who have or are participating in any work program administered by a County Department of Job and Family Services (CDJFS) under Chapters 5101 or 5107 of the ORC.
- F. The MCOP certifies and affirms that, as applicable to the MCOP, that no party listed or described in Division (I) or (J) of Section 3517.13 of the ORC who was in a listed position at the time of the contribution, has made as an individual, within the two previous calendar years, one or more contributions in excess of one thousand and 00/100 (\$1,000.00) to the present governor or to the governor's campaign committees during any time he/she was a candidate for office. This certification is a material representation of fact upon which reliance was placed when this Provider Agreement was entered into. If it is ever determined that the MCOP's certification of this requirement is false or misleading, and not withstanding any criminal or civil liabilities imposed by law, the MCOP shall return to ODM all monies paid to the MCOP under this Provider Agreement. The provisions of this section shall survive the expiration or termination of this Provider Agreement.
- G. The MCOP agrees to refrain from promising or giving to any ODM employee anything of value that is of such a character as to manifest a substantial and improper influence upon the employee with respect to his or her duties.
- H. The MCOP agrees to comply with the false claims recovery requirements of 42 U.S.C

1396a(a)(68) and to also comply with ORC 5162.15.

- I. The MCOP, its officers, employees, members, any subcontractors, and/or any independent contractors (including all field staff) associated with this Agreement agree to comply with all applicable state and federal laws regarding a smoke-free and drug-free workplace. The MCOP will make a good faith effort to ensure that all MCOP officers, employees, members, and subcontractors will not purchase, transfer, use or possess illegal drugs or alcohol, or abuse prescription drugs in any way while performing their duties under this Agreement.
- J. The MCOP certifies and confirms that any performance of experimental, developmental, or research work shall provide for the rights of the Federal Government and the recipient in any resulting invention.
- K. The MCOP certifies and confirms that it agrees to comply with all applicable standards orders or regulations of the Clean Air Act and Federal Water Pollution Control Act.
- L. The MCOP agrees that it is in compliance with the Federal Acquisition Regulation (FAR) for Combatting Trafficking in Persons, 48 CFR Subpart 22.17, in which “the United States Government has adopted a zero tolerance policy regarding trafficking in persons.” The provisions found in 48 CFR Subpart 52.2, specifically Subpart 52.222-50 are hereby incorporated into this Agreement by reference. ODM reserves the right to immediately and unilaterally terminate this Agreement if any provision in this Section is violated and ODM may implement section 106(g) of the Trafficking Victims Protection Act of 2000, as amended (22 USC 7104), *see* 2 CFR Part 175.

ARTICLE XIII - CONSTRUCTION

- A. This Agreement shall be governed, construed and enforced in accordance with the laws and regulations of the state of Ohio and appropriate federal statutes and regulations. The provisions of this Agreement are severable and independent, and if any such provision shall be determined to be unenforceable, in whole or in part, the remaining provisions and any partially enforceable provision shall, to the extent enforceable in any jurisdiction, nevertheless be binding and enforceable.

ARTICLE XIV - INCORPORATION BY REFERENCE

- A. OAC Chapter 5160-58, the Three-Way, and the MyCare Ohio Compliance Methodology document (Compliance Methodology) are hereby incorporated by reference as part of this Provider Agreement having the full force and effect as if specifically restated herein.
- B. Appendices A through Q and any additional appendices are hereby incorporated by reference as part of this Provider Agreement having the full force and effect as if

specifically restated herein. Appendix P and any other applicable obligations set forth in this Provider Agreement will survive the termination or non-renewal of this Agreement.

- C. In the event of inconsistency or ambiguity between the provisions of OAC Chapter 5160-58, and this Agreement, the provisions of OAC Chapter 5160-58 shall be determinative of the obligations of the parties unless such inconsistency or ambiguity is the result of changes in federal or state law, pursuant to the order of precedence established in Section 5.6 of the Three-Way. In the event OAC Chapter 5160-58 is silent with respect to any ambiguity or inconsistency, the Agreement (including Appendices B through Q and any additional appendices), shall be determinative of the obligations of the parties, unless otherwise stated herein. In the event that a dispute arises which is not addressed in any of the aforementioned documents, the parties agree to make every reasonable effort to resolve the dispute, in keeping with the objectives of the Provider Agreement and the budgetary and statutory constraints of ODM.

ARTICLE XV – NOTICES

All notices, consents, and communications hereunder shall be given in writing, shall be deemed to be given upon receipt thereof, and shall be sent to the addresses first set forth below.

ARTICLE XVI – HEADINGS

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

The parties have executed this Agreement as of the date signed by the ODM Director. The Agreement is hereby accepted and considered binding in accordance with the terms and conditions set forth in the preceding statements.

INSERT MCOP NAME

BY: _____
INSERT TITLE

DATE: _____

INSERT ADDRESS

THE OHIO DEPARTMENT OF MEDICAID:

BY: _____
JOHN B. MCCARTHY, MEDICAID DIRECTOR

DATE: _____

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

**Ohio Department of Medicaid (ODM)
MyCare Ohio Provider Agreement
Table of Contents**

<u>APPENDIX</u>	<u>TITLE</u>
APPENDIX A	OAC RULES CHAPTERS 5160-58 & 5160-26
APPENDIX B	SERVICE AREA SPECIFICATIONS
APPENDIX C	MYCARE OHIO PLAN RESPONSIBILITIES
APPENDIX D	ODM RESPONSIBILITIES
APPENDIX E	RATE METHODOLOGY
APPENDIX F	INTENTIONALLY BLANK
APPENDIX G	COVERAGE AND SERVICES
APPENDIX H	PROVIDER PANEL SPECIFICATIONS
APPENDIX I	PROGRAM INTEGRITY
APPENDIX J	FINANCIAL PERFORMANCE
APPENDIX K	QUALITY CARE
APPENDIX L	DATA QUALITY
APPENDIX M	QUALITY MEASURES AND STANDARDS
APPENDIX N	MYCARE OHIO COMPLIANCE ASSESSMENT SYSTEM
APPENDIX O	QUALITY WITHHOLDS
APPENDIX P	MYCARE OHIO PLAN TERMINATIONS/NONRENEWALS
APPENDIX Q	PAYMENT REFORM

APPENDIX A

ODM RULES, OAC CHAPTERS 5160-58 AND 5160-26

The MyCare Ohio managed care program rules can be accessed electronically through the Managed Care page of the Ohio Department of Medicaid website.

APPENDIX B

SERVICE AREA SPECIFICATIONS

MY CARE OHIO PLAN:

The MyCare Ohio Plan agrees to provide Medicaid services to individuals dually eligible for Medicare and Medicaid pursuant to OAC rule 5160-58-02 residing in the following service area(s):

Service Area Regions

- | | |
|-------------------|--------------------------|
| Central | <input type="checkbox"/> |
| East Central | <input type="checkbox"/> |
| Northeast | <input type="checkbox"/> |
| Northeast Central | <input type="checkbox"/> |
| Northwest | <input type="checkbox"/> |
| West Central | <input type="checkbox"/> |
| Southwest | <input type="checkbox"/> |

*The MyCare Ohio Plan must serve all counties in any region they agree to serve. See the next page for a list of counties in each service area region.

OHIO MY CARE OHIO PLAN SERVICE AREA REGIONS BY COUNTY

The MyCare Ohio Program consists of 29 counties grouped into seven service area regions identified below.

Counties in Central: Delaware, Franklin, Madison, Pickaway, and Union counties

Counties in East Central: Portage, Stark, Summit, and Wayne counties

Counties in Northeast: Cuyahoga, Geauga, Lake, Lorain, and Medina counties

Counties in Northeast Central: Columbiana, Mahoning, and Trumbull counties

Counties in Northwest: Fulton, Lucas, Ottawa, and Wood counties

Counties in West Central: Clark, Greene, and Montgomery counties

Counties in Southwest: Butler, Clermont, Clinton, Hamilton, and Warren counties

APPENDIX C

MYCARE OHIO PLAN RESPONSIBILITIES

The following are MyCare Ohio Plan (MCOP) responsibilities that are not otherwise specifically stated in OAC rule provisions or elsewhere in the MCOP provider agreement, but are required by the Ohio Department of Medicaid (ODM).

1. The MCOP agrees to implement program modifications as soon as reasonably possible or no later than the required effective date, in response to changes in applicable state and federal laws and regulations.
2. The MCOP must submit a current copy of its Certificate of Authority (COA) to ODM within 30 days of issuance by the Ohio Department of Insurance (ODI).
3. The MCOP must designate the following:
 - a. A primary contact person, the Contract Compliance Officer, as specified in Sections 2.2.2.1 and 2.2.3.4.1.3 of the Three-Way Contract between MCOP, CMS and ODM (Three-Way), who will dedicate a majority of his or her time to the MyCare Ohio (Medicaid-Medicare) product line and coordinate overall communication between ODM and the MCOP. ODM may also require the MCOP to designate contact staff for specific program areas. The Contract Compliance Officer will be responsible for ensuring the timeliness, accuracy, completeness and responsiveness of all MCOP submissions to ODM.
 - b. A provider relations representative for each service area included in its ODM provider agreement. This provider relations representative can serve in this capacity for only one service area.
4. **Communications.** The MCOP must comply with all aspects of Section 2.2 of the Three-Way. In addition, the MCOP must take all necessary and appropriate steps to ensure that all MCOP staff are aware of, and follow, the following communication process:
 - a. All MCOP employees are to direct all day-to-day submissions and communications to their ODM-designated contract administrator within the Bureau of Managed Care (BMC) unless otherwise notified by ODM. If the MCOP needs to contact another area of ODM in any other circumstance, the contract administrator within the BMC must also be copied or otherwise included in the communication.
 - b. Entities that contract with ODM should never be contacted by the MCOP unless ODM has specifically instructed the MCOP to contact these entities directly.

- c. Because the MCOP is ultimately responsible for meeting program requirements, ODM will not discuss MCOP issues with the MCOP's subcontractor unless the MCOP is also participating in the discussion. MCOP subcontractors, with the MCOP participating, should only communicate with the specific contract administrator assigned to that MCOP.
5. The MCOP must be represented at all meetings and events designated by ODM that require mandatory attendance.
6. The MCOP must have an administrative office located in Ohio.
7. The MCOP must have its MyCare Ohio Medicaid Managed Care program member call center(s) located in the state of Ohio.
8. **Required MCOP Staff.** The MCOP must have the key MyCare Ohio Medicaid Managed Care program staff specified in Section 2.2.3 of the Three-Way based and working in the state of Ohio. Each key staff person identified in Section 2.2.3 of the Three-Way may occupy no more than one of the positions, unless the MCOP receives prior written approval from ODM stating otherwise.
9. Upon request by ODM, the MCOP must submit information on the current status of their company's operations not specifically covered under this Agreement unless otherwise excluded by law.
10. The MCOP must have all new employees trained on applicable program requirements including those in the Three-Way, and represent, warrant and certify to ODM that such training occurs, or has occurred. Plans must conduct staff training sessions on subjects including disability competency, access, cultural sensitivity, person-centered care delivery approaches and independent living philosophies.
11. All employees of the MCOP and the MCOP's delegated/subcontracted entities who have in-person contact with members in their home must comply with criminal record check requirements as specified by ODM.
12. The MCOP must follow requirements related to moral or religious objections in the Three-Way as specified in Section 5.1.12. If an MCOP determines that it does not wish to provide, reimburse, or cover a counseling service or referral service due to an objection to the service on moral or religious grounds, it must immediately notify ODM to coordinate the implementation of this change. The MCOP will be required to notify its members of this change at least 30 days prior to the effective date. The MCOP's member handbook and provider directory, as well as all marketing materials, will need to include information specifying any such services that the MCOP will not provide.

13. For any data and/or documentation that MCOPs are required to maintain, ODM may request that the MCOP provide analysis of this data and/or documentation to ODM in an aggregate format, such format to be solely determined by ODM.
14. The MCOP is responsible for determining medical necessity for services and supplies requested for their members as specified in OAC rule 5160-58-03. Notwithstanding such responsibility, ODM retains the right to make the final determination on medical necessity in specific member situations.
15. In addition to the timely submission of medical records at no cost for the annual external quality review as specified in OAC rules 5160-58-01.1 and 5160-26-07, the MCOP may be required for other purposes to submit medical records at no cost to ODM and/or its designee upon request.
16. **Provider Panel Changes.** The MCOP must follow the requirements set forth in 2.6.1.2 of the Three-Way regarding notification of changes to the MCOP's provider network. In addition, the MCOP must comply with the requirements set forth in OAC rules 5160-58-01.1 and 5160-26-05, and must notify the BMC:
 - a. Within one working day of becoming aware that an MCOP panel provider that served 100 or more of the MCOP's members failed to notify the MCOP that they are no longer available to serve as a MCOP panel provider;
 - b. At least four months before the effective date of a systemic change in panel. ODM defines a systemic change in panel as an MCOP-initiated termination or change in availability of any single provider or combination of providers that are included in the provider contract termination in question, serving 100 or more of the MCOP's members. For example, an MCOP terminates 10 providers each serving 25 members. This termination must be reported, even though the providers individually do not meet the 100 member requirement. Overall, the group termination impacts 250 members and must be reported. ODM reserves the right to require that the MCOP align an MCOP-initiated systemic change in panel to the annual open enrollment month; or
 - c. Within one working day of becoming aware of a provider-initiated hospital unit closure.
17. Upon ODM's request, the MCOP may be required to provide written notice to members of any significant change affecting contractual requirements, member services or access to providers.
18. **Additional Benefits.** The MCOP may elect to provide services in addition to those covered under the Ohio Medicaid fee-for-service (FFS) program. Before the MCOP notifies potential or current members of the availability of those services, the MCOP must first notify ODM of its plans to make such services available. If an MCOP elects to provide additional services, the MCOP must ensure to the satisfaction of ODM that the services are readily available and

accessible to members who are eligible to receive them. Additional benefits must be made available to members for at least six calendar months from the date approved by ODM. All additional benefits available to Medicaid-only members must also be approved and available for dual benefits members. Additional benefits may not vary by county within a region except out of necessity for transportation arrangements (e.g., bus versus cab). An MCOP approved to serve members in more than one region may vary additional benefits between regions.

- a. The MCOP is required to make transportation available to any member requesting transportation when the member must travel 30 miles or more from his or her home to receive a medically-necessary Medicaid-covered service provided by the MCOP pursuant to OAC rule 5160-58-03 and Appendix G of this Provider Agreement. If the MCOP offers transportation to its members as an additional benefit and this transportation benefit only covers a limited number of trips, the required transportation listed above may not be counted toward this trip limit.
 - b. The MCOP must give ODM and members 90 days prior notice when decreasing or ceasing any additional benefits. When an MCOP finds that it is impossible to provide 90 days prior notice for reasons beyond its control, as demonstrated to ODM's satisfaction, ODM must be notified within at least one working day.
19. **Provision of Transportation Services.** The MCOP must ensure transportation pick-up is completed not more than 15 minutes before or 15 minutes after the pre-scheduled pick-up time, ensuring the member is on time for their appointment. Following a scheduled appointment, transportation pick-up must be completed no more than 30 minutes after a request for pick-up.
- a. The vendor must attempt to contact the member if he or she does not respond at pick-up. The vendor must not leave the pick-up location prior to the pre-scheduled pick-up time.
 - b. The MCOP must identify and accommodate the special transportation assistance needs of its members (e.g., door-to-door assistance, attendant support, member-specific timeliness requirements). Member-specific needs must be communicated to the transportation vendor and updated as frequently as is needed to support the member's needs. Where applicable, these needs must be documented in the member's care plan.
 - c. Transportation for members with long-term service and supports (LTSS) needs. MCOPs should contract with providers experienced in transporting members with LTSS needs. Characteristics of LTSS experienced providers include but are not limited to:
 - i. The ability to help the member transfer between the pick-up location and the vehicle, to enter and exit the vehicle, and to transfer between the vehicle and the destination location safely;

- ii. Sensitivity to aging adults living with disabilities;
 - iii. The ability to safely operate, secure and transport a wheel chair or other assistive device;
 - iv. Maintain vehicles equipped with fasteners to secure wheelchairs and prevent movement, and a stable access ramp or hydraulic lift; and
 - v. The capacity to meet individual member needs when transporting.
- d. The MCOP must submit a plan for the provision of transportation services during winter snow and other weather emergencies, specifying identification, triage, transportation of members requiring critical services, notification to members of canceled transportation and rescheduling. The MCOP must specify the snow emergency level and any other weather-related criteria that require a change to scheduled transportation. The MCOP must notify the Contract Administrator immediately when transportation is canceled in accordance with the plan.
- e. MCOPs are required to work with ODM to develop a standardized prior authorization form for transportation services. The standardized form will be developed for an implementation date no later than January 1, 2018.

20. Comprehensive Disaster/Emergency Response Planning. The MCOP must develop and implement an ODM-approved Comprehensive Disaster/ Emergency Response Plan for natural, man-made, or technological disasters and other public emergencies (e.g., floods, extreme heat, extreme cold) The MCOP must notify its Contract Administrator immediately when the Comprehensive Disaster/ Emergency Response Plan has been activated. The MCOP must make a current version of the approved Comprehensive Disaster/Emergency Response Plan available to all staff.

- a. The MCOP must designate both a primary and alternate point of contact who will perform the following functions: be available 24 hours a day, 7 days a week during the time of an emergency; be responsible for monitoring news, alerts and warnings about disaster/emergency events; have decision-making authority on behalf of the MCOP; respond to directives issued by ODM; and cooperate with the local- and state-level Emergency Management Agencies. The MCOP must communicate any changes to the primary and alternate point of contact to the Contract Administrator at least one business day prior to the effective date of the change.
- b. The MCOP must participate in ODM sanctioned workgroups and processes to establish a state-level emergency response plan which will include a provision for Medicaid recipients, and will comply with the resulting procedures.

- c. During the time of an emergency or a natural, technological, or man-made disaster, the MCOP must be able to generate a current list of members for whom an individual disaster plan, according to the specifications below, has been developed, including the risk and the individual-level plan, and distribute to local and state emergency management authorities according to the protocol established by ODM.
 - d. The MCOP must identify members who are at risk for harm, loss, or injury during any potential natural, technological, or manmade disaster. The MCOP must assure that every member who is technology and/or service dependent, with no known reasonable means to access services, is known and documented as part of the plan's Comprehensive Disaster/Emergency Response Plan. For these members, the MCOP must develop an individual-level plan with the member when appropriate. The MCOP must ensure that staff, including care managers, are prepared to respond to and implement the plans in the event of an emergency or disaster. The member-level plan must:
 - i. Include a provision for the continuation of critical services appropriate for the member's needs in the event of a disaster;
 - ii. Identify how and when the plan will be activated;
 - iii. Be documented in the member record maintained by the MCOP; and
 - iv. Be provided to the member.
21. The MCOP must comply with 42 CFR 438.100 and any applicable federal and state laws that pertain to member rights and ensure that its staff adheres to such laws when furnishing services to its members. The MCOP shall include a requirement in its contracts with affiliated providers that such providers also adhere to applicable Federal and State laws when providing services to members.
22. Upon request, the MCOP will provide members and potential members with a copy of their practice guidelines.
23. **Marketing Materials and Member Materials.** Pursuant to OAC rules 5160-58-01.1, 5160-26-08 and 5160-26-08.2, the MCOP is responsible for ensuring all MCOP marketing and member materials are prior approved by ODM before being shared with members or potential members. Member materials must be available in written format, but can be provided to the member in alternative formats (e.g., CD-ROM) if specifically requested by the member, except as specified in OAC rule 5160-58-08.4. Marketing and member materials are defined as follows:
 - a. Marketing materials are those items produced in any medium, by or on behalf of an MCOP, including gifts of nominal value (i.e., items worth no more than \$15.00), which

can reasonably be interpreted as intended to market to eligible individuals as defined in OAC 5160-58-01.

- b. Member materials are those items developed, by or on behalf of an MCOP, to fulfill MCOP program requirements or to communicate to all members or a group of members. Member health education materials that are produced by a source other than the MCOP and which do not include any reference to the MCOP are not considered to be member materials.
- c. MCOP marketing and member materials must not include statements that are inaccurate, misleading, confusing, or otherwise misrepresentative, or which defraud eligible individuals or ODM.
- d. MCOP marketing materials cannot contain any assertion or statement (whether written or oral) that the MCOP is endorsed by the Centers for Medicare and Medicaid Services (CMS), the Federal or State government or similar entity.
- e. The MCOP must establish positive working relationships with the County Department of Job and Family Services (CDJFS) offices and must not aggressively solicit from local Directors, MCOP County Coordinators, or other staff. Furthermore, the MCOP is prohibited from offering gifts to CDJFS offices or Medicaid Consumer Hotline (hereafter referred to as the "Hotline") staff, as these may influence an individual's decision to select a particular MCOP.
- f. MCOP marketing representatives and other MCOP staff are prohibited from offering eligible individuals the use of a portable device (laptop computer, cellular phone, etc.) to assist with the completion of an online application to select and/or change MCOPs, as all enrollment activities must be completed by the Hotline.
- g. Prior to initiating member-requested Medicare marketing contact with a current or pending member for any corporate-family Medicare Advantage (MA) or Medicare Special Needs Plan (SNP) product, an MCOP member services representative or care manager must identify and resolve any confusion or service issues that may have motivated the member's request for a change in enrollment. MCOP member services representatives or care managers must also educate the member about the MCOP's dual benefits membership option. Once the issues are resolved and clarification about MCOP integrated enrollment is made, the member must be invited to rescind the marketing request.
- h. The MyCare Ohio logo must be on all member and marketing materials, excluding nominal gifts.

24. Cultural Competency and Communication Needs. The MCOP is responsible for promoting the delivery of services in a culturally competent manner, as solely determined by ODM, to all members, including those with limited English proficiency (LEP) and diverse cultural and ethnic backgrounds. The MCOP must make oral interpreter services for all languages available free of charge to all members and eligible individuals pursuant to 42 CFR Section 438.10(c)(4). The MCOP must comply with the requirements specified in Section 2.12 of the Three-Way for member communication standards and must comply with OAC rules 5160-58-01.1, 5160-26-03.1, 5160-26-05, 5160-26-05.1, 5160-26-08 and 5160-26-08.2 for providing assistance to LEP members and eligible individuals. In addition, the MCOP must provide written translations of certain MCOP materials in the prevalent non-English languages of members and eligible individuals in accordance with the following:

- a. If ODM identifies prevalent common primary languages other than English in the MCOP's service area, the MCOP, as specified by ODM, must translate marketing and member materials into the primary languages of those groups. In addition, the MCOP must make these marketing and member materials available to eligible individuals free of charge.
- b. The MCOP must utilize a centralized database which records the special communication needs of all MCOP members (i.e., those with LEP, limited reading proficiency [LRP], visual impairment, and hearing impairment) and the provision of related services (i.e., MCOP materials in alternate format, oral interpretation, oral translation services, written translations of MCOP materials, and sign language services). This database must include all MCOP member primary language information (PLI) as well as all other special communication needs information for MCOP members, as indicated above, when identified by any source including but not limited to ODM, the Hotline, MCOP staff, providers, and members. This centralized database must be readily available to MCOP 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 an LEP member, when such a provider is available.
- c. The MCOP must share specific communication needs information with its providers [e.g., PCPs, Pharmacy Benefit Managers (PBMs), and Third Party Administrators (TPAs)], as applicable.
- d. The MCOP must submit to ODM, upon request, detailed information regarding the MCOP's members with special communication needs, which could include individual member names, their specific communication need, and any provision of special services to members (i.e., those special services arranged by the MCOP as well as those services reported to the MCOP which were arranged by the provider).

- e. The MCOP is responsible for ensuring that all member materials use easily understood language and format. The determination of whether materials comply with this requirement is in the sole discretion of ODM.
 - f. The MCOP must participate in ODM's cultural competency initiatives.
 - g. The MCOP will use person-centered language in all communication with eligible individuals and members consistent with the information and examples available at: <http://www.disabilityisnatural.com>.
 - h. MCOP HIPAA privacy notices must be translated into other languages pursuant to Marketing Guidance for Ohio Medicare-Medicaid Plans and Title VI of the Civil Rights Act. MCOPs must also assess member primary languages and provide materials in other prevalent languages.
25. **Member Materials.** The MCOP must provide members with a variety of materials, including at a minimum those specified in OAC rules, this Provider Agreement and the Three-Way. The following provides clarification regarding the issuance of specific member materials.
- a. **New Member Materials.** Pursuant to OAC rules 5160-58-01.1 and 5160-26-08.2, MCOPs must provide to each member who selects or changes MCOPs, or changes Medicaid-only or dual benefit status, an MCOP identification (ID) card, a new member letter, a member handbook (including a waiver handbook if applicable), Notice of Nondiscrimination, and provider panel information, as specified by ODM.
 - i. The MCOP must use the model language specified by ODM and/or CMS for the new member letter and member handbooks.
 - ii. The MCOP must mail ID cards to each member via a method that will ensure receipt no earlier than 15 days prior to the member's effective date of coverage and no later than the day prior to the member's effective date of coverage.
 - 1. An MCOP will meet the timeliness requirement for mailing ID cards to members who select or change MCOPs, or change Medicaid-only or dual benefit status within the five days prior to the end of the month, if the ID cards are mailed within:
 - a. Five working days of the MCOP receiving the ODM produced HIPAA 834C that lists the individual as a Medicaid-only member;
or
 - b. Ten working days of the MCOP receiving the ODM-produced HIPAA 834C that lists the individual as a dual benefits member.

2. The MCOP ID card must contain pharmacy information, and the toll-free 24-hour behavioral health crisis and care management telephone numbers as prescribed by ODM.
 3. For Medicaid Only members when a contracted primary care provider (PCP) is not identified on the consumer contact record (CCR) and the member does not select a PCP, the ID card PCP field must read "Refer to Medicare PCP".
- iii. The MCOP must mail the new member letter and member handbook, including the waiver handbook if applicable, separate from the ID card. An MCOP will meet the timeliness requirement for mailing these materials if they are mailed to members within five working days of the MCOP receiving the ODM produced HIPAA 834C, that lists the individual as a new member.
 - iv. The MCOP must provide access to provider panel information to members via the MCOP's website and printed provider directories.
 1. MCOPs may mail ODM prior-approved provider directory notices to all new members in lieu of mailing printed directories. The notices must be mailed with the member materials specified in 25.a.iii of this Appendix and, at a minimum, advise members they may call the MCOP to request printed provider directories and access the information on the MCOP's website.
 2. MCOPs that mail ODM prior-approved provider directory notices to new members in lieu of mailing printed directories must automatically send printed provider directories to members that voluntarily enroll and request printed provider directories, as reflected on the Consumer Contact Record (CCR). Printed directories must be mailed with the new member materials specified in 25.a.iii of this Appendix.
 3. MCOPs that do not use an ODM prior-approved provider directory notice must mail printed provider directories to all new members with the member materials specified in 25.a.iii of this Appendix except printed provider directories do not need to be mailed to new members that voluntarily enroll and request to not receive printed provider directories as reflected on the CCR.
 4. When a member requests a printed provider directory as a result of provider directory notices or after initial months of enrollment, the printed provider directory must be sent to the member within seven calendar days of the request.

v. Waiver Material

- b. Annual material. The MCOP must issue waiver handbooks annually to members enrolled in the MyCare Ohio Waiver. The MCOP is responsible for ensuring that each MyCare Ohio Waiver enrollee receives the Waiver Member Handbook at the time of enrollment, and also at the time of each annual reassessment. The MCOP is responsible for ensuring that the Waiver Care Manager or Waiver Service Coordinator has verbally reviewed the content of the handbook, and the MCOP shall maintain documentation signed by the enrollee of receipt of this information.
 - i. For a member who has chosen waiver services, the MCOP must have an ODM-developed freedom of choice form signed by the member indicating he or she has chosen waiver services over institutional care. This form must be signed at the time that the member enrolls in the waiver. In addition, it must be signed annually thereafter at the time of reassessment of waiver eligibility, closest to the member's level of care redetermination.
 - ii. The MCOP will provide an ODM-approved handbook on self-direction detailing processes, etc. to all members directing their own care.
- c. The MCOP must use the model language specified by ODM for the new member letter and as applicable, model language for CMS letters regarding Cancellation of Enrollment and Confirmation of Voluntary Disenrollment Following CMS Daily Transaction Reply Report (DTRR).

26. Healthchek and Pregnancy Related Services. Healthchek, Ohio's early and periodic screening, diagnostic, and treatment (EPSDT) and Pregnancy Related Services programs, are outlined in OAC rules 5160:1-2-15 and 5160:1-2-16.

- a. Informing members about Healthchek. The MCOP must:
 - i. Inform each member under the age of 21 within 7 calendar days of their effective date of enrollment in the MCOP about the Healthchek program as prescribed by ODM and as specified by 42 CFR. Section 441.56. An MCOP may meet this requirement by including information with the new member materials specified in section 25 of this Appendix. In addition, the MCOP may be required to communicate with the member's local County Department of Job and Family Services agency any requests made by the member for County coordinated services and/or supports (e.g. social services).
 - ii. Provide members with accurate information in the member handbook regarding Healthchek. The MCOP's member handbooks must be provided to members

within the time frames specified in section 25 of this Appendix, and must include verbatim the model language developed by ODM. The model language at a minimum will include:

1. A description of the types of screening and treatment services covered by Healthchek;
 2. A list of the intervals at which members under age 21 should receive screening examinations, as indicated by the most recent version of the document entitled "Recommendations for Preventive Pediatric Health Care," published by Bright Futures/American Academy of Pediatrics;
 3. Information that Healthchek services are provided at no additional cost to the member; and
 4. Information that providers may request prior authorization for coverage of services that have limitations and/or are not covered for members age 21 and older if the services are medically necessary EPSDT services.
- iii. Provide the above Healthchek information on the MCOP's member website specified in section 48 of this Appendix.
- iv. Deliver Healthchek information as provided, or as approved, by ODM to the MCOP's members at the following intervals:
1. January of each calendar year; and
 2. At the beginning of each school year in the month of July.
- v. Use the mailing templates provided by ODM that will not exceed two 8x11 pages for each mailing with most mailings being one page or less in length. The MCOP must populate the materials with appropriate Healthchek information as required (e. g. type of service, rendering provider, date of service and age of member on the date of service).
- b. Informing members about Pregnancy Related Services (PRS), the MCOP must:
- i. Upon the identification of a member as pregnant, the MCOP must deliver to the member within 14 calendar days a PRS form as designated by ODM.
 - ii. The MCOP may be required to communicate with the member's local County Department of Job and Family Services agency any requests made by the member for County coordinated services and supports (e.g. social services).
- c. Informing providers about Healthchek, the MCOP must:

- i. Provide Healthchek education to all contracted providers on an annual basis which must include, at a minimum, the following:
 1. The required components of a Healthchek exam as specified in OAC rule 5160-14-03;
 2. A list of the intervals at which individuals under age 21 should receive screening examinations, as indicated by the most recent version of the document “Recommendations for Preventive Pediatric Health Care” published by Bright Futures/American Academy of Pediatrics;
 3. A statement that Healthchek includes a range of medically necessary screening, diagnosis and treatment services; and
 4. A list of common billing codes and procedures related to the Healthchek services (e.g., immunizations, well child exams, laboratory tests, and screenings).
- ii. Provide the above information on the MCOP’s provider website as specified in section 48 of this Appendix.
- d. An MCOP must maintain documentation that it informed members and providers of Healthchek and Pregnancy Related Services as specified by ODM.

27. Advance Directives. All MCOPs must comply with the advance directives requirements specified in 42 CFR 422.128. At a minimum, the MCOP must:

- a. Maintain written policies and procedures that meet the requirements for advance directives, as set forth in 42 CFR Subpart I of part 489 (42 CFR 489.100—489.104).
- b. Maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care by or through the MCOP to ensure that the MCOP:
 - i. Provides written ODM-approved information to all adult members concerning:
 1. The member’s rights under state law to make decisions concerning his or her medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;
 2. The MCOP’s policies concerning the implementation of those rights including a clear and precise statement of any limitation regarding the implementation of advance directives as a matter of conscience;

3. Any changes in state law regarding advance directives as soon as possible, but no later than 90 days after the proposed effective date of the change; and
 4. The right to file complaints concerning noncompliance with the advance directive requirements with the Ohio Department of Health.
- ii. Provides for education of staff concerning the MCOP's policies and procedures on advance directives;
 - iii. Provides for community education regarding advance directives directly or in concert with other providers or entities;
 - iv. Requires that each member's medical record document whether or not the member has executed an advance directive; and
 - v. Does not condition the provision of care, or otherwise discriminate against a member, based on whether the member has executed an advance directive.

28. Call Center Standards. The MCOP must follow call center standards requirements pursuant to Sections 2.9.2, 2.9.3 and 2.9.4 of the Three-Way. In doing so, the MCOP must:

- a. Notify ODM of any hours of operation of the member services lines that are outside the required days and time as specified in Section 2.9.2 of the Three-Way.
- b. Ensure access to medical advice pursuant to OAC rule 5160-26-03.1, behavioral health crisis, and care management support services through toll-free 24 hour, 7 days a week (24/7) call-in systems that are available nationwide. The 24/7 call-in systems listed in this section must be staffed by appropriately qualified medical and behavioral health professionals whose scope of practice and licensure permits them to perform the required functions associated with the services. The MCOP must ensure that an appropriately qualified health professional is the caller's first point of live contact to answer the call, triage the issue, and determine an immediate course of action (e.g., warm transfer to care manager or local behavioral health crisis services, provide intervention, and offer medical advice). Only one auto-prompt can be used to get the caller to the live contact.
 - i. For the purpose of meeting the staffing requirement for medical advice, appropriately qualified medical professionals are defined as physicians, physician assistants, licensed practical nurses (LPNs), and registered nurses (RNs).
 - ii. For the purposes of meeting the staffing requirement for behavioral health crisis services, appropriately qualified health professionals must have experience with

behavioral crisis assessment and intervention. Staff must have access to emergency response (e.g., 911, police and fire) and crisis intervention services (pursuant to OAC 5122-29-10 and 3793:2-1-08) in each county in which the plan maintains membership. The MCOP must have arrangements with the county mental health and drug/alcohol crisis lines to assure access to crisis intervention services, and to ensure that contacts with the publicly available or county's crisis line are reported within one business day to the MCOP. The MCOP must document a member's contact with the plan-administered and county-administered behavioral health crisis line in the care management record and ensure follow up by a care manager as soon as warranted but not later than 24 hours from the time the MCOP becomes aware of a member's behavioral health crisis.

- c. Have staff who are knowledgeable of the MyCare Ohio product line and have access to information pertaining to MyCare Ohio membership (e.g., benefits, provider network, care plans, etc.). The MCOP must implement procedures to ensure that emergent issues are identified and assigned the highest priority.
- d. For the purposes of meeting the staffing requirement for care management support services, the calls must be answered and/or forwarded to the member's care manager or other team members designated to act on behalf of the care manager. The MCOP must ensure that if a care manager designee is used that the requirements in section 2.5.3.3.3.4 of the Three-Way are met.
- e. Meet the current American Accreditation HealthCare Commission/ URAC-designed Health Call Center Standards (HCC) for call center abandonment rate, blockage rate and average speed of answer for the medical advice, care management support, and the behavioral health crisis 24/7 toll-free call-in systems. If access to these call-in systems is facilitated through the member services line with auto-prompts to transfer the caller, the MCOP must have a process to measure the above call center standards from the time of selecting the auto prompt. If the MCOP uses the member services line to answer the care management support services contacts (i.e., no auto prompt to transfer), then call center standards for the member services line specified in Section 2.9.2.2 of the Three-Way apply. ODM will inform the MCOPs of any changes to these URAC call center standards.
- f. Not meet the member services call center requirement through the execution of a Medicaid Delegation Subcontract Addendum or Medicaid Combined Services Subcontract Addendum, without prior approval by ODM. With the exception of transportation vendors, the MCOP is prohibited from publishing a delegated entity's general call center number.

- g. At least semi-annually, self-report its monthly and semi-annual performance in meeting the URAC call center standards for the 24/7 hour toll-free call-in systems and the call center standards in Section 2.9.2.2 of the Three-Way for the member services line to ODM as specified. MCOPs must report their July through December performance to ODM by January 10 and their January through June performance by July 10. ODM reserves the right to require more frequent reporting by a MCOP if on-going monitoring (e.g., grievances, complaints, contract administrator review) identifies an egregious access issue or consecutive months of non-compliance with URAC standards.
29. **Notification of Voluntary MCOP Membership.** To comply with the terms of the ODM State Plan Amendment for the managed care program, the MCOP must inform new members that MCOP membership is voluntary and not required to receive their Medicaid healthcare benefits for the following populations and what steps they need to take if they do not wish to be a member of an MCOP.
- a. Indians who are members of federally-recognized tribes.
 - b. Until January 1, 2017, children under 19 years of age who are:
 - i. In foster care or other out-of-home placement;
 - ii. Receiving foster care or adoption assistance;
 - iii. Receiving services through the Ohio Department of Health’s Bureau for Children with Medical Handicaps (BCMh) or any other family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V, and is defined by the state in terms of either program participation or special health care needs.

30. **Privacy Compliance Requirements.** The Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations at 45 CFR 164.502(e) and 164.504(e) require ODM to enter into agreements with MCOPs as a means of obtaining satisfactory assurance that the MCOPs will appropriately safeguard all “protected health information” (PHI), which means information received from or on behalf of ODM that meets the definition of PHI as defined by HIPAA and the regulations promulgated by the United States Department of Health and Human Services, specifically 45 CFR 160.103, 45 CFR 164.501 and any amendments thereto.

In addition to the HIPAA requirements, the MCOP must comply with any other applicable Federal and State laws regarding privacy and confidentiality, including Title VI of the Civil Rights Act of 1964, ORC 5101.26, 5101.27, and 5160.45 through 5160.481, as applicable.

The MCOP acknowledges that ODM is a Covered Entity under HIPAA. A Covered Entity means a health plan, a health care clearinghouse, or health care provider under 45 CFR 160.103. The

MCOP further acknowledges that it is a Business Associate of ODM. A Business Associate means a person or entity that, on behalf of the Covered Entity, maintains, performs, or assists in the performance of a function or activity that involves the use or disclosure of "Protected Health Information" under 45 CFR 160.103. The MCOP, as a Business Associate agrees to comply with all of the following provisions:

- a. Permitted Uses and Disclosures. The MCOP will not use or disclose PHI except as provided in this Agreement or as otherwise required under HIPAA regulations or other applicable law.
- b. Safeguards. The MCOP will implement sufficient safeguards, and comply with Subpart C of 45 CFR Part 164 pertaining to electronic PHI to prevent the use or disclosure of PHI other than as provided for under this Agreement. Safeguards will be implemented for all paper and electronic PHI created, received, maintained, or transmitted on behalf of ODM.
- c. Reporting of Disclosures. The MCOP agrees to promptly report to ODM any inappropriate use or disclosure of PHI that is not in accordance with this Agreement or applicable law, including a breach of unsecured PHI as required at 45 CFR 164.410 and any security incident the MCOP has knowledge of or reasonably should have knowledge of under the circumstances.
- d. Mitigation Procedures. The MCOP agrees to coordinate with ODM to determine specific actions that will be required of the Business Associates for mitigation, to the extent practical, of the breach. These actions will include notification to the appropriate individuals, entities, or other authorities. Notification or communication to any media outlet must be approved, in writing, by ODM prior to any such communication being released. The MCOP must report all of its mitigation activity to ODM and must preserve all relevant records and evidence.
- e. Incidental Costs. The MCOP shall bear the sole expense of all costs to mitigate any harmful effect, of any breaches or security incidents which were caused by the MCOP, or its subcontractors, in violation of the terms of this Agreement. These costs will include, but are not limited to, the cost of investigation, remediation and assistance to the affected individuals, entities or other authorities.
- f. Agents and Subcontractors. The MCOP, in compliance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2) as applicable, must ensure that all its agents and subcontractors that create, receive, maintain, or transmit PHI from or on behalf of MCOP and/or ODM agree to have, in a written agreement, the same restrictions, conditions, and requirements that apply to MCOP with respect to the use or disclosure of PHI.

- g. **Accessibility of Information.** The MCOP must make available to ODM such information as ODM may require to fulfill its obligations to provide access to, provide a copy of any information or documents with respect to PHI pursuant to HIPAA and regulations promulgated by the United States Department of Health and Human Services, including, but not limited to, 45 CFR 164.524 and 164.528 and any amendments thereto.
- h. **Amendment of Information.** The MCOP shall make any amendment(s) to PHI as directed by, or agreed to, by ODM pursuant to 45 CFR 164.526, or take other steps as necessary to satisfy ODM's obligations under 45 CFR 164.526. In the event that the MCOP receives a request for amendment directly from an individual, agent, or subcontractor, the MCOP must notify ODM prior to making any such amendment(s). The MCOP's authority to amend information is explicitly limited to information created by the MCOP.
- i. **Accounting for Disclosure.** The MCOP shall maintain and make available to ODM or individuals requesting the information as appropriate, records of all disclosures of PHI in a Designated Record Set as necessary to satisfy ODM's obligations under 45 CFR 164.528. For every disclosure, the record must include, at a minimum, the name of the individual who is the subject of the disclosure, the date of the disclosure, reason for the disclosure if any, and the name and address of the recipient to which the PHI was disclosed.
- j. **Obligations of ODM.** When the MCOP is required to carry out an obligation of ODM under Subpart E of 45 CFR Part 164, the MCOP agrees to comply with all applicable requirements of Subpart E that would apply to ODM in the performance of such obligation.
- k. **Access to Books and Records.** The MCOP shall make available to ODM and to the Secretary of the U.S. Department of Health and Human Services any and all internal practices, documentation, books, and records related to the use and disclosure of PHI received from ODM, or created or received on behalf of ODM. Such access is for the purposes of determining compliance with the HIPAA Rules.
- l. **Material Breach.** In the event of material breach of the MCOP's obligations under this Article, ODM may immediately terminate this Agreement as set forth in ARTICLE VI, Section B. Termination of this Agreement will not affect any provision of this Agreement, which, by its wording or its nature, is intended to remain effective and to continue to operate after termination.
- m. **Return or Destruction of Information.** Upon termination of this Agreement and at the request of ODM, the MCOP will return to ODM or destroy all PHI in MCOP's possession stemming from this Agreement as soon as possible but no later than 90 days, and will not keep copies of the PHI except as may be requested by ODM or required by law, or as

otherwise allowed for under this Agreement. If the MCOP, its agent(s), or subcontractor(s) destroy any PHI, then the MCOP will provide to ODM documentation evidencing such destruction. Any PHI retained by the MCOP will continue to be extended the same protections set forth in this Section, HIPAA regulations and this Agreement for as long as it is maintained.

- n. Survival. These provisions shall survive the termination of this Agreement.

31. Electronic Communications. The MCOP is required to purchase and utilize Transport Layer Security (TLS) for all e-mail communication between ODM and the MCOP. The MCOP's e-mail gateway must be able to support the sending and receiving of e-mail using TLS and the MCOP's gateway must be able to enforce the sending and receiving of email via TLS.

32. MCOP Membership Acceptance, Documentation and Reconciliation.

- a. The MCOP shall provide to the Medicaid Consumer Hotline contractor ODM prior-approved MCOP materials and directories for distribution to eligible individuals who request additional information about the MCOP.
- b. The MCOP shall maintain the integrity of its membership data through reconciliation of the daily HIPAA 834C (Daily Benefit Enrollment and Maintenance File) and the monthly HIPAA 834F (Monthly Benefit Enrollment and Maintenance File) transactions pursuant to ODM instructions. Discrepancies between the HIPAA 834C and 834F that have a negative impact on a member's access to care must be reported to ODM pursuant to ODM instructions.
- c. The HIPAA 820 (Monthly Remittance Advice) will contain the following: a capitation payment for each member listed on the HIPAA 834F, a capitation payment/recoupment for changes listed in the daily HIPAA 834C, and any other capitation payment/recoupment. Reconciliation for any discrepancies between the HIPAA 834 and HIPAA 820 is due and must be submitted, as instructed by ODM, no later than 60 days after the issuance of the HIPAA 834F. In the event of changes in the processing dates, the due date will be adjusted accordingly.
- d. All reconciliation requests must be submitted in the format specified by ODM. ODM may reject reconciliation requests that are submitted after the due date. Reconciliation requests submitted after the due date will be processed at the discretion of ODM. Recoupments, date of death, duplicative payments made to the same plan due to multiple IDs will always be processed.
- e. When an MCOP learns of a currently hospitalized member's intent to disenroll through the CCR or the HIPAA 834, the disenrolling MCOP must notify the hospital/inpatient facility and treating providers as well as the enrolling MCOP, if applicable, of the change

in enrollment. The disenrolling MCOP must notify the inpatient facility that it will remain responsible for the inpatient facility charges through the date of discharge; and must notify the treating providers that it will remain responsible for provider charges through the date of disenrollment. The disenrolling MCOP shall not request and/or require that a disenrolled member be discharged from the inpatient facility for transfer to another inpatient facility. Should a discharge and transfer to another inpatient facility be medically necessary, the disenrolling MCOP must notify the treating providers to work with the enrolling MCOP or ODM as applicable to facilitate the discharge, transfer and authorization of services as needed.

When the enrolling MCOP learns through the disenrolling MCOP, through ODM or other means, that a new member who was previously enrolled with another MCOP was admitted prior to the effective date of enrollment and remains an inpatient on the effective date of enrollment, the enrolling MCOP must contact the hospital/ inpatient facility. The enrolling MCOP must verify that it is responsible for all medically necessary Medicaid covered services from the effective date of MCOP membership, including professional charges related to the inpatient stay; additionally, the enrolling

MCOP must inform the hospital/inpatient facility that the admitting/disenrolling MCOP remains responsible for the hospital/inpatient facility charges through the date of discharge. The enrolling MCOP must work with the hospital/inpatient facility to facilitate discharge planning and authorize services as needed.

When an MCOP learns that a new member who was previously on Medicaid fee-for-service was admitted prior to the effective date of enrollment and remains an inpatient on the effective date of enrollment, the MCOP must notify the hospital/inpatient facility and treating providers that the MCOP is responsible for the professional charges effective on the date of enrollment, and shall work to assure that discharge planning provides continuity using MCOP-contracted or authorized providers.

- f. As specified by ODM, the MCOP must assist in resolving member-initiated just cause requests affecting membership.
- g. In order to encourage the timely addition of newborns, authorization for Medicaid and enrollment in the MCOP, the MCOP must provide notification of the birth to the CDJFS within five working days of the birth or immediately upon learning of the birth. The MCOP must provide, at a minimum, the mother's name, social security number, eligibility system case number, 12 digit recipient ID, county and the newborn's name, gender, and date of birth, unless the CDJFS and the MCOP have agreed to a different minimum set of information to be transmitted for the CDJFS newborn notification.
- h. If an eligible individual, as defined in OAC rule 5160-58-01, contacts the MCOP, the MCOP must provide any MCOP-specific managed care program information requested. The MCOP must not attempt to assess the eligible individual's health care needs.

However, if the eligible individual inquires about continuing/transitioning health care services, the MCOP shall provide an assurance that all MCOPs must cover all medically necessary Medicaid-covered health care services and assist members with transitioning their health care services.

- i. If a pending member (an eligible individual subsequent to MCOP selection or assignment to an MCOP, but prior to his or her membership effective date) contacts the selected MCOP, the MCOP must provide any membership information requested, including but not limited to explaining how to access services as an MCOP member and assistance in determining whether current services require prior authorization. The MCOP must also ensure that any care coordination (e.g., PCP selection, prescheduled services and transition of services) information provided by the pending member is logged in the MCOP's system and forwarded to the appropriate MCOP staff for processing as required.

The MCOP may confirm any information provided on the CCR at this time. Such communication does not constitute confirmation of membership. Upon receipt of the CCR or the HIPAA 834, the MCOP may contact a pending member to confirm information provided on the CCR or the HIPAA 834, assist with care coordination and transition of care, and inquire if the pending member has any membership questions.

33. The MCOP must use ODM-provided historic utilization and prior authorization data files for care coordination/management activities and transition of care requirements.
34. **Retroactive Coverage Requirements and Transition of Fee-For-Service (FFS) Members.** The MCOP must pay claims for covered services provided to members during retroactive enrollment periods. For services provided during retroactive enrollment periods, MCOPs may review only those services that require FFS prior authorization as documented in Appendix DD of OAC 5160-1-60, OAC 5160-9-12 (regarding pharmacy claims), and all other FFS regulations that set forth prior authorization policy. If the service was reviewed and approved by FFS, the MCOP must also approve the service. MCOPs may also review to determine that home and community-based services were in accordance with the pre-existing or current waiver services plan of care.
 - a. Upon a member's initial enrollment in MyCare Ohio, the MCOP must provide transition of Medicare and Medicaid services in accordance with the requirements specified in Section 2.5.4 of the Three-Way for both contracted and non-contracted providers. Non-contracted providers who provide services during the transition of Medicare and Medicaid services specified in Section 2.5.4 of the Three-Way must be paid the Medicaid fee for service (FFS) rate. Prior to the end of any required transition period, the MCOP must inform the member and non-contracted provider of the effective date of any transition to a contracted provider, during a meeting of the trans-disciplinary care team or by another method documented in the care plan.

- b. Unless the provider has expressly agreed to MyCare Ohio contract terms that include quality incentives and a different secondary claims payment rate, not including simple rate changes proposed by the MCOP, the MCOP must pay Medicare secondary claims at a rate not less than that established by the Medicaid fee for service Part B methodology, set forth in O.A.C. 5160-1-05.3, for contracted and non-contracted providers. Exemptions to the Part B Medicaid maximum policy must be applied, in accordance with the Ohio Administrative Code and other guidance issued by ODM. The Part C Medicaid maximum policy, set forth in O.A.C. 5160-1-05.1, may only be applied for secondary claims on behalf of Medicaid only members enrolled with a Part C plan that is not the MCOP. The MCOP must provide a method for enrollment of any non-contracted provider who is an enrolled provider with ODM for purposes of Medicaid payment of “crossover” claims pursuant to the CMCS-MMCO-CM Informational Bulletin of June 7, 2013.
- c. The MCOP must contract directly with the Fiscal Management Service (FMS) vendor also under contract with ODM to successfully transition and provide ongoing services for waiver consumers who have elected self-directed employer authority for authorized waiver services. The contract must continue for the entire period of this Provider Agreement.
- d. Upon receipt, the MCOP must be able to process and use the FFS historic utilization, prior authorization and care management data files to assess pending members’ risk stratification levels, to coordinate care and to adhere to transition requirements. When waiver service coordination data is omitted from the file transfer for a pending member enrolled in the FFS PASSPORT, or Assisted Living waiver, the MCOP must reconcile the enrollment or data error with the PASSPORT Administrative Agency (PAA). When waiver service coordination data is omitted for pending members in the Ohio Home Care waiver, the MCOP must notify its contract administrator to request enrollment reconciliation and/or data completion.
- e. The MCOP must make express arrangements to obtain current treatment plans from Ohio Department of Mental Health and Addiction Services (OhioMHAS) certified providers when a member’s behavioral health services qualify for transition pursuant to Section 2.5.4 of the Three-Way.
- f. The MCOP is responsible for implementing transition of care processes that prevent access problems for members who are transitioning from the FFS pharmacy benefit administrator to an MCOP. The transition of care processes for prescription drugs must be consistent the requirements outlined in Medicare Part D.

35. Transition of Care Requirements for Existing Members of an Exiting MCOP. When the enrolling MCOP is informed by ODM, or its designee, of a member transitioning from an MCOP that no

longer has a provider agreement in the member's service area, the enrolling MCOP must follow the transition of care requirements required by ODM.

- 36. Transition of Care Requirements for Members Receiving HCBS Waiver Services who Lose MyCare Ohio Eligibility.** As soon as an MCOP is notified by ODM via the 834C or 834F, CCR, and/or via another source of information (e.g., waiver service coordinator, member, provider), that a member who is receiving home and community based services (HCBS) waiver services that his or her enrollment is or may be terminated due to loss of MyCare Ohio eligibility, the MCOP must identify the reason for loss of eligibility and timely assist the member, as appropriate, with maintenance of MyCare Ohio eligibility. Upon confirmation that MyCare Ohio eligibility will be terminated, during the last month of the individual's active membership, the MCOP must instruct the appropriate local Area Agency on Aging (AAA) to end the MyCare Ohio waiver span in alignment with enrollment termination, and facilitate, as appropriate, referrals to programs (e.g., Medicaid waivers) and/or community resources that may assist the individual with continuation of long-term services and supports. The MCOP must notify the member and all current waiver providers of the member's termination from MyCare Ohio, and as applicable, of any referral made to other Medicaid waivers. These referrals and notifications must be completed prior to the end of the month of termination, and when this is not possible, as soon as possible thereafter. If the member is found eligible for a Medicaid waiver program, the MCOP must provide the MyCare Ohio waiver service plan and any identified service issues or follow-up necessary to successfully transfer care to the waiver case management agency.
- 37. Transition of Care Requirements for Members Receiving HCBS Waiver Services who Move Outside of the MCOP's Service Area.** If the MCOP becomes aware through its member services, waiver service coordination or care management processes that a member receiving HCBS waiver services is changing residence to an address outside the MCOP service area, upon confirmation, the MCOP must identify service providers and arrange for services that will align with the member's future HCBS waiver or MCOP enrollment, and inform the AAA of the proposed or actual change in address (for entry in the eligibility system). When the member is moving to another MyCare Ohio service area, the MCOP must assist the member with contacting the Ohio Medicaid Consumer Hotline to select a new MCOP as soon as possible to avoid any break in MyCare Ohio enrollment.
- 38. Transition of Care Requirements for Members who are Changing MyCare Ohio Plans.** When the MCOP is informed by ODM, or its designee, of a member who is changing to a different MCOP, the disenrolling MCOP must share, at a minimum, the current assessment and care plan, including the waiver service plan, with the enrolling MCOP prior to the new enrollment effective date.
- 39.** The MCOP must assist members with maintenance of Medicaid eligibility by providing timely reminders of annual redetermination dates.

40. The MCOP must ensure accurate claims payment to nursing facility (NF) and home and community-based services (HCBS) waiver providers by appropriately modifying payment when a member has patient liability obligations, lump sum amount(s) pursuant to 5160-3-39.1, and/or restricted Medicaid coverage periods (RMCP). The MCOP is prohibited from paying for NF services and LTSS during a (RMCP). The MCOP must accept provider documentation of determinations made by County Department of Job and Family Services (CDJFS) for patient liability obligations, lump sum amounts, and RMCPs.
41. **Patient Liability and Cost of Care Reconciliation.** Pursuant to Appendix B-5.c.i of the approved 1915(c) MyCare Ohio waiver, following a four month claims run-out period, MCOPs must provide monthly reconciliation reports, as designated by ODM, to each AAA documenting any month for which the waiver member's actual cost of HCBS waiver services is less than the member's patient liability amount for the same period. For all members except those using the Assisted Living Service, the report must specify the actual payment amount of HCBS waiver services delivered and the patient liability amount for the applicable month. The report must be submitted to the AAA no later than the 15th of the month. If no members meet the reporting criteria, the MCOP must enter 'N/A' in the first row of all columns and submit as instructed.
42. **Waiver Enrollment.** For new enrollment on the MyCare waiver, the MCOP or its designee must assist the member in contacting the local waiver agency for assessment and in coordinating waiver eligibility requests through the CDJFS. The CDJFS will generate a waiver eligibility approval or denial notice with hearing rights. MCOPs must authorize waiver services in accordance with OAC 5160-58-01.1 and 5160-26-03.1.
43. **Health Information System Requirements.** The ability to develop and maintain information management systems capacity is crucial to successful plan performance. ODM therefore requires MCOPs to demonstrate their ongoing capacity in this area by meeting several related specifications.
 - a. Health Information System
 - i. As required by 42 CFR 438.242(a), the MCOP must maintain a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and MCOP membership terminations for other than loss of Medicaid eligibility.
 - ii. As required by 42 CFR 438.242(b)(1), the MCOP must collect data on member and provider characteristics and on services furnished to its members.
 - iii. As required by 42 CFR 438.242(b)(2), the MCOP must ensure that data received from providers is accurate and complete by verifying the accuracy and timeliness of reported data, screening the data for completeness, logic, and

consistency, and collecting service information in standardized formats to the extent feasible and appropriate.

- iv. As required by 42 CFR 438.242(b)(4), the MCOP must make all collected data available upon request by ODM or CMS.
 - v. Acceptance testing of any data that is electronically submitted to ODM is required:
 - 1. Before the MCOP may submit production files;
 - 2. Whenever the MCOP changes the method or preparer of the electronic media; and/or
 - 3. When ODM determines that the MCOP's data submissions have an unacceptably high error rate.
 - vi. When the MCOP changes or modifies information systems that are involved in producing any type of electronically submitted files, either internally or by changing vendors, it is required to submit to ODM for review and approval a transition plan that includes the submission of test files in the ODM-specified formats. Once an acceptable test file is submitted to ODM, as determined solely by ODM, the MCOP can return to submitting production files. ODM will inform the MCOP in writing when a test file is acceptable. Once the MCOP's new or modified information system is operational, that MCOP will have up to 90 days to submit an acceptable test file and an acceptable production file.
 - vii. Submission of test files can start before the new or modified information system is in production. ODM reserves the right to verify any MCOP's capability to report elements in the minimum data set prior to executing the provider agreement for the next contract period. Sanctions for noncompliance with this requirement are specified in the Compliance Methodology document.
- b. Claims Adjudication and Payment Processing Requirements
- i. The MCOP must have the capacity to electronically accept and adjudicate all claims to final status (payment or denial). Information on claims submission procedures must be provided to non-contracting providers within 30 days of a request. The MCOP must inform providers of its ability to electronically process and adjudicate claims and the process for submission. Such information must be initiated by the MCOP and not only in response to provider requests. The MCOP must have a sufficient number of provider service representatives who are knowledgeable of the MCOP's claims system.

- ii. The MCOP must notify providers who have submitted claims of claims status [paid, denied, pended (suspended)] within one month of receipt by the MCOP or its designee. Such notification may be in the form of a claim payment/remittance advice produced on a routine monthly, or more frequent, basis. The MCOP provider portal must allow for the availability of all remittance advices upon request.
- iii. The MCOP must implement an Electronic Visit Verification (EVV) system in a timeframe determined by ODM. The timeframe will be no earlier than the timeframe when Fee-For-Service Medicaid implements the EVV system, scheduled for January 1, 2018. The MCOP may use the data collection system established by ODM, or may elect to implement another EVV data collection system so long as it meets all of the ODM data collection system requirements. The MCOP EVV data collection system must successfully provide data to the ODM data gathering system. The MCOP shall utilize data from the EVV data collection system to adjudicate service claims for private duty nursing, state plan home health nursing and aide services, RN assessment services, and waiver nursing and aide services. Prior to implementation, the MCOP must inform providers of the use of the EVV data collection system and how the data will be utilized by the MCOP. The MCOP must also provide assistance on utilization of the collection system, as appropriate, to individuals receiving services, direct care workers and providers.
- iv. Except in the event of fraud or abuse, the MCOP is prohibited from recovering back or adjusting any payments that are beyond two years from the date of payment of the claim due to the MCOP member's retroactive termination of coverage from the MCOP, unless the MCOP is required to do so by CMS, ODM, or applicable state or federal law and regulation.
- v. The MCOP must have policies providing that, upon discovery of claims payment systemic errors that resulted in incorrectly underpaying or denying claims, the MCOP is required to reprocess and correctly pay such claims, from the date of identification of the error retroactively through the period specified in the contract between the MCOP and the provider for claims payment corrective activity. A claims payment systemic error is defined as involving more than five providers, or involving a significant number of payment errors if five or fewer providers are affected. If a claims payment systemic error occurs, the MCOP shall notify ODM of the error and shall specify its process and timeline for corrective action, unless the MCOP corrects the payments within 60 days from the date of identification of the error. The MCOP's policies must include how corrective action will be taken on behalf of all affected providers, regardless of whether the claims payment systemic error is identified by the MCOP or by any

provider. If the error is not a claims payment systemic error, the MCOP shall correct the payments within 60 days from the date of identification of the error.

- vi. The MCOP must load rate changes into applicable systems within 30 calendar days of being notified by ODM of the change.
- vii. The MCOP is prohibited from engaging in practices that unfairly or unnecessarily delay the processing or payment of any claim for MCOP members.
- viii. The MCOP is required to give a 30 calendar day advance notice to providers of any new edits or system changes related to claims adjudication or payments processing.

c. Electronic Data Interchange (EDI)

- i. The MCOP shall comply with all applicable provisions of HIPAA including EDI standards for code sets and the following electronic transactions:
 - Health care claims;
 - Health care claim status request and response;
 - Health care payment and remittance status;
 - Standard code sets; and
 - National Provider Identifier (NPI).
- ii. Each EDI transaction processed by the MCOP shall be implemented in conformance with the appropriate version of the transaction implementation guide, as specified by applicable federal rule or regulation.
- iii. The MCOP must have the capacity to accept the following transactions from ODM consistent with EDI processing specifications in the transaction implementation guides and in conformance with the 820 and 834 Transaction Companion Guides issued by ODM:
 - ASC X12 820 - Payroll Deducted and Other Group Premium Payment for Insurance Products; and
 - ASC X12 834 - Benefit Enrollment and Maintenance.
- iv. The MCOP shall comply with the HIPAA mandated EDI transaction standards and code sets no later than the required compliance dates as set forth in the federal regulations.
- v. The capacity of the MCOP and/or applicable trading partners and business associates to electronically conduct claims processing and related transactions in compliance with standards and effective dates mandated by HIPAA must be demonstrated, to the satisfaction of ODM, as outlined below.

- vi. The MCOP shall comply with the transaction standards and code sets for sending and receiving applicable transactions as specified in 45 CFR Part 162 (HIPAA regulations). In addition the MCOP must enter into the appropriate trading partner agreement and implemented standard code sets. If the MCOP has obtained third-party certification of HIPAA compliance for any of the items listed below, that certification may be submitted in lieu of the MCOP's written verification for the applicable items.
 1. Trading Partner Agreements
 2. Code Sets
 3. Transactions
 - a. Health Care Claims or Equivalent Encounter Information (ASC X12N 837 & NCPDP 5)
 - b. Eligibility for a Health Plan (ASC X12N 270/271)
 - c. Referral Certification and Authorization (ASC X12N 278)
 - d. Health Care Claim Status (ASC X12N 276/277)
 - e. Enrollment and Disenrollment in a Health Plan (ASC X12N 834)
 - f. Health Care Payment and Remittance Advice (ASC X12N 835)
 - g. Health Plan Premium Payments (ASC X12N 820)
 - h. Coordination of Benefits
 - vii. The MCOP must complete and submit an EDI trading partner agreement in a format specified by ODM. Submission of the copy of the trading partner agreement prior to entering into this Agreement may be waived at the discretion of ODM. If submission prior to entering into this Agreement is waived, the trading partner agreement must be submitted at a subsequent date determined by ODM.
 - viii. Noncompliance with the EDI and claims adjudication requirements will result in the imposition of sanctions, as outlined in the Compliance Methodology document.
- d. Encounter Data Submission Requirements

- i. Each MCOP must collect data on services furnished to members through a claims system and must report encounter data electronically to ODM as specified in Appendix L.
 - ii. The MCOP must have the capability to report all elements in the Minimum Data Set as set forth in the ODM Encounter Data Specifications and must submit a test file in the ODM-specified medium in the required formats prior to contracting or prior to an information systems replacement or update. Acceptance testing of encounter data is required as specified in Section 43 of this Appendix.
 - iii. A certification letter must accompany the submission of an encounter data file in the ODM-specified medium. The certification letter must be signed by the MCOP's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for, and who reports directly to, the MCOP's CEO or CFO.
- e. The MCOP must submit files as specified in the *MyCare Ohio Nursing Facility Specifications and Submission Instructions* within timeframes specified by ODM. In addition, the MCOP must collect and submit to ODM upon request the actual nursing facility admission date (any payer) of each member for whom a 100-day threshold was submitted.
- f. In accordance with 42 CFR 438.606, the MCOP must submit a signed data certification letter to ODM attesting to the accuracy and completeness of its audited HEDIS IDSS data submitted to ODM. Each MCOP must also submit to ODM a signed data certification letter attesting to the accuracy and completeness of its final HEDIS audit report (FAR) submitted to ODM. Each data certification letter is due to ODM on the same day the respective HEDIS IDSS data/FAR is to be submitted. For complete instructions on submitting the data certification letters, see ODM Methodology for MCOP Self-Reported, Audited HEDIS Results.
- g. ODM or its designee may review the information system capabilities of each MCOP at the following times: before ODM enters into a provider agreement with a new MCOP, when a participating MCOP undergoes a major information system upgrade or change, when there is identification of significant information system problems, or any time at ODM's discretion. Each MCOP must participate in the review. The review will assess the extent to which the MCOP is capable of maintaining a health information system including producing valid encounter data, performance measures, and other data necessary to support quality assessment and improvement, as well as managing the care delivered to its members. The following activities, at a minimum, will be carried out during the review. ODM or its designee will:
- i. Review the Information Systems Capabilities Assessment (ISCA) forms, as developed by CMS, which the MCOP will be required to complete;

- ii. Review the completed ISCA and accompanying documents;
 - iii. Conduct interviews with MCOP staff responsible for completing the ISCA, as well as staff responsible for aspects of the MCOP's information systems function;
 - iv. Analyze the information obtained through the ISCA, conduct follow-up interviews with MCOP staff, and write a statement of findings about the MCOP's information system;
 - v. Assess the ability of the MCOP to link data from multiple sources;
 - vi. Examine MCOP processes for data transfers;
 - vii. If an MCOP has a data warehouse, evaluate its structure and reporting capabilities;
 - viii. Review MCOP processes, documentation, and data files to ensure that they comply with state specifications for encounter data submissions; and
 - ix. Assess the claims adjudication process and capabilities of the MCOP.
44. If the MCOP will be using the Internet functions that will allow approved users to access member information (e.g., eligibility verification), the MCOP must ensure that the proper safeguards, firewalls, etc., are in place to protect member data.
45. The MCOP must receive prior written approval from ODM before adding any information to its website that would require ODM prior approval in hard copy form (e.g., provider listings, member handbook information).
46. Pursuant to 42 CFR 438.106(b), the MCOP acknowledges that it is prohibited from holding a member liable for the cost of services provided to the member in the event that ODM fails to make payment to the MCOP.
47. In the event of an insolvency of an MCOP, the MCOP, as directed by ODM, must cover the continued provision of services to members until the end of the month in which insolvency has occurred, and must also continue the coverage of inpatient services until the date of discharge for a member who is institutionalized when insolvency occurs.
- 48. Information Required for MCOP Websites.**
- a. On-line Provider Directory. The MCOP must have an internet-based provider directory in the same format as its ODM-approved provider directory, that allows members to electronically search for the MCOP panel providers based on name, provider type and geographic proximity (as specified in Appendix H and the Three-Way Contract). MCOP provider directories must include all MCOP-contracted providers (except as specified by

ODM) as well as all federally qualified health centers, rural health centers, qualified family planning providers, and free-standing birth centers (FBCs) as defined in OAC 5160-18-01 located in the MCOP's service regions. If an MCOP does not have contracted certified nurse midwives (CNMs) or certified nurse practitioners (CNPs) in a service region, then the MCOP must specify that CNM and CNP services are available and that members can contact the MCOP for information on accessing those services. The provider directory must be the same for both Medicaid-only and dual eligible members.

- b. On-line Member Website. The MCOP must have a secure internet-based website which provides members the ability to submit questions, comments, grievances, and appeals, and receive a response. Members must be given the option of a response by return e-mail or phone call. The MCOP's responses to questions or comments must be made within one working day of receipt. The MCOP's responses to grievances and appeals must adhere to the timeframes specified in OAC rule 5160-58-08.4. The member website must be regularly updated to include the most current ODM-approved materials, although this website must not be the only means for notifying members of new and/or revised MCOP information (e.g., change in holiday closures, changes in additional benefits, and revisions to approved member materials). The MCOP must make a copy of its Authorized Representative request form available to members through its online member portal located on the MCOP's website.
- c. The MCOP member website must also include, at a minimum, the following information which must be accessible to members and the general public without any log-in restriction:
 - i. MCOP contact information, including the MCOP's toll-free member services phone number, service hours, and closure dates;
 - ii. A listing of the counties the MCOP serves unless the MCOP serves the entire state in which case the MCOP may indicate it services the entire state;
 - iii. The ODM-approved MCOP member handbook, recent newsletters and announcements;
 - iv. The MCOP's on-line provider directory as referenced in section 48.a. of this Appendix;
 - v. A list of services requiring prior authorization (PA);
 - vi. (6) tThe MCOP's preferred drug list (PDL), including an explanation of the list and identification of any preferred drugs that require PA, the MCOP's list of drugs that require PA, including an explanation of the list, identification of first

line drugs for drugs that require PA for step therapy, how to initiate a PA, and the MCOP's policy for coverage of generic versus brand name drugs;

- vii. A 30 days advance notice of changes to the list of all services requiring PA, as well as, the MCOP's PDL and list of drugs requiring PA. MCOPs must provide a hard copy of notification of any PA changes upon request;
 - viii. The toll-free telephone numbers for the 24/7 medical advice, behavioral health crisis and care management support services call-in systems specified in section 28 of this Appendix;
 - ix. Contact information to schedule non-emergency transportation assistance, including an explanation of the available services and to contact member services for transportation services complaints.
 - x. The toll-free member services, 24/7 call-in systems and transportation scheduling telephone numbers must be easily identified on either the MCOP's website home page or a page that is a direct link from a contact button on the home page. ODM may require the MCOP to include additional information on the member website as needed; and
 - xi. All Healthchek information as specified in 26.a.i. of this Appendix.
- d. The MCOP must have a secure internet-based website for contracting providers through which providers can confirm a member's enrollment and through which providers can submit and receive responses to prior authorization requests (an e-mail process is an acceptable substitute if the website includes the MCOP's e-mail address for such submissions). The provider website must contain accurate enrollment information for all members including whether a member is a dual benefits member or a Medicaid-only member, specifically using those terms.
- e. The MCOP provider website must also include, at a minimum, the following information which must be accessible to providers and the general public without any log-in restrictions:
- i. MCOP contact information, including the MCOP's designated contact for provider issues;
 - ii. A listing of the counties the MCOP serves unless the MCOP serves the entire state in which case the MCOP may indicate it services the entire state;
 - iii. The MCOP's provider manual including the MCOP's claims submission process, as well as a list of services requiring PA, recent newsletters and announcements;

- iv. The MCOP's policies and procedures for out-of-network providers to seek payment of claims for emergency, post-stabilization and any other services authorized by the MCOP;
 - v. The MCOP's on-line provider directory as referenced in section 48.a. of this appendix; and
 - vi. The MCOP's PDL, including an explanation of the list and identification of any preferred drugs that require PA, the MCOP's list of drugs that require PA, including an explanation of the list, identification of first line drugs for drugs that require PA for step therapy, how to initiate a PA, and the MCOP's policy for coverage of generic versus brand name drugs. ODM may require the MCOP to include additional information on the provider website as needed.
 - vii. The MCOP must publish a 30 days advance notice of changes to the MCOP's PDL, the list of drugs requiring PA or any other service or device requiring PA via their website. In addition, 30 days prior to all PA requirement changes, MCOPs must notify providers, via email or standard mail, the specific location of prior authorization change information on the website, pursuant to ORC 5160.34(B)(9-10).
 - viii. The MCOP must provide documentation specifics for PA completion and details about Medicaid programs and their services requiring PA (e.g., drugs, devices) pursuant to ORC 5160.34(B)(11).
 - ix. The MCOP must provide prescribers with in-office access to their preferred drug and PA lists via the availability of at least one hand-held software application.
 - x. The MCOP must provide all Healthchek information as specified in 26. of this Appendix.
- f. The MCOP must adhere to website requirements set forth in 2.12.5.1.4 and 2.14.3.1.3 of the Three-Way Contract.
49. The MCOP must provide members with a printed version of its Preferred Drug List (PDL) and Prior Authorization (PA) lists upon request.
50. **Provider Feedback.** The MCOP must have the administrative capacity to offer feedback to individual providers on their adherence to evidence-based practice guidelines; and positive and negative care variances from standard clinical pathways that may impact outcomes or costs. In addition, the feedback information may be used by the MCOP for activities such as provider performance improvement projects that include incentive programs or the development of quality improvement programs.

51. **Coordination of Benefits Agreement (COBA).** The MCOP must maintain and update their COBA Attachment to the ODM COBA Agreement with CMS' Benefits Coordination and Recovery Center (BCRC). The MCOP must provide ODM with a COBA communication contact to coordinate communication and attend meetings with the BCRC and ODM. The MCOP must also provide ODM with a technical contact to answer questions about the file transfer process and attend technical meetings as required to successfully test and administer the COBA process. Technical and Communication contacts are required to attend a monthly conference call for Group 2 titled: Medicaid/Fiscal Agents, hosted by the BCRC.

- a. The MCOP must initiate file testing with the BCRC upon request from ODM and/or the BCRC. The MCOP must inform ODM in writing upon successful conclusion of testing and readiness for production.
- b. Production files must be submitted on the same schedule as ODM, the 2nd and 15th of each calendar month, in accordance with the file specifications issued by the BCRC, and must include all enrollment spans added or deleted on the MCOP's 834 C and F files.
- c. The MCOP must submit a monthly status report ODM by the 25th of each month, documenting production file status and any issues affecting testing and/or production. Production status reports must contain an attestation that the file submissions to the BCRC were accurate, complete, and timely; that the information submission and receipt of data were made in accordance with 45 CFR 164.502 and 45 CFR 164.504(e); and that all protected health information was safeguarded appropriately. If there was a problem with any production file, the status report must document the reason for the error

52. **Third Party Liability (TPL)**

- a. **Coordination of Benefits.** When a claim is denied due to TPL, the MCOP must timely share appropriate and available information regarding the third party to the provider for the purposes of coordination of benefits, including, but not limited to TPL information received from ODM. In addition, the MCOP must follow the requirements set forth in 5.1.13 of the Three-Way Contract.
- b. **Recovery.** ODM reserves the right to collect and retain any recovery of third party resources for individuals assigned to the MCOPs for collection to the extent that the third party resources remain uncollected from one year from the payment date of the claim.

53. Unless otherwise indicated, MCOP submissions with due dates that fall on a weekend or holiday are due the next business day.

54. The MCOP must subscribe to the appropriate distribution lists for notification of all OAC rule clearances, final rules published with medical assistance letters (MALs), Medicaid handbook

transmittal letters (MHTLs), and other transmittal letters affecting managed care program requirements. The MCOP is solely responsible for submitting its names and email addresses to the appropriate distribution lists and is also responsible for ensuring the validity of any e-mail addresses maintained on those distribution lists.

55. Transfer of PHI from ODM Incident Management and Provider Oversight Contractors. ODM contracts with a vendor, Public Consulting Group (PCG), to serve as the incident management vendor for ODM with respect to the management and investigation of incidents and provider oversight for certain Ohio Medicaid waiver and Specialized Recovery Services (SRS) program consumers. The MCOP shall report and investigate incidents for MyCare Ohio waiver and SRS program members in accordance with OAC rule 5160-58-05.3. Additionally, the MCOP shall report each month to the ODM Bureau of Long-Term Services and Supports (BLTSS), incidents reported to the MCOP for members who are also enrolled in the SRS program that fall under OAC rule 5160-58-05.3 (F)(6) – (F)(11). The report shall be in a format provided to the MCOP by ODM BLTSS.

- a. ODM has instructed PCG to accept and provide data to the MCOPs. The data to be transferred includes Protected Health Information (PHI) as defined in 45 C.F.R. Parts 160 and 164 (“Privacy Regulations”).
- b. ODM and the MCOP are covered entities under HIPAA. Both PCG and the MCOP are Business Associates of ODM, as defined in the Privacy Regulations, and have executed Business Associate Agreements directly with ODM in accordance with HIPAA and the Privacy Regulations.
- c. Data shall be transferred in electronic format. It shall include the data fields set forth in the data transfer document that was jointly developed by ODM, PCG, and the MCOPs. MCOPs must also provide waiver member case notes (at least one month prior to the incident), the most recent assessment, and the service plan in effect at the time of the incident. Plans are encouraged to submit these documents at the time the incident report is made to PCG, but when that is not possible, MCOPs must send them to PCG no later than three working days after submitting the incident report to PCG. For the purpose of investigating incidents set forth in OAC rule 5160-58-05.3 (F)(1) through (F)(5), PCG, ODM or PCG and ODM jointly may ask for additional information, records, data, documentation, prevention plans, etc. as deemed necessary by ODM or PCG to complete the investigation or prevention plan evaluation. If necessary to ensure the immediate health and welfare of the members, the request may be made before the three working days standard. The MCOP shall respond promptly to PCG and/or ODM requests for documentation (to ensure that incident investigations may be completed within the required timeframe established in OAC rule 5160-58-05.3 or as otherwise instructed by ODM). MCOPs and PCG shall exchange such information as necessary for the MCOP to meet both entities’ contractual duties under this Agreement. The MCOP

shall be held to the requirements set forth in the ODM MyCare Ohio Waiver Incident Escalation Procedure. If ODM learns that an MCOP has not promptly submitted required materials, ODM may impose a sanction on the MCOP in accordance with Appendix N.

- d. ODM represents and warrants that separate from this Provider Agreement, a Business Associate agreement that complies fully with the Health Insurance Portability and Accountability Act of 1996 and the HITECH provisions of the American Recovery and Reinvestment Act of 2009 (collectively "HIPAA") and with 45 C.F.R. Parts 160 and 164 (the "Privacy Regulations") has been executed by PCG and is currently effective, and will remain in effect for the Term of this Agreement.
 - e. The MCOP must also establish SFTP and VPN secure data transfer methods with PCG, in order to comply with requirements pursuant to the MyCare Ohio 1915(c) approved waiver and OAC 5160-58-05.3.
56. Pursuant to O.R.C. 5167.14, the MCOP must enter into a data security agreement with the State of Ohio's Board of Pharmacy that governs the MCOP's use of the Board's drug database established and maintained under O.R.C. 4729.75.
57. Upon request by ODM, the MCOP must share data with ODM's actuary. ODM and the MCOP are covered entities under HIPAA. ODM represents and warrants that separate from this Provider Agreement, a Business Associate agreement that complies fully with HIPAA and the Health Information Technology for Economic and Clinical Health Act ("HITECH") and the implementing federal regulations under both Acts, has been executed by Mercer, is currently in effect, and will remain in effect for the Term of this Agreement.
58. As outlined in OAC rules 5160-58-01.1 and 5160-26-05 and the Three-Way, MCOP subcontractors and referral providers may not bill enrollees any amount greater than would be owed if the entity provided the services directly (i.e., no balance billing by providers).
- 59. Conducting Business Outside the United States.**
- a. The MCOP must comply with Executive Order 2011-12K. A copy of Executive Order 2011-12K can be found at <http://governor.ohio.gov/MediaRoom/ExecutiveOrders.aspx>. This Executive Order prohibits the use of public funds to purchase services that will be provided outside of the United States except under certain circumstances. Such services include the use of offshore programming or call centers. Additionally, the MCOP must not transfer PHI to any location outside the United States or its territories.
 - b. Pursuant to 42 CFR 438.602, no MCOP claim paid to any provider, out-of-network provider, subcontractor, or financial institution located outside of the United States is

considered in capitation rates. In addition, no contracting ODM MCOP shall be located outside the United States or its territories.

- 60. National Committee for Quality Assurance (NCQA) Requirements.** The MCOP must hold and maintain accreditation by the NCQA for the Medicare or Medicaid line of business as specified in 2.2.4 of the Three-Way. The MCOP must achieve and/or maintain an Excellent, Commendable or Accredited status. If the MCOP receives a provision or denied status from NCQA, the MCOP will be subject to sanctions as noted in Appendix N. Compliance will be assessed annually based on the MCOP's accreditation status as of September 15th of each year. Upon completion of the accreditation survey, the MCOP must provide any and all documents related to achieving accreditation upon ODM's request as specified in 2.2.4 of the Three-Way.
- 61. Advisory Councils.** The MCOP must comply with Section 2.9.5 of the Three-Way, and must report the following to ODM on the 15th of July, October, January and April of each calendar year:
- a. List of attending members during the prior quarter for each regional Consumer Advisory Board;
 - b. Meeting dates, agenda and the minutes from each regional meeting that occurred during the prior quarter; and
 - c. The MCOP's method for determining the Board's membership reflects the diversity of its enrolled population and includes members with disabilities.
- 62. Home and Community Based Services (HCBS) Waiver Requirements.** For reconciliation of existing waiver enrollees to the MyCare waiver, the MCOP must report to ODM any MyCare member for whom an active waiver span is indicated on the 834 file that documents any waiver but the MyCare Ohio waiver. The MCOP must submit monthly waiver enrollment information to ODM, and must participate in an annual waiver enrollment reconciliation process at the end of each waiver year.
- 63. Payment/Adjustment to Capitation in Consideration of the ACA Section 9010 Health Insurance Providers Fee.** The following payment/adjustment to capitation information applies only to MCOPs that are covered entities under Section 9010 of the Patient Protection and Affordable Care Act, as amended by Section 10905 of the same Act, and as further amended by Section 1406 of the Health Care and Education Reconciliation Act of 2010 (collectively, the "ACA"), and thus required to pay an annual fee ("Annual Fee") for United States health risks.
- a. The ACA requires the MCOP to pay the Annual Fee no later than September 30th (as applicable to each relevant year, the "Fee Year") with respect to premiums paid to the MCOP in the preceding calendar year (as applicable to each relevant year, the "Data Year"), and continuing similarly in each successive year.

- b. In order to satisfy the requirement for actuarial soundness set forth in 42 CFR 438.6(c) with respect to amounts paid by ODM under this Agreement, the parties agree that ODM shall make a payment or an adjustment to capitation to the MCOP for the full amount of the Annual Fee allocable to this Agreement, as follows:
- i. Amount and method of payment: For each Fee Year, ODM shall make a payment or an adjustment to capitation to the MCOP for that portion of the Annual Fee that is attributable to the premiums paid by ODM to the MCOP (the "Ohio Medicaid-specific Premiums") for risks in the applicable Data Year under the Agreement, less any applicable exclusions and appropriate credit offsets. These payments or adjustments to be made by ODM will include the following:
1. The amount of the Annual Fee attributable to this Agreement;
 2. The corporate income tax liability, if any, that the MCOP incurs as a result of receiving ODM's payment for the amount of the Annual Fee attributable to this Agreement; and
 3. Any Ohio state and local Sales and Use taxes and Health Insuring Corporation taxes.

Because the amount of the Annual Fee will not be determinable until after ODM makes the regular capitation payment to the MCOP, ODM shall annually make this payment or adjustment to capitation separately from the regular capitation rate paid to the MCOP.

- ii. Documentation Requirements: ODM shall pay the MCOP after it receives sufficient documentation, as determined by ODM, detailing the MCOP's Ohio Medicaid-specific liability for the Annual Fee. The MCOP shall provide documentation that includes the following:
1. Total premiums reported on IRS Form 8963;
 2. Ohio Medicaid-specific premiums included in the premiums reported on Form 8963;
 3. The amount of the Annual Fee as determined by the IRS; and
 4. The corporate income tax rate applicable to the year of such payments.

Payment by ODM is intended to put the MCOP in the same position as the MCOP would have been in had no Annual Fee been imposed upon the MCOP.

This provision shall survive the termination of the Agreement.

64. The MCOP must have a listing of available independent providers and assist a member in finding an independent provider when requested by the member.
65. **MCOP Portfolio Expansion.** An MCOP must immediately report to ODM all arrangements wherein services or contracts may overlap with Medicaid plans when seeking to expand their portfolio through contracts with other entities.
66. **Subcontractual Relationships and Delegation.** An MCOP that delegates to any first tier, downstream and related entity (FDRs) as defined in 42 CFR 423.4, must ensure that it has an arrangement with the FDR to perform administrative services as defined below on the MCOP's behalf.
 - a. Unless otherwise specified by ODM, administrative services include: care management, marketing, utilization management, quality improvement, enrollment, disenrollment, membership functions, claims administration, licensing and credentialing, provider network management, and coordination of benefits.
 - b. Before an MCOP enters into an arrangement with an FDR to perform an administrative function not listed above that could impact a member's health, safety, welfare or access to Medicaid covered services, the MCOP must contact ODM to request a determination of whether or not the function should be included as an administrative service that complies with the provisions listed herein.
 - c. An MCOP that enters into a written arrangement with an FDR shall include the following enforceable provisions:
 - i. A description of the administrative services to be provided by the FDR and any requirements for the FDR to report information to the MCOP.
 - ii. The beginning date and expiration date or automatic renewal clause for the arrangement, as well as applicable methods of extension, renegotiation and termination.
 - iii. Identification of the service area and Medicaid population, either "dual" or "dual and non-dual" the FDR will serve.
 - iv. A provision stating that the FDR shall release to the MCOP and ODM any information necessary for the MCOP to perform any of its obligations under the MCOP's provider agreement with ODM, including but not limited to compliance with reporting and quality assurance requirements.
 - v. A provision that the FDR's applicable facilities and records will be open to inspection by the MCOP, ODM, its designee or other entities as specified in OAC rule.
 - vi. A provision that the arrangement is governed by, and construed in accordance

with all applicable state or federal laws, regulations and contractual obligations of the MCOP. The arrangement shall be automatically amended to conform to any changes in laws, regulations and contractual obligations without the necessity for written amendment.

- vii. A provision that Medicaid eligible individuals and ODM are not liable for any cost, payment, copayment, cost-sharing, down payment, or similar charge, refundable or otherwise for services performed, including in the event the FDR or MCOP cannot or will not pay for the administrative services. This provision does not prohibit waiver entities from collecting patient liability payments from MCOP members as specified in OAC rule 5160:1-3-04.3.
- viii. The procedures to be employed upon the ending, nonrenewal or termination of the arrangement including at a minimum to promptly supply any documentation necessary for the settlement of any outstanding claims or services.
- ix. A provision that the FDR will abide by the MCOP's written policies regarding the False Claims Act and the detection and prevention of fraud, waste and abuse.
- x. A provision that the FDR, and all employees of the FDR, are subject to the applicable provider qualifications in OAC rule 5160-26-05.
- xi. For an FDR providing administrative services that result in direct contact with a Medicaid eligible individual, a provision that the FDR will identify, and where indicated, arrange pursuant to the mutually agreed upon policies and procedures between the MCOP and FDR for the following at no cost to the individual or ODM:
 - 1. Sign language services; and
 - 2. Oral interpretation and oral translation services.
- xii. For an FDR providing licensing and credentialing services of medical providers an provision that:
 - 1. The credentials of medical professionals affiliated with the party or parties will be reviewed by the MCOP; or
 - 2. The credentialing process will be reviewed and approved by the MCOP and the MCOP will audit the credentialing process on an ongoing basis.
- xiii. For an FDR providing administrative services that result in the selection of providers, a provision that the MCOP retains the right to approve, suspend, or terminate any such selection.

- xiv. A provision that permits ODM or the MCOP to seek revocation or other remedies, as applicable, if ODM or the MCOP determine that the FDR has not performed satisfactorily or the arrangement is not in the best interest of the MCOP's members.

- d. The MCOP is ultimately responsible for meeting all contractual obligations under the MCOP's provider agreement with ODM. The MCOP must:
 - i. Ensure that the performance of FDR is monitored on an ongoing basis to identify any deficiencies or areas for improvement;
 - ii. Impose corrective action on the FDR as necessary; and
 - iii. Maintain policies and procedures that ensure there is no disruption in meeting their contractual obligations to ODM, if the FDR or MCOP terminates the arrangement between the FDR and the MCOP.

- e. Unless otherwise specified by ODM, all information required to be submitted to ODM must be submitted directly by the MCOP.

- f. Information regarding new, changes to, or termination of FDR arrangements must be reported to ODM no less than 15 days prior to it taking effect.

- g. Delegation requirements do not apply to care management arrangements between an MCOP and a Recovery Management entity as cited in appendix K.

APPENDIX D

ODM RESPONSIBILITIES

The following are the Ohio Department of Medicaid (ODM) responsibilities or clarifications that are not otherwise specifically stated in OAC Chapter 5160-26, 5160-58 or elsewhere in the ODM MyCare Ohio Plan (MCOP) Provider Agreement.

General Provisions

1. ODM will provide MCOPs with an opportunity to review and comment on the rate-setting time line and proposed rates, and proposed changes to the OAC program rules and the provider agreement.
2. ODM will notify MCOPs of managed care program policy and procedural changes and, whenever possible, offer sufficient time for comment and implementation.
3. ODM will provide regular opportunities for MCOPs to receive program updates and discuss program issues with ODM staff.
4. ODM will provide technical assistance sessions where MCOP attendance and participation is required. ODM will also provide optional technical assistance sessions to MCOPs, individually or as a group.
5. ODM will provide MCOPs with linkages to organization(s) that can provide guidance on the development of effective strategies to eliminate health disparities.
6. ODM will conduct an annual analysis of Medicaid eligible individuals to identify whether there are any prevalent common primary languages, other than English, in an MCOP's service area. ODM will notify the MCOP of any languages that are identified as prevalent for the purpose of translating marketing and member materials.
7. ODM will provide each MCOP with an annual MCOP Calendar of Submissions outlining major submissions and due dates.
8. ODM will identify contact staff, including the Contract Administrator (CA), selected for each MCOP.
9. ODM will provide each MCOP with an electronic Provider Master File containing all the Ohio Medicaid fee-for-service (FFS) providers, which includes their Medicaid Provider Numbers, as well as all providers who have been assigned a provider reporting number for current encounter data purposes. This file will also include NPI information when available.

10. Consumer Information

- a. ODM, or its delegated entity, will provide membership notices, informational materials, and instructional materials to members and eligible individuals in a manner and format that may be easily understood. At least annually, ODM or its designee will provide current MCOP members with an open enrollment notice which describes the MyCare Ohio program and includes information on the MCOP options in the service area and other information regarding the MyCare Ohio program.
- b. ODM will notify members or ask MCOPs to notify members about significant changes affecting contractual requirements, member services or access to providers.
- c. If an MCOP elects not to provide, reimburse, or cover a counseling service or referral service due to an objection to the service on moral or religious grounds, ODM will provide coverage and reimbursement for these services for the MCOP's members. As applicable, ODM will provide information to the MCOP's members on what services the MCOP will not cover and how and where the MCOP's members may obtain these services.

11. Membership Selection and Premium Payment

- a. The Medicaid Consumer Hotline (henceforth referred to as the "Hotline") - The ODM-contracted Hotline is responsible for providing unbiased education and selection services for the Medicaid managed care program. The Hotline operates a statewide toll-free telephone center to assist eligible individuals in selecting an MCOP or choosing a health care delivery option.
- b. Auto-Assignment Eligible individuals that fail to select a plan will be assigned to an MCOP at the discretion of ODM.
- c. Consumer Contact Record (CCR): ODM or their designated entity shall provide CCRs to MCOPs on no less than a weekly basis. A CCR is a record of each consumer-initiated MCOP enrollment, change, or termination, and each Hotline-initiated MCOP assignment processed through the Hotline.
- d. ODM verifies MCOP enrollment via a membership roster. ODM or its designated entity will provide a full member roster (F) and a change roster (C) via HIPAA 834 compliant transactions.
- e. Monthly Premiums - ODM will remit payment to the MCOPs via an electronic funds transfer (EFT), or at the discretion of ODM, by paper warrant.
- f. Remittance Advice (RA) - ODM will confirm all premium payments paid to the MCOP during the month via a monthly RA. ODM or its designated entity will provide a record of each recipient detail level payment via HIPAA 820 compliant transactions. ODM or its

- designee will keep a record of each MCOPs Accounts Payable (e.g. Pay 4 Performance, and Health Insurance Provider Fee) and Accounts Receivable (e.g. Penalty, Credit Balance) transaction on the MITS Provider Portal Report Tab.
- g. ODM will provide optional dual benefits enrollment and will not require mandatory Medicaid only enrollment for individuals who are determined eligible for County Board of Developmental Disabilities Services.
12. ODM will make available a website which includes current program information.
 13. ODM will regularly provide information to MCOPs regarding different aspects of MCOP performance including, but not limited to, information on MCOP-specific and statewide external quality review organization surveys, focused clinical quality of care studies, consumer satisfaction surveys and provider profiles.
 14. Communications - The Bureau of Managed Care (BMC) is responsible for the oversight of the MCOPs' provider agreements with ODM. Within the BMC, a specific Contract Administrator (CA) has been assigned to each MCOP. Unless expressly directed otherwise, an MCOP shall first contact its designated CA for questions/assistance related to Medicaid and/or the MCOP's program requirements /responsibilities. If its CA is not available and the MCOP needs immediate assistance, MCOP staff should request to speak to a supervisor within the Managed Care Contract Administration Section.

APPENDIX E
RATE METHODOLOGY



Calendar Year 2017 MyCare Ohio Provider Agreement Rate Certification Summary

Opt-In Capitation Rates

January 1, 2017 through December 31, 2017

Ohio Department of Medicaid

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Table of Contents

INTRODUCTION.....	2
SUMMARY OF CAPITATION RATES.....	2
FISCAL IMPACT ESTIMATE	4
ACTUARIAL CERTIFICATION.....	4
METHODOLOGY.....	5
LIMITATIONS	7

APPENDIX 1: CERTIFIED RATES

INTRODUCTION

This document is an abridged version of the capitation rate certification entitled *MyCare Opt-In Rate Certification CY 2017 – Final* and delivered to the Ohio Department of Medicaid (ODM) on November 17, 2017. For a complete version, please reference the specified document.

Milliman, Inc. (Milliman) has been retained by the Ohio Department of Medicaid (ODM) to provide actuarial and consulting services related to the development of the calendar year 2017 (demonstration year 3) capitation rates for MyCare Ohio. MyCare Ohio is Ohio's managed care program for the dual eligible (Medicare-Medicaid) population. Eligible individuals are required to either receive both Medicare and Medicaid services (Opt-In) or Medicaid services only (Opt-Out) through the managed care plan. Enrollees who select to Opt-In become participants in the Dual Demonstration program.

Actuarially sound capitation rates for the calendar year 2017 rate period were developed for the Medicaid Opt-Out population, which serve as the baseline Medicaid costs in the development of the Medicaid Opt-In rates. The baseline Medicaid costs were adjusted for enrollee selection assumptions, the removal of long-term supports and services (LTSS) rebalancing adjustments, and the 4% integrated care joint savings (joint savings) percentage for the Opt-In population for Demonstration Year 3 as identified in the three-way contract between ODM, CMS, and the MyCare Ohio Plans (MCOPs).

This report documents the adjustments made to the baseline Medicaid costs to develop the Opt-In capitation rates. Documentation of the development of the baseline Medicaid costs is contained in the Opt-Out rate certification, provided as a separate document. Any user of this report should have access to the document "MyCare Opt-Out Rate Certification CY 2017 - Final" dated November 17, 2016.

Unless otherwise specified, all references to "rates" or "capitation rates" throughout this document refer to the Medicaid-covered services under the MyCare Ohio Opt-In capitation rates.

CERTIFIED CAPITATION RATES

The underlying capitation rates by rate cell and region are effective from January 1, 2017 through December 31, 2017 are illustrated in Appendix 1. The composite rates illustrated for July 2016 through December 2016 and calendar year 2017 have both been developed based on projected average monthly enrollment for calendar year 2017.

ACTUARIAL CERTIFICATION

The capitation rates provided with this certification are "actuarially sound" for purposes of 42 CFR 438.4(a), according to the following criteria:

- The capitation rates provide for all reasonable, appropriate, and attainable costs that are required under terms of the contract and for the operation of the managed care plan for the time period and population covered under the terms of the contract, and such capitation rates were developed in accordance with the requirements under 42 CFR 438.4(b).

To ensure compliance with generally accepted actuarial practices and regulatory requirements, we referred to published guidance from the American Academy of Actuaries (AAA), the Actuarial Standards Board (ASB), the Centers for Medicare and Medicaid Services (CMS), and federal regulations. Specifically, the following were referenced during the rate development:

- Actuarial standards of practice applicable to Medicaid managed care rate setting which have been enacted as of the capitation rate certification date, including: ASOP 1 (Introductory Actuarial Standard of Practice); ASOP 5 (Incurred Health and Disability Claims); ASOP 23 (Data Quality); ASOP 25 (Credibility Procedures); ASOP 41 (Actuarial Communications); ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies); and ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification).
- Actuarial soundness and rate development requirements in the Medicaid and CHIP Managed Care Final Rule (CMS 2390-F) for the provisions effective as of January 1, 2017.

- The most recent *Medicaid Managed Care Rate Development Guide* published by CMS.
- Throughout this document and consistent with the requirements under 42 CFR 438.4(a), the term “actuarially sound” will be defined as in ASOP 49:

“Medicaid capitation rates are “actuarially sound” if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits; health benefit settlement expenses; administrative expenses; the cost of capital, and government-mandated assessments, fees, and taxes.”

METHODOLOGY

The CY 2017 Opt-In capitation rates were developed from the Opt-Out capitation rates (baseline Medicaid data). The baseline Medicaid data was adjusted for the following factors:

- Selection adjustments
- Removal of LTSS rebalancing assumption
- Application of 4% joint savings as required under demonstration year 3

Selection. The baseline Medicaid data was adjusted through a selection adjustment to reflect the estimated health status and underlying utilization of the Opt-In population relative to the Opt-Out population. Selection adjustments were developed based on a review of cost relativities between the Opt-In and Opt-Out populations by population and category of service. CY 2015 and CY 2016 YTD cost report data, along with cost relationships underlying the CY 2016 capitation rates were reviewed in the development of the selection factor assumptions.

We reviewed the benefit expense experience between the Opt-Out and Opt-In populations on a regional basis to evaluate whether the Opt-In penetration rate (the percentage of the total MyCare population participating in the dual demonstration) materially impacted the benefit expense relationship between the Opt-In and Opt-Out populations. Because both the Opt-In penetration and cost relationships did not exhibit a high degree of variance, we elected to develop selection factors between the Opt-In and composite Opt-In/Out experience on a program-wide basis. The selection factors were applied on a budget neutral basis to the regionally smoothed data (the composite Opt-Out and Opt-In benefit expense after the selection adjustments is equal to the combined benefit expense prior to the application of the selection adjustments). Refer to the Opt-Out rate certification for additional information related to the data sources used to develop the selection factor adjustments.

Removal of LTSS rebalancing assumption. In the Medicaid baseline data, the blended nature of the NFLOC rate cell encourages MCOPs to manage the mix of the population towards lower cost settings. For the Medicaid baseline data, our assumption for CY 2017 is that the average mix between HCBS and nursing facility will shift by 1% in favor of HCBS for the year. While the blended NFLOC rate cell structure is maintained for the Opt-In capitation rates, we do not assume a shift from nursing facility to HCBS during the year. We have assumed that the 4% joint savings adjustment applied to the Opt-In population encompasses this rebalancing impact appropriately.

Application of 4% joint savings as required under demonstration year 3. As documented in Section 4.2.3.1.3 of the MyCare three-way contract¹, a 4% aggregate savings percentage is applied to the Medicare A/B Component and the Medicaid component of the MyCare capitated rate. The 4% savings was applied to the Medicaid baseline data, adjusted for the selection and the removal of the LTSS rebalancing assumption. The adjusted Medicaid baseline data includes the same care management per member per month (PMPM) rate as the Opt-Out certification for each region and population.

¹ <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/OhioContract.pdf>

Administrative costs and risk margin are the same percentage of the overall Opt-In capitation rates as included in the starting base data (Opt-Out rates).

The MCOP premium revenue is subject to a Sales and Use tax that varies by county. We obtained the tax rates by county from the State of Ohio website (http://www.tax.ohio.gov/sales_and_use.aspx) and weighted the county-level tax amounts by August 2016 enrollment by county for each population. Sales and Use tax amounts were composited at the population and region level from the county estimates and applied as a percentage of the total capitation rate for each population and region combination. Developing Sales and Use tax amounts through the use of membership versus capitation rate weighting produces equivalent results when the fees are applied at the region and population level.

LIMITATIONS

The information contained in this report has been prepared for the Ohio Department of Medicaid (ODM) to provide documentation of the development of the CY 2017 actuarially sound capitation rates for the MyCare Ohio program. The data and information presented may not be appropriate for any other purpose.

It is our understanding that the information contained in this letter will be shared with CMS and may be utilized in a public document. Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for ODM by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

Milliman relied upon certain data and information provided by ODM, their vendors and the participating MCOPs in the development of the calendar year 2017 capitation rates. Milliman has relied upon ODM and the MCOPs for the accuracy of the data and accepted it without audit. To the extent that the data provided is not accurate, the capitation rate development would need to be modified to reflect revised information.

It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this report.

The services provided by Milliman to ODM were performed under the signed contract agreement between Milliman and ODM dated June 11, 2015.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The actuaries preparing this report are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

APPENDIX 1: CERTIFIED RATES

**Ohio Department of Medicaid
MyCare Managed Care Program
CY 2017 Opt-In Certified Rates**

Population Group:	NFLOC Total		
Region	Full Medicaid Rate	Quality Withhold	Guaranteed Rate
Central / Southeast	\$ 4,321.59	\$ 129.65	\$ 4,191.94
East Central	3,294.91	98.85	3,196.06
Northeast	3,922.00	117.66	3,804.34
Northeast Central	3,598.30	107.95	3,490.35
Northwest	3,764.89	112.95	3,651.94
Southwest	4,031.71	120.95	3,910.76
West Central	3,521.75	105.65	3,416.10
Statewide Total	\$ 3,805.01	\$ 114.15	\$ 3,690.86

Population Group:	Community Well 18-44		
Region	Full Medicaid Rate	Quality Withhold	Guaranteed Rate
Central / Southeast	\$ 464.67	\$ 13.94	\$ 450.73
East Central	292.58	8.78	283.80
Northeast	360.49	10.81	349.68
Northeast Central	264.43	7.93	256.50
Northwest	415.29	12.46	402.83
Southwest	325.35	9.76	315.59
West Central	366.31	10.99	355.32
Statewide Total	\$ 356.39	\$ 10.69	\$ 345.70

Population Group:	Community Well 45-64		
Region	Full Medicaid Rate	Quality Withhold	Guaranteed Rate
Central / Southeast	\$ 645.92	\$ 19.38	\$ 626.54
East Central	349.28	10.48	338.80
Northeast	426.71	12.80	413.91
Northeast Central	311.10	9.33	301.77
Northwest	461.25	13.84	447.41
Southwest	402.82	12.08	390.74
West Central	433.69	13.01	420.68
Statewide Total	\$ 435.77	\$ 13.07	\$ 422.70

Population Group:	Community Well 65+		
Region	Full Medicaid Rate	Quality Withhold	Guaranteed Rate
Central / Southeast	\$ 799.20	\$ 23.98	\$ 775.22
East Central	643.27	19.30	623.97
Northeast	565.83	16.97	548.86
Northeast Central	614.03	18.42	595.61
Northwest	511.02	15.33	495.69
Southwest	731.36	21.94	709.42
West Central	671.08	20.13	650.95
Statewide Total	\$ 640.07	\$ 19.20	\$ 620.87



Calendar Year 2017 MyCare Ohio Provider Agreement Rate Certification Summary

Opt-Out Capitation Rates

January 1, 2017 through December 31, 2017

Ohio Department of Medicaid

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Table of Contents

INTRODUCTION.....	3
Background.....	3
Certified Capitation Rates.....	3
SECTION I. MEDICAID MANAGED CARE RATES.....	4
1. GENERAL INFORMATION.....	4
A. Annual basis.....	4
B. Documentation.....	4
2. DATA.....	5
A. Description of the data.....	5
i. Description of the data.....	5
(a) Types of data.....	5
(b) Age of the data.....	5
(c) Data sources.....	5
(d) Sub-capitation.....	6
ii. Availability and quality of the data.....	6
(a) Steps taken to validate the data.....	6
(b) Actuary’s assessment.....	6
(c) Data concerns.....	7
iii. Use of encounter and fee-for-service data.....	7
iv. Use of managed care encounter data.....	7
v. Reliance on a data book.....	7
B. Data adjustments.....	7
i. Credibility adjustment.....	7
ii. Completion adjustment.....	8
iii. Errors found in the data.....	8
iv. Program change adjustments.....	8
Retrospective program changes.....	9
Prospective program changes.....	9
v. Exclusion of payments or services from the data.....	12
3. PROJECTED BENEFIT COST AND TRENDS.....	13
A. Final Capitation Rate Compliance.....	13
B. Basis for variations in assumptions.....	13
C. Development of projected benefit costs.....	13
i. Description of the data, assumptions, and methodologies.....	13
(a) Benefit adjustments.....	14
(b) Reimbursement adjustments.....	15
(c) Managed care efficiency adjustments.....	15

ii.	Material changes to the data, assumptions, and methodologies	15
D.	Projected benefit cost trends	15
i.	Description of the data, assumptions, and methodologies	15
(a)	Data.....	16
(b)	Methodology.....	16
(c)	Comparisons	16
ii.	Benefit cost trend components	16
iii.	Variation	16
iv.	Material adjustments	16
v.	Any other adjustments.....	17
(a)	Impact of managed care.....	17
(b)	Trend changes other than utilization and unit cost	17
E.	Mental health parity and addiction equity act service adjustment	17
F.	In lieu of services	17
	The projected benefit costs do not include costs for in lieu of services.	17
G.	Benefit expenses associated with members residing in an IMD	17
H.	Retrospective eligibility periods.....	17
i.	Health plan responsibility	17
ii.	Base data treatment.....	17
iii.	Enrollment treatment	17
iv.	Adjustments	17
4.	PASS-THROUGH PAYMENTS.....	17
5.	PROJECTED NON-BENEFIT COSTS.....	18
A.	Basis for variations in assumptions.....	18
B.	Data, assumptions and methodologies	18
i.	Description of the data, assumptions, and methodologies	18
(a)	Data.....	18
(b)	Assumptions and methodology	18
ii.	Material changes	18
C.	Non-benefit costs, by cost category	18
i.	Administrative costs	18
ii.	Care coordination and care management.....	19
iii.	Provision for margin	19
iv.	Taxes, fee, and assessments.....	20
v.	Other material non-benefit costs	20
D.	PMPM versus percentage.....	20
E.	Health insurer fee	20
i.	Whether the fee is incorporated in the rates	20
ii.	Fee year or data year.....	20
iii.	Determination of fee impact to rates.....	20
iv.	Identification of long-term care benefits.....	20
F.	Health insurer fee moratorium	21

6.	RATE RANGE DEVELOPMENT	21
7.	RISK MITIGATION AND RELATED CONTRACTUAL PROVISIONS	21
A.	Description of risk mitigation	21
B.	Risk adjustment model and methodology	21
i.	Risk adjustment model	21
ii.	Data and adjustments	21
iii.	Changes from the prior year	21
iv.	Frequency	21
v.	How the risk scores will be used to adjust the capitation rates	21
vi.	An attestation that the risk adjustment is cost neutral	22
C.	Address cost neutrality	22
D.	Other risk sharing arrangements	22
E.	Medical loss ratio	22
i.	Description	22
ii.	Financial consequences	22
F.	Reinsurance requirements and effect on capitation rates	22
G.	Attestation of incentive arrangements	22
H.	Incentives and withholds	22
i.	Withholds	22
ii.	Estimate of percent to be returned	23
iii.	Effect on the capitation rates	23
8.	OTHER RATE DEVELOPMENT CONSIDERATIONS	23
A.	Different FMAP	23
B.	Basis for variations in assumptions	23
C.	Effective dates	23
D.	Actuarially accepted practices and principles	23
i.	Reasonable, appropriate, and attainable	23
ii.	Outside the rate setting process	23
iii.	Rates within ranges	23
9.	PROCEDURES FOR RATE CERTIFICATION AND CONTRACT AMENDMENTS	23
SECTION II. MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES AND SUPPORTS		25
1.	MANAGED LONG-TERM SERVICES AND SUPPORTS	25
A.	Completion of section I	25
B.	MLTSS Rate structure	25
(a)	Capitation rate structure	25
(b)	Methodology	26
C.	Managed care effect	26
D.	Non-Benefit cost	26
E.	Experience and assumptions	26
LIMITATIONS		27
APPENDIX 1: CERTIFIED RATES		

INTRODUCTION

This document is an abridged version of the capitation rate certification entitled *MyCare Opt-Out Rate Certification CY 2017 – Final* and delivered to the Ohio Department of Medicaid (ODM) on November 17, 2017. For a complete version, please reference the specified document.

BACKGROUND

Milliman, Inc. (Milliman) has been retained by the Ohio Department of Medicaid (ODM) to provide actuarial and consulting services related to the development of the calendar year 2017 (demonstration year 3) capitation rates for MyCare Ohio. MyCare Ohio is Ohio's managed care program for the dual eligible (Medicare-Medicaid) population. Eligible individuals are required to either receive both Medicare and Medicaid services (Opt-In) or Medicaid services only (Opt-Out) through the managed care plan. Enrollees who select to Opt-In become participants in the Dual Demonstration program.

This letter provides the development of the actuarially sound calendar year 2017 capitation rates for Opt-Out individuals. Unless otherwise specified, all references to "rates" or "capitation rates" throughout this document refer to the Medicaid-covered services under the MyCare Ohio Opt-Out capitation rates.

To facilitate review, this document has been organized in the same manner as the most recent Managed Care Rate Development Guide, released by CMS in October 2016 (CMS Guide).

CERTIFIED CAPITATION RATES

The certified Opt-Out capitation rates by rate cell with and without the 2017 quality withhold are illustrated in Appendix 1. The rates are effective from January 1, 2017 through December 31, 2017.

SECTION I. MEDICAID MANAGED CARE RATES

1. GENERAL INFORMATION

This section provides information listed under the General Information section of the Managed Care Rate Development Guide (CMS guide), Section I.

The capitation rates provided with this certification are “actuarially sound” for purposes of 42 CFR 438.4(a), according to the following criteria:

- The capitation rates provide for all reasonable, appropriate, and attainable costs that are required under terms of the contract and for the operation of the managed care plan for the time period and population covered under the terms of the contract, and such capitation rates were developed in accordance with the requirements under 42 CFR 438.4(b).

To ensure compliance with generally accepted actuarial practices and regulatory requirements, we referred to published guidance from the American Academy of Actuaries (AAA), the Actuarial Standards Board (ASB), the Centers for Medicare and Medicaid Services (CMS), and federal regulations. Specifically, the following were referenced during the rate development:

- Actuarial standards of practice applicable to Medicaid managed care rate setting which have been enacted as of the capitation rate certification date, including: ASOP 1 (Introductory Actuarial Standard of Practice); ASOP 5 (Incurred Health and Disability Claims); ASOP 23 (Data Quality); ASOP 25 (Credibility Procedures); ASOP 41 (Actuarial Communications); ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies); and ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification).
- Actuarial soundness and rate development requirements in the Medicaid and CHIP Managed Care Final Rule (CMS 2390-F) for the provisions effective as of January 1, 2017.
- The most recent *Medicaid Managed Care Rate Development Guide* published by CMS.
- Throughout this document and consistent with the requirements under 42 CFR 438.4(a), the term “actuarially sound” will be defined as in ASOP 49:

“Medicaid capitation rates are “actuarially sound” if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits; health benefit settlement expenses; administrative expenses; the cost of capital, and government-mandated assessments, fees, and taxes.”

A. ANNUAL BASIS

The actuarial certification contained in this report is effective for the capitation rates for the one-year rate period from January 1, 2017 through December 31, 2017.

B. DOCUMENTATION

This report contains appropriate documentation of all elements described in the rate certification, including data used, assumptions made, and methods for analyzing data and developing assumptions and adjustments.

2. DATA

A. DESCRIPTION OF THE DATA

i. Description of the data

(a) Types of data

The following experience served as the primary data sources for the calendar year 2017 MyCare Ohio Opt-Out capitation rate development:

Base Data Source

- Calendar year (CY) 2015 Opt-In and Opt-Out cost report data submitted by the MCOPs (financial summaries).

Supplemental Data Sources

- YTD June 2016 Opt-In and Opt-Out cost report data submitted by the MCOPs (financial summaries);
- Historical Fee for service (FFS) claims and enrollment data for the MyCare eligible population;
- FFS claims and enrollment data for non-MyCare counties;
- Survey responses from Area Agencies on Aging (AAAs) related to January 2016 through June 2016 costs for waiver service coordination;
- Survey responses from MCOPs related to AAA contracting and other care management costs for CY 2016;
- MyCare eligibility data maintained by ODM; and,
- Encounter data submitted by the MCOPs.

(b) Age of the data

The predominant data used in the development of the capitation rates is the CY 2015 MCOP Opt-In and Opt-Out cost report data. The CY 2015 cost report data represents claims incurred January 1, 2015 through December 31, 2015, reported with claims run-out through March 31, 2016. The YTD June 2016 MCOP Opt-In and Opt-Out cost report data, which was used on a limited basis, represents claims incurred January 1, 2016 through June 30, 2016, and paid through June 30, 2016.

The FFS data for the MyCare eligible population reflects claims incurred from May 1, 2013 through April 30, 2014 and paid through June 30, 2016 (i.e., prior to implementation of the MyCare program). The May 1, 2013 through April 30, 2014 incurred FFS claims data formed the basis for development of the CY 2016 capitation rates, but had a limited role in the CY 2017 capitation rate development. The FFS data for non-MyCare counties was predominantly used for trend development and represents claims incurred from January 1, 2013 through June 30, 2016 and paid through June 30, 2016.

We received detailed MyCare enrollment data from program inception (May 1, 2014) through June 2016.

We additionally reviewed MyCare encounter data submitted by the MCOPs for the period of January 1, 2015 through December 31, 2015, submitted through June 30, 2016; however, the encounter data was not of sufficient quality to be relied upon for the development of actuarially sound capitation rates. It was, however, used to assist in the impact analysis for a very limited number of program and policy changes.

(c) Data sources

The cost report data was submitted to ODM and Milliman by each of the five MCOPs. We received the cost report data in separate Opt-In and Opt-Out Microsoft Excel files that the MCOPs submit to ODM on a cumulative quarterly basis, as well as final calendar year versions at each year end that include three months of claims run-out. To increase credibility, the Opt-In CY 2015 cost report data was combined with the CY 2015 Opt-Out data for the development of the actuarial sound CY 2017 Opt-Out capitation rates.

The YTD June 2016 cost report data was used primarily to verify consistency with the CY 2015 cost report data, to review the emerging impact of recent policy and program changes, to identify significant emerging utilization patterns, and to strengthen development of regional geographic adjustments.

The FFS data sets were provided by ODM through monthly vendor files. The vendor files are developed and maintained by Hewlett Packard (HP), ODM's fiscal agent. While historical FFS data was used as the primary data source for the 2016 capitation rate development, FFS data was limited to a supplemental role in the CY 2017 capitation rate development because of the increasing age of the data. Historical FFS data based upon a proxy population from non-MyCare counties was used in the analysis of trend adjustments.

The historical encounter data experience for the MyCare program is submitted by the five MCOPs on an ongoing basis. This data is stored in ODM's Medicaid Information Technology System (MITS). As mentioned previously, the encounter data was not of sufficient quality to be relied upon for the development of CY 2017 actuarially sound capitation rates. It was, however, used to assist in the impact analysis for a very limited number of program and policy changes.

Medicaid enrollment data is additionally stored in MITS and maintained by ODM. The enrollment data was provided to us for the purposes of comparison to the submitted cost reports and projection of 2017 enrollment distributions.

(d) Sub-capitation

We relied on the separate reporting of non-sub-capitated and sub-capitated experience by the MCOPs in the medical cube worksheets of the CY 2015 and YTD June 2016 cost reports. In the MCOP cost reports, sub-capitated expenditures represent the amounts paid by MCOPs for sub-capitated services, rather than "shadow priced" claims as expected in the submitted encounter data. Sub-capitation was limited to 2% of total reported medical expenses in CY 2015. The FFS base data does not include sub-capitation amounts.

ii. Availability and quality of the data

(a) Steps taken to validate the data

The base experience used in the capitation rates relies on cost report data submitted to ODM by participating MCOPs. MyCare eligibility is maintained in MITS by ODM. The actuary, the MCOPs, and ODM all play a role in validating the quality of the cost report data used in the development of the capitation rates. The MCOPs play the initial role, collecting and summarizing financial data which is sent to the state. We receive cost report data from ODM for every MCOP on a quarterly and annual basis. The cost report data for each MCOP is reconciled to prior cost reports and to ODM-maintained MyCare eligibility records. We review every cost report submission for quality and data concerns and provide ODM with a list of identified issues specific to each MCOP. In certain circumstances, MCOPs are required to resubmit cost report data to correct data anomalies. Composite and health plan specific data are loaded into a dashboard which is presented to ODM for discussion and review.

Comparison between the CY 2015 cost reports and the other data sources required normalization for CY 2015 and CY 2016 program and policy changes, as well as estimated trend. Further discussion of trend rate assumptions is documented in the trend rate development section of this report.

(b) Actuary's assessment

As required by Actuarial Standard of Practice No. 23, Data Quality, we disclose that we have relied upon certain data and information provided by ODM and their vendors, primarily the MCOPs and ODM's fiscal agent. The certification is dependent upon this reliance.

We find the cost report data used to develop the 2017 capitation rates to be of appropriate quality and suitable for the purpose of developing actuarially sound rates (subject to the data concerns and resolutions indicated in the *Data concerns* section below). The resulting base data PMPM expenditures for CY 2015, after adjustments for data quality, is approximately 1.9% greater than the PMPM expenditures submitted by the MCOPs. The cost report data additionally appears reasonable in relation to Medicaid dual eligible managed care industry experience.

We believe developing the Opt-Out capitation rates from a blend of Opt-Out and Opt-In experience, with appropriate adjustments, represents the most reasonable usage of available base experience data. We believe this methodology provides greater stability to capitation rates on a year to year basis.

The MCOP encounter data is not of sufficient quality to be relied upon for development of the majority of adjustments for reimbursement or policy changes that will impact MyCare expenditures during the rate period beginning January 1, 2017. Adjustments for reimbursement or policy changes were primarily developed from a combination of May 1, 2013 through April 30, 2014 FFS data for the MyCare eligible population located in participating counties, along with CY 2015 FFS data for beneficiaries who would otherwise be eligible for MyCare, but reside in non-participating counties. We believe the historical FFS data corresponding to the MyCare eligible population to be the most appropriate data for development of the majority of program and policy change adjustments. The specified FFS data was used in the development of the CY 2016 MyCare capitation rates and has been reviewed for reasonableness and completeness.

(c) Data concerns

Comparison between the CY 2015 cost report data and the YTD June 2016 cost report data, between the CY 2015 cost report data, and historical FFS MyCare eligible data, identified several data quality concerns. CY 2015 estimated PMPM expenditures increased by approximately 1.9% over the CY 2015 incurred and paid claims basis from the CY 2015 cost reports following the data revisions discussed in this section.

iii. Use of encounter and fee-for-service data

Historical FFS claims and enrollment were not used as the primary data source for this certification. Rather, the FFS data was used to assist with the development and verification of program and pricing adjustments and other modeling assumptions. The FFS data used to supplement the CY 2017 rate development reflects historical experience and covered services closely aligned with the MyCare program.

iv. Use of managed care encounter data

The MCOP encounter data is not of sufficient quality to be relied upon for the development of actuarially sound capitation rates. It was, however, used to assist in the impact analysis for a very limited number of program and policy changes. While validation efforts continue, there remain numerous reporting issues that have not been resolved.

v. Reliance on a data book

We relied upon detailed MyCare cost report data provided by the MCOPs for all covered services and populations. Capitation rate development was supplemented using historical FFS data and enrollment for a MyCare eligible population.

B. DATA ADJUSTMENTS

Capitation rates were developed from CY 2015 program-wide Opt-In and Opt-Out cost report data with claims runout through March 31, 2016. The base data year adjustments include claims completion adjustments, regional smoothing adjustments, opt-in/opt-out selection adjustments, retrospective program adjustments, and other program adjustments.

i. Credibility adjustment

Combining of Opt-In and Opt-Out cost report data and Selection Adjustments

CY 2015 Opt-Out cost report data was combined with corresponding Opt-In MyCare Ohio Medicaid cost report data because the Opt-Out data alone was not fully credible for certain populations and most categories of service.

Smoothing by region

The CY 2015 cost report data was considered fully credible by population on a statewide basis following resolution of the data anomalies identified in Section 2.A.ii(c). However, regional adjustments were developed from aggregation of multiple data sources to improve credibility and to protect the proprietary nature of the cost report data due to the limited number of MCOPs which participate in each region. The application of the regional adjustments to the CY 2015 base experience data was normalized to a 1.000 statewide basis using August 2016 Opt-In and Opt-Out combined enrollment.

Selection adjustments

The composite Opt-In and Opt-Out experience was allocated using a selection adjustment to reflect the estimated health status and underlying utilization of the Opt-Out population. Selection adjustments were developed based on a review of cost relativities between the Opt-In and Opt-Out populations by population and category of service. CY 2015 and CY 2016 YTD cost report data, along with cost relationships underlying the CY 2016 capitation rates, were reviewed in the development of the selection factor assumptions.

We reviewed the benefit expense experience between the Opt-Out and Opt-In populations on a regional basis to evaluate whether the Opt-In penetration rate (the percentage of the total MyCare population participating in the Dual Demonstration) materially impacted the benefit expense relationship between the Opt-In and Opt-Out populations. Because the Opt-In penetration and cost relationships did not exhibit a high degree of variance, we elected to develop selection factors between the Opt-In and composite Opt-In/Out experience on a program-wide basis. The selection factors were applied on a budget neutral basis to the regionally smoothed data (the composite Opt-Out and Opt-In benefit expense after the selection adjustments is equal to the combined benefit expense prior to the application of the selection adjustments).

ii. Completion adjustment

The CY 2015 cost report data submitted by the MCOPs includes 12 months of incurred claims, with 3 additional months of claims payments. We developed IBNP adjustments by MCOP and Major Service Category (Inpatient, Outpatient, Nursing Facility, Physician, Pharmacy, Waiver Services, and Other).

An identical process was used to develop completion adjustments for the YTD June 2016 cost report data. The YTD June 2016 cost report data included no additional months of claims payments subsequent to the January 1, 2016 through June 30, 2016 incurred period. Consequently, the resulting factors have greater probability of variation from actual incurred claims and the YTD June 2016 cost report data was relied upon in limited manner.

The May 1, 2013 through April 30, 2014 FFS data reflected 26 months of claims runout and was assumed to be fully complete.

iii. Errors found in the data

Comparison between the CY 2015 cost report data and the YTD June 2016 cost report data, between the CY 2015 cost report data, and historical FFS MyCare eligible data, identified several data quality concerns.

CY 2015 estimated PMPM expenditures increased by approximately 1.9% over the CY 2015 incurred and paid claims basis from the CY 2015 cost reports following the data revisions discussed in this section.

iv. Program change adjustments

The CY 2015 base data year represents a historical time period from which projections were developed. We reviewed materials from ODM to identify program changes that were implemented during CY 2015. To the extent the program adjustments were estimated to have a material impact on MCOP service or administrative costs, an adjustment was considered for the calendar year 2017 rate development process. Adjustments were made to the portion of the base data prior to the implementation of each program change in order to ensure the entire base period was on a consistent basis. Relevant historical program changes are discussed below. In some cases, multiple program changes impacted a single service category.

Retrospective program changes

- **5.a. Outpatient Hospital Reimbursement Adjustment**

According to Ohio Rule 5160-2-21, reimbursement for outpatient hospital services was revised effective April 30, 2015, January 1, 2016 and October 1, 2016.

- **5.b. James Cancer Center Reimbursement Adjustment**

For James Cancer Center, a DRG-exempt facility, reimbursement for hospital services was set at 97% of the calculated cost-to-charge ratio for services incurred from October 1, 2014 through June 30, 2015, 94% of the calculated cost-to-charge ratio for services incurred from July 1, 2015 through June 30, 2016, and 91.7% of the calculated cost-to-charge ratio for services incurred after July 1, 2016¹.

- **5.c. Inpatient Hospital Medicare Reimbursement Adjustment**

Medicare reimbursement for inpatient hospital services was revised effective October 1, 2015 (FY16) and October 1, 2016 (FY17).

- **5.d. Physician Fee Schedule Adjustment**

Fees for codes included in the Physician fee schedule in Appendix DD of Ohio Rule 5160-1-60 were revised effective July 1, 2015, January 1, 2016, and January 1, 2017.

- **5.e. Nurse & Aide Service Modernization**

Effective July 1, 2015, ODM instituted new services and reimbursement changes for nurse and aide services.

- **5.f. Semi-annual Nursing Facility Costs Per Diem Updates**

In the MyCare program, the plans are required to pay the nursing facilities (NFs) at the same rate rates used by ODM for FFS claims. ODM currently updates the NF payment rates and acuity scores on a semi-annual basis. An adjustment was applied to reflect the regional impact of the semi-annual NF per diem update, effective July 1, 2015.

Prospective program changes

Calendar Year 2016

- **5.g. Dental Fee Schedule Increase**

Effective January 1, 2016, ODM instituted a 5% rate increase for dental providers in rural counties, and also implemented reimbursement increases to specific dental codes related to denture repair codes (D5510, D5520, D5610, D5620, D5630, and D5640), along with tooth extraction code D7140.

- **5.h. Home Health Aide Reimbursement and Non-Agency Home Health Nurse/Aide Overtime**

Effective January 1, 2016, the reimbursement for home health aide services, other than those provided by an independent provider, was increased by 5%. This policy change impacted procedure code G0156, home health aide services.

¹ <http://codes.ohio.gov/oac/5160-2-22>

ODM received federal guidance requiring the payment of overtime by non-agency home health providers, effective January 1, 2016. We developed an adjustment for this program change by reviewing claims on a weekly basis for the impacted procedures and providers. The overtime payment is only applied to the wage component of each procedure fee.

- **5.i. Hospital-Administered Drugs**

Effective January 1, 2016, when a hospital independently bills for prescription drugs on ODM's provider-administered pharmaceuticals fee schedule, reimbursement is based on the fee schedule amount. To the extent the drug is not on the fee schedule, the drug continues to be reimbursed at 60% of cost.

- **5.j. 5% Outpatient Hospital Reimbursement Reduction**

Effective January 1, 2016, outpatient hospital facility reimbursement for all providers, with the exception of children's hospitals, was reduced by 5%. Ambulatory surgical centers were not impacted by this reimbursement change.

- **5.k. Physician Crossover Policy Change to Medicaid Maximum Payment**

The crossover reimbursement for physician services reflected in the base data includes all Medicare allowed amounts not paid by Medicare. Effective January 1, 2016, ODM made a program change to limit reimbursement to the Medicaid maximum amount rather than providing payment up to the Medicare allowed amount. Other Medicare Part B services transitioned to the Medicaid maximum payment methodology on January 1, 2014. Services associated with dialysis clinics and ambulatory surgical centers will continue to be exempt from Medicaid maximum policy changes.

- **5.l. Other Non-Facility Reimbursement Changes**

Effective January 1, 2016, ODM provided an enhanced payment amount to providers that bill for office or outpatient service codes, and preventive services codes.

- **5.m. Nursing Facility Program Changes**

Effective July 1, 2016, ODM updated the resource utilization group (RUGs) methodology used to measure resident acuity. The methodology was updated from RUGS III to RUGS IV to coincide with the calculation of new rate components during the rebasing process. Along with the per diem update, Trumbull County was reassigned from Peer Group 3 to Peer Group 2. The change in peer group in Trumbull County is expected to increase average per diem for the corresponding region. Additionally, as of July 1, 2016 the gross daily rate paid for the lowest acuity individuals in Ohio's NFs was reduced from \$130 per resident day to \$115 per resident day to more closely correspond with the expected cost of serving these individuals. Finally, NF per diems were rebased effective January 1, 2017.

- **5.n. Elimination of Spenddown**

Effective August 1, 2016, ODM eliminated the Medicaid spenddown program as a result of its conversion from a 209(b) to 1634 state. Spenddown amounts were historically applied to provider expenses, resulting in a net reduction to MCOP-paid benefit expense for the MyCare population. CY 2015 spenddown amounts by population and region have been added to the CY 2017 benefit expense.

- **5.o. 1915(i) - Specialized Recovery Services**

Effective August 1, 2016, ODM covers specialized recovery services (SRS) to individuals who are 21 years of age or older, under 150% FPL and meet specific Severe and Persistent Mental Illness (SPMI) criteria. The only population groups to be effected are the community well populations, because a Medicaid enrollee cannot be covered under a 1915(c) HCBS Waiver and also receive 1915(i) services.

Also, individuals who gain eligibility under 1915(i) standards rather than traditional Medicaid eligibility will be covered under fee-for-service until January 1, 2018 which further reduces the potential impact on the 2017 MyCare capitation rates.

Calendar Year 2017

- **5.p. Personal Care Service (PCS) Rate Increase**

Effective January 1, 2017, the current Ohio Home Care (OHC) waiver reimbursement for agency and non-agency providers of PCS will be increased by 3%. Additionally, a statewide rate for ODA-certified PCS providers of \$4.36 per unit will be adopted. At this time, consistent Ohio Administrative Code (OAC) PCS service specification rules will be established for the OHC and PASSPORT waivers.

- **5.q. Nursing Services Fee Schedule Increase.** Effective January 1, 2017, registered nurse (RN) and licensed practical nurse (LPN) base rates and unit rates will be increased for agency and non-agency providers. Procedure codes G0154, T1000, T1002 and T1003 by an average 6.18%.

Program Changes Assumed to be Immaterial to the Capitation Rates

- **Acupuncture Coverage.** Effective January 1, 2017, acupuncture services for low back pain and migraines will be a covered service. At this time, we did not make a service coverage adjustment for this program change as projected expenditures are estimated to be immaterial.
- **Advanced Imaging Reimbursement Changes.** Effective January 1, 2017, ODM will modify its reimbursement policy for radiology services that occur when more than one radiology procedure is performed by the same provider or provider group for an individual patient on the same date. Based on prior analyses completed related to reimbursement refinements for radiology services, we did not make a program adjustment for this reimbursement change.

ESRD Reimbursement Changes. Effective April 1, 2017, reimbursement for End-Stage Renal Disease (ESRD) clinics will be based on the prospective payment system (PPS) base rate published by the Centers for Medicare and Medicaid services (CMS). We reviewed CY 2015 experience data for applicable services and estimate this program change is not material to the CY 2017 rate development process.

- **Patient Liability.** Members receiving LTSS may be required to contribute income towards their long-term care costs. This can be applied to both nursing facility and HCBS services. In general, the providers are collecting the patient liability directly and therefore these payments are not included in the base data. The exception to this is for legacy PASSPORT and Choices waiver individuals where ODM collects the patient liability amounts. For these two waiver types, the base data represents payments gross of patient liability amounts. We expect the proportion of legacy individuals to decrease over time; however, the expected impact to patient liability is not material to the CY 2017 rate development process.
- **Potentially Preventable Readmissions (PPR).** Effective January 1, 2017, hospitals with excessive preventable readmissions will be penalized in the form of hospital-specific base rate reductions. For hospitals with actual-to-expected readmission ratios greater than 1.0, a base rate reduction of 1% will be effective on January 1, 2017. ODM provided a list of hospitals impacted by this program change and estimated the impact to inpatient expenditures under the MyCare program. Estimated cost reductions were not material.
- **209(b) to 1634 Conversion (Non-Spenddown Impacts).** Effective August 1, 2016, Ohio converted from the status of a 209(b) to a 1634 state. As a 209(b) state, Ohio's eligibility determination standard was more restrictive than the criteria used by the Social Security Administration (SSA). Under the 1634 conversion, Ohio has adopted the SSA definition of disability and extended Medicaid eligibility to all individuals who receive Supplemental Security Income (SSI). Individuals with SSI are automatically enrolled in Medicaid. Additionally, on July 31, 2016, ODM eliminated the Medicaid spend down program. A 1915(i) state plan option created a special benefit program for adults with serious and persistent mental illness (SPMI) with income up to 225% of the federal poverty level.

We anticipate minimal population impact related to the 1634 conversion prior to January 1, 2018, because individuals who gain eligibility under 1915(i) standards rather than traditional Medicaid eligibility will be covered under fee-for-service until January 1, 2018. We evaluated any potential population shifts anticipated to occur during CY 2017 as a result of ODM's conversion to the status of a 1634 state and estimated the impacts to be immaterial.

- **Voluntary Enrollment of Individuals with Intellectual Disabilities.** Effective January 1, 2017, beneficiaries with intellectual disabilities and other developmental disabilities (IDD) receiving services through a 1915(c) home and community based services (HCBS) waiver may voluntarily enroll in MyCare. However, to the extent such an individual enrolled in MyCare, IDD HCBS waiver services would be terminated. Therefore, we do not anticipate a material number of these beneficiaries enrolling in the MyCare program in CY 2017.
- **Insect Repellent Coverage.** Effective June 6, 2016, ODM began requiring the coverage of insect repellent for enrolled members². Based on a review of the coverage requirements and estimated expenditures, we did not make a service coverage adjustment for this program change.
- **Occupational Therapy Provided in FQHCs.** Federally Qualified Health Centers (FQHC) do not currently receive payment for providing occupational therapy (OT) services; however, physical therapy (PT) is provided in FQHCs. Effective October 1, 2016, OT will be added to this list of services provided by FQHCs. Because FQHC costs are immaterial to the overall benefits costs due to very low utilization of these services, and OT and PT are closely related services, we did not make an adjustment for this program change.
- **Podiatry Program Change.** Under Ohio Medicaid Rule 5160-7-03, effective December 1, 2016, covered podiatric services will include payment for additional evaluation and management of services. Based on an analysis completed by ODM, projected expenditures are assumed to be immaterial and we did not make an adjustment for this program change.
- **Wheelchair Benefit Changes.** Effective January 1, 2017, new coverage and payment policies for wheelchairs and associated accessories will be adopted³. Analyses completed by ODM suggest that the payment policy changes will result in increases to base payments for wheelchairs, which will be offset by decreases to wheelchair accessory payments. As the aggregate financial impact was estimated to be cost-neutral to the MyCare program, we did not make a program adjustment in the rate development process. Additionally, a 5% reimbursement increase to the wheelchair van procedure code A0130 was estimated to be immaterial.

Each of the program adjustments listed above were determined to be immaterial on a stand-alone basis (i.e., impacted the rates by less than 0.1%). We evaluated the composite impact of all of the immaterial items listed above to assess whether an aggregate impact should be applied in the 2017 rate development process. Based on this analysis, the impact of immaterial program adjustments is immaterial on a composite basis (i.e., impacted the rates by less than 0.1%), so no further adjustments were applied.

v. Exclusion of payments or services from the data

- ***Third-Party Liability and Fraud & Abuse Recoveries***

We estimated third party liability (TPL) and fraud recoveries based on data available in calendar year 2015 cost report. These data sources indicated that approximately 0.4% of total claims were recovered and not reflected in the baseline experience data. Because the cost report claims data is gross of TPL and fraud recoveries, we adjusted it by region to reflect an estimated reduction for TPL and fraud recoveries using data reported by the MCOPs.

² <http://medicaid.ohio.gov/Portals/0/Resources/Publications/Guidance/MedicaidPolicy/NonInst/MAL601.pdf>

³ <http://medicaid.ohio.gov/Portals/0/Resources/Publications/Guidance/MedicaidPolicy/NonInst/MTL-3344-16-01.pdf>

- ***Disproportionate Share Hospital (DSH) Payments***

The base data year cost report claims do not include DSH payments. Therefore, no adjustment was necessary to exclude these payments.

- ***Graduate Medical Education (GME) Payments***

The base data year cost report claims include payments secondary to Medicare for crossover services and primary for non-Medicare covered inpatient claims. The inpatient fee schedule includes GME payments as part of the prospective payment rate, and were therefore included in the data as part of the Medicaid payment. For crossover claims, GME will be included only to the extent (or proportion) that the Medicaid allowed is included in the payment.

3. PROJECTED BENEFIT COST AND TRENDS

This section provides information on the development of projected benefit costs in the capitation rates.

A. FINAL CAPITATION RATE COMPLIANCE

The final capitation rates developed are in compliance with 42 CFR 438.4(b)(6) and are only based on services outlined in 42 CFR 438.36(c)(1)(ii) and 438.3(e). MCOPs do not provide any in-lieu services.

B. BASIS FOR VARIATIONS IN ASSUMPTIONS

Any assumption variation between covered populations is the result of program differences and is no way based on the rate of Federal financial participation associated with the population.

C. DEVELOPMENT OF PROJECTED BENEFIT COSTS

i. Description of the data, assumptions, and methodologies

This section of the report outlines the data, assumptions, and methodology used to project the benefit costs to the rating period. The baseline benefit costs were developed using the following steps:

Step 1: Create per member per month (PMPM) cost summaries

The capitation rates were developed from historical claims and enrollment data from the managed care populations enrolled in the MyCare program. This data consisted of calendar year 2015 cost report data, which was supplemented with FFS data and YTD CY 2016 cost report data to address identified data quality concerns. Benefit expense experience for the Opt-Out and Opt-In (Dual Demonstration enrollees) populations was combined on a regional and population basis (Institutional, Community Waiver [18-44, 45-64, 65+], and Community Well [18-44, 45-64, 65+]). Benefit expense experience was summarized by category of service, with detailed categories of service for crossover, non-crossover, and waiver services. For the Opt-In population, benefit expense was grossed up by 1% (benefit expense ÷ 0.99) to reflect the elimination of the 1% joint savings applied in Year 1 of the MyCare Dual Demonstration. In the absence of the demonstration, we believe it is appropriate to assume a degree of care management (consistent with the required joint savings) would be lost as a result of the MCOP not coordinating both Medicaid and Medicare services.

Step 2: Apply claims completion and care management adjustment

Claims completion was applied to the base experience summaries created in Step 1, using the methodology outlined in Section I.2.B of this report.

Step 3: Develop regional adjustments

Regional adjustment factors were developed from a combination of three data sources: CY 2015 projected regional costs using pre-MyCare FFS data, CY 2015 adjusted cost report data, and YTD cost report data through June 30, 2016. Regional factors were developed by comparing the composite Opt-In and Opt-Out cost from the three data sources for the following population groupings: Institutional (NF), Community Waiver, Community Well <65, and Community Well 65+.

Regional factors were developed on a grouped-basis for the Community Waiver (18-44, 45-64, 65+) and Community Well <65 (18-44, 45-64) populations due to credibility concerns on a regional basis. Because of a high degree of regional cost variability between the projected pre-MyCare FFS data, CY 2015 cost reports, and YTD 2016 cost reports, we elected to develop regional factors using a weighted average of the three data sources.

On a program-wide basis, the application of the regional adjustment factors maintains the budget neutrality of the base experience developed in Step 2 on a population basis: (Institutional, Community Waiver [18-44, 45-64, 65+], and Community Well [18-44, 45-64, 65+]).

Step 4: Develop selection adjustments

The composite Opt-In and Opt-Out experience was allocated through a selection adjustment to reflect the estimated health status and underlying utilization of the Opt-Out population. Selection adjustments were developed based on a review of cost relativities between the Opt-In and Opt-Out populations by population and category of service. CY 2015 and CY 2016 YTD cost report data, along with cost relationships underlying the CY 2016 capitation rates, was reviewed in the development of the selection factor assumptions.

We reviewed the benefit expense experience between the Opt-Out and Opt-In populations on a regional basis to evaluate whether the Opt-In penetration rate (the percentage of the total MyCare population participating in the Dual Demonstration) materially impacted the benefit expense relationship between the Opt-In and Opt-Out populations. Because both the Opt-In penetration and cost relationships did not exhibit a high degree of variance, we elected to develop selection factors between the Opt-In and composite Opt-In/Out experience on a population and program-wide basis. The selection factors were applied on a budget neutral basis to the regionally smoothed data resulting from Step 3.

Step 5: Apply historical and other adjustments to cost summaries

As documented in the previous section, benefit expenses from the base experience period were adjusted for a number of policy and program changes that occurred in calendar year 2015. Additional adjustments were applied for third-party liability and fraud recoveries.

Step 6: Adjust for prospective program and policy changes and trend to calendar year 2017

We adjusted the CY 2015 base experience for known policy and program changes that have occurred or are expected to be implemented in calendar years 2016 and 2017. In the previous section, we documented these items and the adjustment factors for each covered population. The adjusted PMPM values from the base experience period were trended forward from the midpoint of the base experience period to the midpoint of the rate period (July 1, 2017). We applied 24 months of trend based on an experience period midpoint of 7/1/2015. However, separate trend assumptions were applied for the first and second twelve-month period. Trend assumptions for the first twelve-month period are inclusive of experience adjustments for a small number of categories of service that exhibited significant cost changes between the CY 2015 cost report and YTD CY 2016 cost report.

The following items provide more information regarding significant and material items in developing the projected benefit costs.

(a) Benefit adjustments

Effective August 1, 2016, ODM covers SRS for individuals who are 21 years of age or older, under 150% FPL and meet specific Severe and Persistent Mental Illness (SPMI) criteria. The only population groups to be effected are the community well populations, because a Medicaid enrollee cannot be covered under a 1915(c) HCBS Waiver and also receive 1915(i) services.

Also, individuals who gain eligibility under 1915(i) standards rather than traditional Medicaid eligibility will be covered under fee-for-service until January 1, 2018 which further reduces the potential impact on the 2017 MyCare capitation rates. A more detailed description of the methodology regarding the addition of SRS is outlined in Section I.2.B of this report.

(b) Reimbursement adjustments

Reimbursement adjustments are listed in more detail in Section I.2.B of this report.

(c) Managed care efficiency adjustments

The base data represents the MyCare managed care population in CY 2015. We expect continued improvement in managed care. We applied a 1% rebalancing shift between NFLOC beneficiaries residing in NFs and a community setting (please see Section II of this report for additional information). We did not apply any further managed care adjustments.

ii. Material changes to the data, assumptions, and methodologies

The capitation rates calculated for CY 2017 reflect a complete rebasing of claims and assumptions compared to the CY 2016 capitation rates.

- The base data source has changed from historical FFS data to the CY 2015 Opt-In and Opt-Out MyCare cost report data submitted by each MCOP. In addition to moving from FFS to managed care data, the base data period has been updated from May 1, 2013 through April 30, 2014 to January 1, 2015 through December 31, 2015.
- Opt-In cost report data was combined with Opt-Out cost report data following normalization to an Opt-Out equivalent cost basis. For the Opt-In population, benefit expense was grossed up by 1% ($\text{benefit expense} \div 0.99$) to reflect the elimination of the 1% joint savings applied in Year 1 of the MyCare Dual Demonstration. In the absence of the demonstration, we believe it is appropriate to assume a degree of care management (consistent with the required joint savings) would be lost as a result of the MCOP not coordinating both Medicaid and Medicare services.
- The CY 2015 cost report data was relied upon for statewide base data which was then adjusted to a regional basis based upon a blending of the following sources: regional relationships from the existing capitation rates, CY 2015 cost report relativities and YTD 2016 cost report relativities.
- The development of certain adjustment factors, for historical program and policy changes, has been revised to include analysis of actual claims experience subsequent to the program or policy changes. Both YTD June 2016 cost report experience and recent non-MyCare county FFS data was reviewed when applicable.
- Trend adjustments have been developed using recent non-MyCare county FFS data. Additional trend adjustments were developed for certain categories of service through comparison of CY 2015 cost report data to YTD June 2016 cost report data.
- The CY 2017 care management costs were fully rebased from survey data provided by the AAAs and the MCOPs as well as composite expense levels indicated in the cost reports.
- The risk margin was increased from 2.0% to 3.0% for CY 2017 in recognition of (1) the uncertainty of specific withhold measures and calculations, and (2) the increase in withhold percentage from 2.0% to 3.0%.

D. PROJECTED BENEFIT COST TRENDS

i. Description of the data, assumptions, and methodologies

This section discusses the data, assumptions, and methodologies used to develop the benefit cost trends, i.e., the annualized projected change in benefit costs from the historical base period CY 2015 to the CY 2017 rating period.

Total benefit cost trends were developed on a PMPM basis consistent with prior years' certifications. The move to a utilization and unit cost approach is expected once encounter data can be used as the basis for the data. While the trends are illustrated on a PMPM basis, they reflect primarily utilization and mix/intensity of services. Unit cost trend is primarily handled through the program changes to reflect expected CY 2017 provider reimbursement.

(a) Data

The primary data source used in the development of the historical non-MyCare counties FFS trends reflected 42 months of incurred claims beginning January 2013 and ending June 2016. For select categories of service, the emerging 2016 incurred claims from the Q2 2016 cost reports submitted by the MCOPs were considered in the trend development process.

Data sources that were additionally referenced include:

National Health Expenditure (NHE) projections developed by the CMS office of the actuary, specifically those related to Medicaid.

- U.S. Bureau of Labor Statistics (BLS) wage trends over the past three years for those occupations providing waiver services (e.g. direct care wage and home health workers).
- Public capitation rate reports from other state programs. We collect and maintain certifications from other Milliman offices as well as states that make their documents publicly available.

(b) Methodology

The non-MyCare counties FFS data was summarized by population group, service category, and service month. The data was adjusted for completion and normalized for material program adjustments to reflect a consistent reimbursement and covered benefit structure across the historical data period. The resulting historical trends were summarized as a data point in our process. For behavioral health, dental, and waiver service categories, emerging 2016 cost report data was also summarized and considered in the trend selection process.

Historical trends should not be used in a simple formulaic manner to determine future trends; a great deal of actuarial judgment is also needed. We also referred to the sources listed in the prior section, considered changing practice patterns, the impact of reimbursement changes on utilization in this specific population, and shifting population mix.

(c) Comparisons

The previous section summarizes our selected annualized trend rates.

ii. Benefit cost trend components

Total benefit cost trends were developed on a PMPM basis consistent with prior years' certifications. The move to a utilization and unit cost approach is expected once encounter data can be used as the basis for the data. While the trends are illustrated on a PMPM basis, they reflect primarily utilization and mix/intensity of services. Unit cost trend is generally handled through the program changes to reflect expected 2017 reimbursement.

iii. Variation

The trends have been developed by high level service category. Trend variations between service categories reflect variation in the underlying historical experience and our actuarial judgment.

iv. Material adjustments

Historical trends should not be used in a simple formulaic manner to determine future trends; a great deal of actuarial judgment is also needed. We also referred to the sources listed in the prior section, considered changing practice patterns, the impact of reimbursement changes on utilization in this specific population, and shifting population mix.

We made adjustments to the trends derived from historical experience in cases where the resulting trends did not appear reasonably sustainable, or were not within consensus parameters derived from other sources.

v. Any other adjustments

(a) Impact of managed care

We did not adjust the trend rates to reflect a managed care impact on utilization or unit cost. The capitation rates have an explicit adjustment for the managed care adjustments.

(b) Trend changes other than utilization and unit cost

We did not adjust the benefit cost trend for changes other than utilization or unit cost.

E. MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT SERVICE ADJUSTMENT

It was not necessary for projected benefit costs to include additional services for compliance with the Mental Health Parity and Addiction Equity Act.

F. IN LIEU OF SERVICES

The projected benefit costs do not include costs for in lieu of services.

G. BENEFIT EXPENSES ASSOCIATED WITH MEMBERS RESIDING IN AN IMD

For enrollees age 21 to 64, the projected benefit costs do not include costs associated with an Institution for Mental Diseases (IMD) stay of more than 15 days in a month during the base experience period, nor other managed care plan costs for services delivered in a month when an enrollee has an IMD stay of more than 15 days. Additionally, member months associated with enrollee with an IMD stay of more than 15 days in a month have been excluded from the base experience data.

H. RETROSPECTIVE ELIGIBILITY PERIODS

i. Health plan responsibility

Under the MyCare contract, the health plans are not responsible for retrospective eligibility periods. Services during retrospective eligibility periods are provided on a fee-for-service basis.

ii. Base data treatment

No base data adjustment was required for retroactive eligibility.

iii. Enrollment treatment

Enrollment is treated consistently with claims. We have not adjusted for retrospective eligibility.

iv. Adjustments

No adjustments to the rates for retrospective eligibility periods were applied.

4. PASS-THROUGH PAYMENTS

This section is not applicable because there are no pass-through payments for the MyCare program as defined by the CMS Rate Setting Guide.

5. PROJECTED NON-BENEFIT COSTS

This section provides information on the development of projected non-benefit costs.

A. BASIS FOR VARIATIONS IN ASSUMPTIONS

Any assumption variation between covered populations is the result of program differences and is no way based on the rate of Federal financial participation associated with the population.

B. DATA, ASSUMPTIONS AND METHODOLOGIES

i. Description of the data, assumptions, and methodologies

(a) Data

The primary data sources used in the development of the CY 2017 non-benefit costs are listed below:

- Cost report data (financial summaries) from the MCOPs covered under the MyCare contract;
- AAA Survey data – waiver coordination cost;
- MCOP Survey data – care management contracting and costs;
- Publicly available information for other state Medicaid programs; and,
- Actuarial judgment.

(b) Assumptions and methodology

In developing the administrative costs, we reviewed the CY 2015 and YTD June 2016 cost reports and found large variations among the MCOPs. We addressed administrative cost projections similar to our approach for the CY 2016 capitation rate development by adjusting the administrative expense percentages to achieve an administrative PMPM increase of approximately 2.0% for the combined MyCare Opt-In and Opt-Out rates. Care management costs, however, were fully rebased from survey data provided by the AAAs and the MCOPs as well as composite expense levels indicated in the cost reports.

ii. Material changes

The only material changes to the data, assumptions, or methodology used to develop the projected non-benefit cost correspond to care management costs and risk margin. The rebasing of care coordination and care management expenses is summarized in Section 5.B.ii. The margin percentage was increased from 2.0% to 3.0% for CY 2017 in recognition of (1) the uncertainty of specific withhold measures and calculations, and (2) the increase in withhold percentage from 2.0% to 3.0%.

C. NON-BENEFIT COSTS, BY COST CATEGORY

i. Administrative costs

For the CY 2017 rate development process, the administrative cost has not been developed from the ground up (based on individual components). However, individual components were reviewed within MCP cost reports and financial statement data. The components may appropriately interact, and ODM does not wish to dictate to the plans how these may be allocated.

The CY 2017 administrative cost allowance for MyCare was determined as a percentage of the capitation rates before fees and taxes. CY 2017 administrative cost percentages were developed by trending the CY 2016 administrative costs PMPM by 2.0% for the combined MyCare Opt-In and Opt-Out rates.

ii. Care coordination and care management

Care coordination and care management is calculated on a PMPM basis separately from general administrative expense in the MyCare program.

AAA Plus Plan Management: Community Waiver Enrollees 60+

MCOPs are required to contract with Area Agencies on Aging (AAAs) to perform core waiver coordination services for members who are 60 years or older and on a 1915(c) waiver. Care management (plan management) for coordination of non-core services must be provided by the plans as well, but is not required to be provided through the AAAs.

The AAA waiver service coordination costs provided by each of the AAAs (i.e., provided on a regional basis) were rebased from cost reports for the period of January 2016 through June 2016. Several of the cost reports include resource estimates and expenditures related to the annual comprehensive needs assessment. Based on the May 1, 2014 MyCare Implementation Summary and discussions with ODM, the annual comprehensive needs assessment falls outside of the core waiver coordination services required to be provided by the AAAs. Consequently, we have removed the estimated cost related to the annual assessments from the AAA component of the care management cost.

The care management survey data collected from the MCOPs was used to develop a plan management cost component applicable to waiver enrollees who are 60 years or older. The CY 2017 capitation rates were developed assuming no variation in plan management costs by region.

Because the comprehensive needs assessment is a required plan management component, the cost estimate for the annual assessment has been included as a third component of the care management cost development for community waiver enrollees who are age 60 years or older. The cost by region for the comprehensive needs assessment was estimated through analysis and review of applicable assumptions in the AAA cost reports for certain regions and from the MCOP surveys of care management costs. The estimated cost of the comprehensive needs assessment for those regions for which no data was available was developed using the ratio of average cost of the needs assessment where available to the net cost of AAA waiver coordination services in those regions.

A 2.0% trend adjustment was additionally made to total care management costs to project to CY 2017.

Plan Management: Other Populations

Neither waiver coordination services nor non-waiver care management services are required to be contracted with the AAAs for the other MyCare populations. Thus, the total care management costs are additionally referenced as plan management costs. Care management costs from the YTD June 2016 cost reports were used to develop expenditure estimates for these populations. Because large variances exist among MCOP care management costs on a population by population basis, the cost report care management data was composited and normalized for comparison to composite care management costs included in the current capitation rates.

We determined that the 2.0% trend increase over the current PMPM care management values, after rebasing of the Community Waiver 60+ costs, would result in a reasonable composite normalized PMPM in comparison to the YTD June 2016 cost report data. As a result, care management costs for the Institutional, Community Waiver 18 – 44 and all Community Well populations were increased by 2.0% over current levels. The resulting PMPMs were then averaged based upon August 2016 MyCare enrollment to develop plan management rates that are uniform across.

The care management costs for the Community Waiver 45-64 population were developed as a member weighted average of the Community Waiver 18-44 and 65+ amounts.

iii. Provision for margin

The risk margin included in the CY 2017 MyCare capitation rates is 3.0% for each population group consistent with the margin assumption included in the CY 2016 rates. As stated under the material changes section, the margin percentage was increased from 2.0% to 3.0% for CY 2017 in recognition of (1) the uncertainty of specific withhold measures and calculations, and (2) the increase in withhold percentage from 2.0% to 3.0%.

iv. Taxes, fee, and assessments

The MCOP revenue is subject to a Sales and Use tax that varies by county. We sourced the tax rates by county from the State of Ohio website (http://www.tax.ohio.gov/sales_and_use.aspx) and weighted the county-level tax amounts by August 2016 enrollment by county for each population. Sales and Use tax amounts were composited at the population and region level from the county estimates and applied as a percentage of the total capitation rate for each population and region combination. Developing Sales and Use tax amounts through the use of membership versus capitation rate weighting produces equivalent results when the fees are applied at the region and population level.

v. Other material non-benefit costs

No other non-benefit costs were included in the rate development process.

D. PMPM VERSUS PERCENTAGE

The non-benefit cost for MyCare were applied as a percentage of the capitation rate for administrative costs and risk margin. Care management costs were applied on a PMPM basis.

E. HEALTH INSURER FEE

i. Whether the fee is incorporated in the rates

The calendar year 2015 rates, calendar year 2017 rates will be amended based on the calculated HIF attributable to ODM premium revenue. To the extent the actual paid HIF is less than the calculated HIF, the rates for the MCP will be amended based on actual paid HIF.

ii. Fee year or data year

The HIF for each insurer is calculated based on the data year. Amended calendar year 2017 rates will be based on the 2018 HIF attributable to the 2017 data year.

iii. Determination of fee impact to rates

The calculation of the fee for each MCOP subject to the HIF will be based on the final Form 8963 premium amounts reported by the insurer, aggregate HIF premium base, final IRS invoices provided to the MCOPs subject to the HIF, Form 8963 premium amounts attributable to ODM, data year HIF tax percentage, and adjustments for premium revenue based on benefits described in 26 CFR 57.2(h)(2)(ix) such as nursing home and home health care. Final fee amounts are adjusted for applicable fees and taxes that are applied to ODM capitation rate revenue (documented in the non-benefit expense section of this report). The 2017 capitation rates will be amended based on the 2018 HIF attributable to the 2017 data year. We anticipate amending the rates in the last quarter of calendar year 2018.

iv. Identification of long-term care benefits

The long term care benefit costs associated with MyCare are extensive. This will significantly limit the amount of the MyCare revenue that is subject to the fee. An estimated percentage of each capitation rate cell that is attributable to long-term care services as described in 26 CFR 57.2(h)(2)(ix) will be estimated for the purposes of the HIPF payment.

F. HEALTH INSURER FEE MORATORIUM

No HIF payments will be made for calendar year 2016 capitation rates due to the HIF moratorium established by the Consolidated Appropriations Act of 2016⁴. Adjustments will be made to the calendar year 2017 capitation rates based on HIF collected in calendar year 2018 attributable to 2017 net premiums.

6. RATE RANGE DEVELOPMENT

This section is not applicable because rate ranges were not established for the MyCare program.

7. RISK MITIGATION AND RELATED CONTRACTUAL PROVISIONS

A. DESCRIPTION OF RISK MITIGATION

The MyCare rates have been developed as full risk rates. The MCOPs assume risk for the cost of services covered under the contract and incur losses if the cost of furnishing the services exceeds the payments under the contract. The regional NFLOC rates will be prospectively adjusted by MCOP to reflect mix differences in the enrolling population between nursing facility and HCBS services. This adjustment will be made to the rates prospectively. No additional risk adjustment is planned for this population in CY 2017.

B. RISK ADJUSTMENT MODEL AND METHODOLOGY

i. Risk adjustment model

For the prospective member mix, we will continue to employ MEMA. This methodology adjusts the NFLOC capitation rates based on a MCOPs mix of nursing facility and HCBS membership.

ii. Data and adjustments

- The MEMA is a budget-neutral adjustment which will be updated January and July of each year.
- October 2016 MyCare enrollment data will be used for the January 1, 2017 through June 30, 2017 MEMA development
- April 2017 MyCare enrollment data will be used for the July 1, 2017 through December 31, 2017 MEMA development

iii. Changes from the prior year

Aside from timing, there are no methodology changes from the prior year.

iv. Frequency

MEMA factors will be calculated each six-month period. The prospective adjustment will be made once prior to the beginning of the contract period and once in July 2017.

v. How the risk scores will be used to adjust the capitation rates

The MEMA adjustment is applied by region for the NFLOC rate cell for each MCOP. Each population group within the NFLOC rate cell is given a weight based on its relative capitation rate compared to the composite NFLOC capitation rate.

⁴ <https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010>

Each MCOP will receive a calculated risk score based on their enrollment of each population group within the NFLOC rate cell. To ensure budget neutrality, the MEMA scores will be normalized to 1.000 for each region.

vi. An attestation that the risk adjustment is cost neutral

The MyCare MEMA is designed to be cost neutral. Relative adjustments will be normalized to result in an aggregate adjustment of 1.000 for each region, across all plans.

C. ADDRESS COST NEUTRALITY

This section is not applicable to MyCare Ohio as the MEMA adjustment is designed to be budget neutral.

D. OTHER RISK SHARING ARRANGEMENTS

No other risk sharing arrangements are proposed for the 2016 capitation rates.

E. MEDICAL LOSS RATIO

i. Description

The MCOPs have a target medical loss ratio (MLR) of eighty-five percent (85%). The MLR calculation for the Opt-Out shall be determined consistent with Opt-In as defined in the 3-way contract.

ii. Financial consequences

The MCOPs have a target MLR of eighty-five percent (85%). If an MCOP has an MLR between eighty-five percent (85%) and ninety percent (90%) of the joint Medicare and Medicaid payment to the MCOP, ODM and CMS may require a corrective action plan.

If an MCOP has an MLR below eighty-five percent (85%) of the joint Medicare and Medicaid payment, the MCOP must remit the amount by which the eighty-five percent (85%) threshold exceeds the MCOPs actual MLR multiplied by the total capitation rate revenue of the contract. Any collected remittances would be distributed proportionally back to the Medicaid and Medicare programs on a percent of premium basis.

F. REINSURANCE REQUIREMENTS AND EFFECT ON CAPITATION RATES

MyCare MCOPs are required to maintain minimum reinsurance protection as set out in the Ohio Administrative Code. Refer to the 3-way contract for specific requirements. Opt-Out requirements are consistent with the Opt-In requirements. An adjustment was not made in the rate development process due to the immateriality of the net impact of reinsurance (premium and recoveries).

G. ATTESTATION OF INCENTIVE ARRANGEMENTS

There are no bonuses or incentives offered in the MyCare Ohio program.

H. INCENTIVES AND WITHHOLDS

i. Withholds

Withholds constitute 3% of the certified rates.

ii. Estimate of percent to be returned

Experience from the MyCare withhold measures from prior years has yet to be measured. The amount of withhold that will be returned in CY 2017 is uncertain.

iii. Effect on the capitation rates

The rate is certified as actuarially sound assuming the withhold amount is not returned.

8. OTHER RATE DEVELOPMENT CONSIDERATIONS

A. DIFFERENT FMAP

None of the MyCare population groups are eligible for an FMAP higher than the regular state FMAP of 62.32%.

B. BASIS FOR VARIATIONS IN ASSUMPTIONS

All differences in capitation rates between covered populations are based on valid rate development standards and are in no way based on the rate of Federal financial participation associated with the population.

C. EFFECTIVE DATES

To the best of our knowledge, the effective dates of changes to the MyCare program are consistent with the assumptions used in the development of the certified CY 2017 capitation rates.

D. ACTUARIALLY ACCEPTED PRACTICES AND PRINCIPLES

i. Reasonable, appropriate, and attainable

In our judgment, all adjustments to the capitation rates, or to any portion of the capitation rates, reflect reasonable, appropriate, and attainable costs. To our knowledge, there are no reasonable, appropriate, and attainable costs that have not been included in the certification.

ii. Outside the rate setting process

There are no adjustments to the rates performed outside the rate setting process, with the exception of the budget neutral MEMA adjustment described in Section 7.

iii. Rates within ranges

The final contracted rates will match the final certified capitation rates, with the exception of the budget neutral MEMA adjustment methodology, the capitation withholds, and any capitation incentives described in Section 7.

9. PROCEDURES FOR RATE CERTIFICATION AND CONTRACT AMENDMENTS

In general, a new rate certification will be submitted when the rates change. The following exceptions are allowed:

1. A contract amendment that does not affect the rates.

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2. Risk adjustment, under a budget-neutral methodology described in the initial certification, changes the rates paid to the plans

In case 1 listed above, a contract amendment must still be submitted to CMS.

SECTION II. MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES AND SUPPORTS

1. MANAGED LONG-TERM SERVICES AND SUPPORTS

A. COMPLETION OF SECTION I

MyCare Ohio is Ohio's managed care program for the dual eligible (Medicare-Medicaid) population. Eligible individuals are required to either receive both Medicare and Medicaid services (Opt-In) or Medicaid services only (Opt-Out) through the managed care plan. Enrollees who select to Opt-In become participants in the Dual Demonstration program. This population covers a significant amount of long-term services and support (LTSS) including nursing facility, home care, and HCBS waiver services.

We completed Section I of this report for MLTSS and other medical services.

B. MLTSS RATE STRUCTURE

(a) Capitation rate structure

The MyCare Ohio rate structure for calendar year 2017 did not change from the 2016 rate structure. Rates continue to vary by region consistent with current geographic definitions. The NFLOC rate cell continues to reflect a composite of the institutional, community waiver 18 – 44, community waiver 45 – 64 and community waiver 65+ population groups. The NFLOC rate cell will be adjusted by the MEMA (discussed more in Section I.7) on a semi-annual basis. The community well population groups includes three separate rate cells: community well 18 – 44, community well 45 – 64, and community well 65+ for a total of four MyCare Ohio rate cells.

Community Well

The community well category represents eligible dual members who do not meet the NFLOC standard (including the transition rules) as described later in this section. Within the community well category, capitation rates vary by contracting region and the following age groups: 18 - 44, 45 - 64 and 65+.

NFLOC

The NFLOC category represents MyCare-eligible members who are enrolled in the MyCare Waiver or covered as a long-term nursing facility (NF) resident (i.e. Institutional population group).

MyCare Waiver enrollees

- An individual who enrolls in the MyCare Waiver will be assigned to the NFLOC rate cell at the beginning of the month following enrollment in the waiver or in the current month if enrollment begins on the first day of the month.

Institutional Population

- An individual must have 100 or more consecutive days billed as NF services based on combined Medicare and Medicaid days to be considered a long-term resident of a NF and included in the Institutional population group.
- Gaps in NF care of 15 days or less per discharge count toward the consecutive day requirement.
- Any days that a member spends in an inpatient hospital setting, once already admitted to a NF, count toward the 100-day requirement.
- Hospice Room and Board days count toward the 100 consecutive day requirement.

Once a Medicaid recipient achieves the one-hundredth NF day (regardless of payer), the member will be assigned to the NFLOC rate cell in the subsequent month and the plan would then be paid the higher rate associated with this population. NF residents that have been in a NF for 100 or more days immediately preceding that member's enrollment in the MyCare program will be classified into the NFLOC rate cell on the first day of enrollment.

For the NFLOC rate cell, there is a single rating category for each contracting region. The rates will be developed using data from the following NFLOC population groups: Institutional, Community Waiver 18 - 44, Community Waiver 45 - 64 and Community Waiver 65+. Current enrollment in MyCare will be used as a basis for the projected enrollment distribution by population group for CY 2017. The composite NFLOC rates will reflect the anticipated mix of NFLOC members achieved through effective managed care activities.

Transition Rules

Members who had met the criteria for inclusion in the NFLOC rate cell, but later do not, will be transitioned to the community well category. The MCOP will continue to receive the NFLOC capitation rate for three full months following the change in categorization. Beginning with the fourth month, the plan will receive the community well capitation rate. For members who transition from community well to a nursing facility, the member will be assigned to the NFLOC rate cell in the month following the member's one-hundredth day. Members who transition from community well to the MyCare waiver will be assigned to the NFLOC rate cell in the month immediately following transition.

(b) Methodology

The structure, rationale, and payment methodology are discussed in (a) above.

C. MANAGED CARE EFFECT

The blended nature of the NFLOC rate cell encourages MCOPs to manage the mix of the population towards lower cost settings. This is the basis for efficiencies in LTSS programs. This transition between settings (e.g. nursing facility to HCBS waiver services) is gradual in nature and is not an immediate transition. Most often, individuals that are in a nursing facility for a long period of time have lost their community supports and it becomes difficult to change the setting away from a nursing facility. Therefore, MCOPs will need to seek individuals that are newer to LTSS benefits and avoid or delay nursing facility placement. Because of this, we assumed gradual increases in HCBS percentages and decreases in nursing facility percentages. Our assumption for CY 2017 is that the average mix between HCBS and nursing facility will shift by 1% in favor of HCBS for the year. We believe this assumption is reasonable, appropriate, and attainable, as the MCOPs reported on a composite basis for the Opt-Out population in the June 2016 YTD cost reports a 2% rebalancing shift from January 2016 through June 2016.

D. NON-BENEFIT COST

The non-benefit cost assumptions are discussed in Section 5. The non-benefit costs vary by population group and are appropriate for the MLTSS benefits and services.

E. EXPERIENCE AND ASSUMPTIONS

Section I details the experience and assumptions employed for the MLTSS and non-MLTSS services included in the MyCare program.

LIMITATIONS

The information contained in this report has been prepared for the Ohio Department of Medicaid (ODM) to provide documentation of the development of the CY 2017 actuarially sound capitation rates for the MyCare Ohio program. The data and information presented may not be appropriate for any other purpose.

It is our understanding that the information contained in this letter will be shared with CMS and may be utilized in a public document. Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for ODM by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

Milliman relied upon certain data and information provided by ODM, their vendors and the participating MCOPs in the development of the calendar year 2017 capitation rates. Milliman has relied upon ODM and the MCOPs for the accuracy of the data and accepted it without audit. To the extent that the data provided is not accurate, the capitation rate development would need to be modified to reflect revised information.

It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this report.

The services provided by Milliman to ODM were performed under the signed contract agreement between Milliman and ODM dated June 11, 2015.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The actuaries preparing this report are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

APPENDIX 1: CERTIFIED RATES

**Ohio Department of Medicaid
MyCare Managed Care Program
CY 2017 Opt-Out Certified Rates**

Population Group:	NFLOC Total		
	Full Medicaid	Quality	Guaranteed
Region	Rate	Withhold	Rate
Central / Southeast	\$ 4,777.16	\$ 143.31	\$ 4,633.85
East Central	3,892.59	116.78	3,775.81
Northeast	4,319.74	129.59	4,190.15
Northeast Central	4,456.99	133.71	4,323.28
Northwest	4,472.59	134.18	4,338.41
Southwest	4,712.23	141.37	4,570.86
<u>West Central</u>	<u>3,687.58</u>	<u>110.63</u>	<u>3,576.95</u>
Statewide Total	\$ 4,297.13	\$ 128.91	\$ 4,168.22

Population Group:	Community Well 18-44		
	Full Medicaid	Quality	Guaranteed
Region	Rate	Withhold	Rate
Central / Southeast	\$ 542.66	\$ 16.28	\$ 526.38
East Central	345.05	10.35	334.70
Northeast	436.40	13.09	423.31
Northeast Central	304.05	9.12	294.93
Northwest	472.90	14.19	458.71
Southwest	382.73	11.48	371.25
<u>West Central</u>	<u>444.42</u>	<u>13.33</u>	<u>431.09</u>
Statewide Total	\$ 419.95	\$ 12.60	\$ 407.35

Population Group:	Community Well 45-64		
	Full Medicaid	Quality	Guaranteed
Region	Rate	Withhold	Rate
Central / Southeast	\$ 746.75	\$ 22.40	\$ 724.35
East Central	408.82	12.26	396.56
Northeast	509.30	15.28	494.02
Northeast Central	356.92	10.71	346.21
Northwest	522.64	15.68	506.96
Southwest	471.20	14.14	457.06
<u>West Central</u>	<u>516.58</u>	<u>15.50</u>	<u>501.08</u>
Statewide Total	\$ 507.24	\$ 15.22	\$ 492.02

Population Group:	Community Well 65+		
	Full Medicaid	Quality	Guaranteed
Region	Rate	Withhold	Rate
Central / Southeast	\$ 994.94	\$ 29.85	\$ 965.09
East Central	827.21	24.82	802.39
Northeast	713.92	21.42	692.50
Northeast Central	789.60	23.69	765.91
Northwest	640.52	19.22	621.30
Southwest	949.75	28.49	921.26
<u>West Central</u>	<u>874.02</u>	<u>26.22</u>	<u>847.80</u>
Statewide Total	\$ 831.47	\$ 24.94	\$ 806.53

APPENDIX F

This Appendix is intentionally blank.

APPENDIX G

COVERAGE AND SERVICES

1. **Basic Benefit Package.** After consideration of third party liability including Medicare coverage pursuant to OAC rules 5160-58-01.1 and 5160-26-09.1, a MyCare Ohio Plan (MCOP) must ensure that its members have access to all medically-necessary medical, drug, behavioral health, nursing facility and home and community-based waiver services covered by Medicaid pursuant to OAC rule 5160-58-03 and 42 CFR 438.114. This coverage must be with limited exclusions, limitations and clarifications (see OAC rule 5160-58-03 and below in this Appendix). An MCOP must also ensure that its members have access to any additional services specified in this Agreement. For information on Medicaid-covered services, MCOPs must refer to the Ohio Department of Medicaid (ODM) website.

Services covered by the MCOP benefit package include, but are not limited to the following:

- a. Inpatient hospital services;
- b. Outpatient hospital services;
- c. Rural health clinics (RHCs) and federally qualified health centers (FQHCs);
- d. Physician services whether furnished in the physician's office, the covered person's home, a hospital, or elsewhere;
- e. Laboratory and x-ray services;
- f. Screening, diagnosis, and treatment services to children under the age of 21 under the Healthchek, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. These services include all mandatory and optional medically necessary services (including treatment) and items listed in 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and mental illness and conditions. Such services and items, if approved through prior authorization, include those services and items listed at [42 U.S.C. 1396d\(a\)](#) that are in excess of state Medicaid plan limits applicable to adults. An EPSDT screening is an examination and evaluation of the general physical and mental health, growth, development, and nutritional status of an individual under age 21. It includes the components set forth in 42 U.S.C. 1396d(r) and must be provided by plans to children under the age of twenty-one;
- g. Family planning services and supplies;
- h. Home health and private duty nursing services;
- i. Podiatry;
- j. Chiropractic services;

- k. Physical therapy, occupational therapy, developmental therapy, and speech therapy;
- l. Nurse-midwife, certified family nurse practitioner, and certified pediatric nurse practitioner services;
- m. Free-standing birth center services in free-standing birth centers as defined in OAC rule 5160-18-01;
- n. Prescription drugs;
- o. Ambulance and ambulette services;
- p. Dental services;
- q. Durable medical equipment and medical supplies, including expedited wheelchair fitting, purchase, maintenance and repair, professional evaluation, home assessment, the services of skilled wheelchair technicians, pick-up and delivery, timely repairs, training, demonstration and loaner chairs;
- r. Vision care services, including eyeglasses;
- s. Nursing facility services;
- t. Hospice care;
- u. Behavioral health services provided by the Ohio Department of Mental Health and Addiction Services (OhioMHAS)-certified providers, as described in OAC Chapters 5160-27 and 5160-30.
- v. Immunizations (An MCOP must follow the coverage requirements provided by ODM for any newly approved vaccine under the Vaccines for Children (VFC) program.);
- w. Preventive services covered by Ohio Medicaid in accordance with Section 4106 of the Affordable Care Act and 42 CFR 440.130(c);
- x. All U.S. Preventive Services Task Force (USPSTF) grade A and grade B preventive services and approved vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) and their administration, without cost-sharing, as provided in section 4106 of the Affordable Care Act. Additionally, MCOPs must cover, without cost-sharing, services specified under Public Health Service Act section 2713, in alignment with the Alternative Benefit Plan;
- y. Screening and counseling for obesity provided during an evaluation and management or preventive medicine visit, as described in OAC rule 5160-4-34;
- z. Telemedicine; and

- aa. Home and community-based waiver services specified below using providers that are certified by the Ohio Department of Aging (ODA) or approved by ODM and meet the requirements in OAC Chapters 173-39 or 5160-45, as appropriate:
- i. Adult day health;
 - ii. Homemaker;
 - iii. Personal care;
 - iv. Alternative meals service;
 - v. Assisted living service;
 - vi. Home care attendant service;
 - vii. Chore services;
 - viii. Community transition service;
 - ix. Emergency response services;
 - x. Enhanced community living service;
 - xi. Home care attendant;
 - xii. Home delivered meals;
 - xiii. Home medical equipment and supplemental adaptive and assistive device services (contingent upon the completion of an evaluation from a licensed health care professional, occupational therapist, physical therapist or other skilled therapist, as appropriate to the service being rendered);
 - xiv. Home modification, maintenance and repair (contingent upon the evaluation from a licensed physical therapist or occupational therapist to evaluate the need for home modification, maintenance and repair services for members);
 - xv. Independent living assistance;
 - xvi. Nutritional consultation;
 - xvii. Out-of-home respite;
 - xviii. Pest control;
 - xix. Shared living (beginning July 1, 2017);
 - xx. Social work counseling;
 - xxi. Waiver nursing service; and
 - xxii. Waiver transportation.
2. **Exclusions.** An MCOP is not required to pay for services not covered by the Medicaid program, except as otherwise specified in OAC rule 5160-58-03 or this Agreement. Information regarding non-covered services can be found on the ODM website.

Services not covered by the Medicaid program include, but are not limited to, the following:

- a. Services or supplies that are not medically necessary;
- b. Treatment of obesity unless medically necessary;
- c. Experimental services and procedures, including drugs and equipment not covered by Medicaid, and not in accordance with customary standards of practice;
- d. Abortions, except in the case of a reported rape, incest, or when medically necessary to save the life of the mother;

- e. Infertility services for males or females;
- f. Voluntary sterilization if under 21 years of age or legally incapable of consenting to the procedure;
- g. Reversal of voluntary sterilization procedures;
- h. Plastic or cosmetic surgery that is not medically necessary. (These services could be deemed medically necessary if medical complications or conditions in addition to the physical imperfection are present);
- i. Sexual or marriage counseling;
- j. Biofeedback services;
- k. Services to find cause of death (autopsy) or services related to forensic studies;
- l. Paternity testing;
- m. Services determined by another third-party payor as not medically necessary;
- n. Drugs not covered by the Ohio Medicaid pharmacy program as specified in OAC 5160-9-03, including drugs for the treatment of obesity;
- o. Assisted suicide services, defined as services for the purpose of causing, or assisting to cause, the death of an individual. Assisted suicide services do not include withholding or withdrawing medical treatment, nutrition or hydration or the provision of a service for the purpose of alleviating pain or discomfort, even if the use may increase the risk of death, so long as the service is not furnished for the specific purpose of causing death;
- p. Medical services if the service was caused by a provider-preventable condition as defined in 42 CFR 447.26. The prohibition on payment for provider-preventable conditions shall not result in a loss of access to care or services for Medicaid recipients; and
- q. An MCOP is not required to pay for non-emergency services or supplies provided by non-panel providers, unless the member has followed the instructions in the MCOP member handbook for seeking coverage of such services, or unless otherwise directed by ODM.

3. Clarifications.

- a. **Member Cost-Sharing.** As specified in Appendix A, Section 3.3 of the Three-Way, an MCOP may elect to implement co-payments for Medicaid-covered drugs, but shall not charge cost sharing to members above levels established under the Medicare Part D Low Income Subsidy. Pursuant to Appendix C, Section 3.3(C) of the Three-Way, members who reside in a nursing facility or are enrolled in the MyCare 1915(c) waiver

may be required to contribute to the cost of care the amount of patient liability established by the County Department of Job and Family Services.

- b. **Abortion and Sterilization.** The use of federal funds to pay for abortion and sterilization services is prohibited unless the specific criteria found in federal law and OAC rules 5160-17-01 and 5160-21-02.2 are met. An MCOP must verify that all of the information on the applicable required forms [ODM 03197, ODM 03199, HHS-687 and HHS-687-1 (SPANISH VERSION)] is provided and that the service meets the required criteria before any such claim is paid.

Additionally, payment must not be made for associated services such as anesthesia, laboratory tests, or hospital services if the abortion or sterilization itself does not qualify for payment. The MCOP is responsible for educating its providers on the requirements; implementing internal procedures including systems edits to ensure that claims are only paid once the MCOP has determined if the applicable forms are completed and the required criteria are met, as confirmed by the appropriate certification or consent forms; and for maintaining documentation to justify any such claim payments. If the MCOP has made the determination that the requirements associated with an abortion, sterilization, or hysterectomy were sufficiently met by the provider, then no additional information (i.e. operative notes, history and physical, ultrasound) is required from ancillary providers.

- c. **Behavioral Health Services Limitations.** An MCOP is not responsible for providing mental health services to persons between 22 and 64 years of age while residing in an institution for mental disease (IMD) as defined in Section 1905(i) of the Social Security Act. The MCOP is not prohibited from contracting with an IMD to provide mental health services to persons between 22 and 64 years of age, but the MCOP will not be compensated by Medicaid for the provision of such services (i.e. either through direct payment or considering any associated costs in the Medicaid rate setting process).
- d. **Organ Transplants.** An MCOP must ensure coverage for organ transplants and related services in accordance with OAC rule 5160-2-07.1. Coverage for all organ transplant services, except kidney transplants, is contingent upon review and recommendation by the "Ohio Solid Organ Transplant Consortium" based on criteria established by Ohio organ transplant surgeons and authorization from the ODM prior authorization unit. Reimbursement for bone marrow transplant and hematopoietic stem cell transplant services, as defined in OAC rule 3701-84-01, is contingent upon review and recommendation by the "Ohio Hematopoietic Stem Cell Transplant Consortium" based on criteria established by Ohio experts in the field of bone marrow transplant. While an MCOP may require prior authorization for these transplant services, the approval criteria must be limited to confirming that the member is being considered and/or has been recommended for a transplant by either consortium. Additionally, in accordance with OAC rule 5160-2-03 all services related to organ donations are covered for the donor recipient when the member is Medicaid eligible.
- e. **Acupuncture.** Ohio Medicaid acupuncture coverage is limited to the pain management of migraine headaches and lower back pain.

- f. **Gender Transition.** Under section 92.207(b)(4), 81 Federal Register (FR) 31471-72, MCOPs are prohibited from having or implementing a categorical coverage exclusion or limitation for all health services related to gender transition. However, section 92.207(d) clarifies that this does not prevent MCOPs from determining whether a particular health service is medically necessary or otherwise meets applicable coverage requirements in individual cases.
4. **Information Sharing with Non-Panel Providers.** To assist members in accessing medically-necessary Medicaid-covered services, an MCOP is required to share specific information with certain non-panel providers. The information is to assist non-panel providers to recognize MCOP membership, access information needed to provide services and, if applicable, successfully submit claims to the MCOP.
 - a. **ODM-Designated Providers.** In accordance with OAC rules 5160-58-01.1 and 5160-26-03.1, the MCOP must share specific information with FQHCs/RHCs, qualified family planning providers (QFPPs), hospitals and if applicable, certified nurse midwives (CNMs), certified nurse practitioners (CNP), and free-standing birth centers (FBCs) as defined in OAC rule 5160-18-01 within the MCOP's service area and in bordering regions if appropriate based on member utilization information. The information must be shared within the first month after the MCOP has been awarded a Medicaid provider agreement for a specific region and annually thereafter.

At a minimum, the information must include the following:

 - i. The information's purpose;
 - ii. Claims submission information including the MCOP's Medicaid provider number for each region (this information is only required to be provided to non-panel FQHCs/RHCs, QFPPs, CNMs, CNPs and hospitals);
 - iii. The MCOP's prior authorization and referral procedures;
 - iv. A picture of the MCOP's member ID card (front and back);
 - v. Contact numbers for obtaining information for eligibility verification, claims processing, referrals, prior authorization, post-stabilization care services and if applicable information regarding the MCOP's behavioral health administrator; and
 - vi. A listing of the MCOP's laboratories and radiology providers.
 - b. **MCOP-Authorized Providers.** In accordance with OAC rules 5160-58-01.1 and 5160-26-05, an MCOP authorizing the delivery of services from a non-panel provider must ensure that it has a mutually agreed upon compensation amount for the authorized service and must notify the provider of the applicable provisions of OAC rules 5160-58-01.1 and 5160-26-05. This notice is provided when an MCOP authorizes a non-panel provider to furnish services on a one-time or infrequent basis to an MCOP member and must include required ODM-model language and information.

APPENDIX H

PROVIDER PANEL SPECIFICATIONS

1. **Federal Access Standards.** A MyCare Ohio Plan (MCOP) must provide or arrange for the delivery of all medically necessary, Medicaid-covered health services, as well as ensure that it is in compliance with the following federally defined provider panel access standards as required by 42 CFR 438.206:
 - a. In establishing and maintaining its provider panel, the MCOP must consider the following:
 - i. The anticipated Medicaid membership.
 - ii. The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the MCOP.
 - iii. The number and types (in terms of training, experience, and specialization) of panel providers required to deliver the contracted Medicaid services.
 - iv. The geographic location of panel providers and Medicaid members, considering distance, travel time, the means of transportation ordinarily used by Medicaid members, and whether the location provides physical access for Medicaid members with disabilities.
 - v. The MCOP must adequately and timely cover services from an out-of-network provider if the MCOP's contracted provider panel is unable to provide the services covered under the MCOP's provider agreement. The MCOP must cover the out-of-network services for as long as the MCOP network is unable to provide the services. The MCOP must coordinate with the out-of-network provider with respect to payment and ensure that the provider agrees with the applicable requirements.
 - b. Contracting providers must offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid FFS, if the provider serves only Medicaid members. The MCOP must ensure that services are available 24 hours a day, 7 days a week, when medically necessary. The MCOP must establish mechanisms to ensure that panel providers comply with timely access requirements, and must take corrective action if there is failure to comply.
 - c. In order to comply with 42 CFR 438.206 and 438.207 and demonstrate adequate provider panel capacity and services, the MCOP must submit documentation as specified to the Ohio Department of Medicaid (ODM), in a format specified by ODM, demonstrating that the MCOP offers an appropriate range of preventive, primary care,

specialty, behavioral health and waiver services adequate for the anticipated number of members in the service area, while maintaining a provider panel that is sufficient in number, mix, and geographic distribution to meet the needs of the number of members in the service area. This documentation of assurance of adequate capacity and services must be submitted to ODM no less frequently than at the time the MCOP enters into a contract with ODM; at any time there is a significant change (as defined by ODM) in the MCOP's operations that would affect adequate capacity and services (including changes in services, benefits, geographic service or payments); and at any time there is enrollment of a new population in the MCOP.

- d. When a waiver enrollee expresses a preference for an independent (non-agency) provider for an eligible service identified on the member's waiver service plan, the MCOP must seek out an available independent provider. The MCOP must offer the independent provider a contract for provision of the services to the member when the provider is willing, acceptable to the member, and appropriate to the member's care, and approved by ODM or the Ohio Department of Aging (ODA) with an active Medicaid provider agreement to render services in accordance with OAC Chapters 173-39 and 5160-45 as appropriate.
2. **General Provisions.** An MCOP must meet requirements as specified in Section 2.7.9 of the Three-Way and this appendix including, but not limited to, Section 4 Provider Panel Requirements of this appendix. The MCOP must remain in compliance with these requirements for the duration of this Provider Agreement.
- a. If an MCOP is unable to provide the medically necessary, Medicaid-covered services through its contracted provider panel, the MCOP must ensure access to these services on an as needed basis. For example, if an MCOP meets the orthopedist requirement but a member is unable to obtain a timely appointment from an orthopedist on the MCOP's provider panel, the MCOP will be required to secure an appointment from a panel orthopedist or arrange for an out-of-panel referral to an orthopedist.
 - b. If the MCOP offers transportation to its members as an additional benefit and this transportation benefit only covers a limited number of trips, the required transportation listed above may not be counted toward this trip limit (as specified in Appendix C).
 - c. In developing the provider panel requirements, ODM considered the population size and the potential availability of the designated provider types. ODM integrated existing utilization patterns into the provider network requirements to avoid disruption of care. Most provider panel requirements are county-specific but in certain circumstances, ODM requires providers to be located anywhere in the region or within a set number of miles from a zip code.
 - d. The MCOP must ensure that providers submitted to the Managed Care Provider Network (MCPN), or listed in MCOP published directories, are available to both dual benefits and Medicaid only members of the MCOP.

- e. ODM will recalculate the minimum provider panel specifications if ODM determines that significant changes have occurred in the availability of specific provider types and the number and composition of the eligible population. The MCPN is the tool that will be used for ODM to determine if the MCOP meets all the panel requirements that are identified within Appendix H; therefore the plans must enter all network providers as specified within the file specs.
 - f. On at least a monthly basis, ODM or its designee will provide each MCOP with an electronic file containing the MCOP's provider panel as reflected in the ODM MCPN database, or other designated system.
3. **Provider Subcontracting.** Unless otherwise specified in this appendix or OAC rules 5160-58-01.1 and 5160-26-05, an MCOP is required to enter into fully-executed subcontracts with its providers. These subcontracts must include a baseline contractual agreement, as well as the appropriate ODM-approved Model Medicaid Addendum. The Model Medicaid Addendum incorporates all applicable OAC rule requirements specific to provider subcontracting and therefore cannot be modified except to add personalizing information such as the MCOP's name.
- a. The MCOP may not employ or contract with providers excluded from participation in federal health care programs under either section 1128 or section 1128A of the Social Security Act. Only those providers who meet the applicable criteria specified in this document, and as determined by ODM, will be counted toward meeting minimum panel requirements. The MCOP must credential and re-credential providers in accordance with OAC rules 5160-58-01.1 and 5160-26-05. The MCOP must ensure that the provider has met all applicable credentialing criteria before the provider can be listed as a panel provider. At the direction of ODM, the MCOP must submit documentation verifying that all necessary contract documents have been appropriately completed.
 - b. The MCPN is a centralized database system that maintains information on the status of MCOP-submitted providers. At a minimum, the MCOP must submit providers associated with the provider types specified in this Appendix, which includes Sections 2.6 and 2.7 of the Three-Way with the exception of independent providers. The MCOP must notify ODM of the addition and deletion of its contracting providers as specified in OAC rules 5160-58-01.1 and 5160-26-05, and must notify ODM within one working day, in instances where the MCOP has identified that it is not in compliance with the provider panel requirements specified in this appendix. For provider deletions, the MCOP must complete and submit an electronic record terminating the provider from the MCPN or other designated system.
4. **Provider Panel Requirements.** Failure to contract with, and properly report to the MCPN, the minimum necessary panel will result in sanctions as outlined in Appendix N. ODM will grant an 'exception to the issuance of sanction' only when an action taken by ODM has adversely impacted a plan's ability to meet the provider panel network or when a provider is not available in the required zip code, county, and/or region.

- a. All MCOPs must provide all medically-necessary Medicaid-covered services to their members. MCOPs must ensure that all network providers follow community standards in the scheduling of routine appointments (i.e., the amount of time members must wait from the time of their request to the first available time when the visit can occur).
- b. The MCOP must comply with all provider network requirements set forth in the Three-Way and the provider network requirements included as part of this appendix except as explicitly noted herein.
 - i. Certified Nurse Midwives (CNMs) and Certified Nurse Practitioners (CNPs). The MCOP must ensure access to CNM and CNP services in the region if such provider types are present within the region. The MCOP may contract directly with the CNM or CNP providers, or with a physician or other provider entity which is able to obligate the participation of a CNM or CNP. If an MCOP does not contract for CNM or CNP services and such providers are present within the region, the MCOP will be required to allow members to receive CNM or CNP services outside of the MCOP's provider network.
 - ii. Vision Care Providers. MCOPs must contract with at least the minimum number of ophthalmologists and optometrists for each specified county and region, all of whom must maintain a full-time practice at a site(s) located in the specified county and region to count toward minimum panel requirements. All ODM-approved vision providers must regularly perform routine eye exams. MCOPs will be expected to contract with an adequate number of ophthalmologists as part of its overall provider panel, but only ophthalmologists who regularly perform routine eye exams can be used to meet the vision care provider panel requirement. If optical dispensing is not sufficiently available in a region through the MCOP's contracting ophthalmologists/optometrists, the MCOP must separately contract with an adequate number of optical dispensers located in the region.
 - iii. Dental Care Providers. MCOPs must contract with at least the minimum number of dentists.
 - iv. Waiver Providers. The MCOP shall ensure that MyCare HCBS waiver providers listed in the charts within Appendix H meet the requirements set forth in OAC Chapters 173-39 and 5160-45, as appropriate, and have an active Medicaid provider agreement with ODM.

The MCOP must have a written policy setting forth a regular payment cycle for clean claims submitted by independent providers. The MCOP must adhere to the policy and any communications from the MCOP to a provider must be consistent with the policy.

- v. Nursing Facilities. The MCOP must contract with at least the minimum number of facilities that are identified in the attached Appendix H chart.

- vi. Behavioral Health Providers. MCOPs must evaluate each region's network capacity of behavioral health services (both Medicare and Medicaid). An MCOP must perform an assessment of no less than its contracted Medicare providers in each region and county regarding providers' willingness and preparedness to become Medicaid providers of the behavioral health services. The MCOP must also assess whether each region and county's CMHC's are currently certified for Medicare or are prepared and willing to pursue certification for Medicare services. MCOP's must report the results to ODM upon request.
 - vii. Alcohol and Drug Providers. The MCOP must contract with at least the minimum number of certified Ohio Department of Mental Health and Addiction Services providers identified on the Appendix H charts. In addition, MCOP must ensure there exist adequate provider panel capacity to provide its members with reasonable and timely access to the following services; alcohol/drug screening analysis/lab urinalysis, ambulatory detoxification, assessment, case management, crisis intervention, individual counseling, group counseling, induction of buprenorphine, injection of naltrexone (to treat addiction), intensive outpatient (to treat addiction) and medical somatic services.
 - viii. Mental Health Providers. MCOPs must contract with at least the minimum number of certified Ohio Department of Mental Health and Addiction Services providers identified on the Appendix H charts. In addition, MCOPs must ensure adequate provider panel capacity to provide its members with reasonable and timely access to the following services within the region, if available; Community Psychiatric Supportive Treatment, Crisis Intervention, Health Home Comprehensive Care Coordination, individual counseling, group counseling, injections (long-acting antipsychotic medications), mental health assessment, partial hospitalization, pharmacological management, psychiatric diagnostic interview and psychological testing.
5. **Provider Directories.** An MCOP's provider directory must include all MCOPN-contracted providers as well as certain non-contracted providers as specified by ODM with the exception of independent providers and those providers operating under single case agreements. At the time of ODM's review, the information listed in the MCOP's provider directory for all ODM-required provider types specified on the attached charts must exactly match the data currently on file in the ODM MCPN, or other designated process.
- a. The MCOP's provider directory must utilize a format specified by ODM. The directory may be region-specific or include multiple regions; however, the providers within the directory must be divided by region, county, and provider type, in that order. The directory must also specify:
 - i. Provider addresses and phone numbers;

- ii. An explanation of how to access providers (e.g. referral required vs. self-referral);
 - iii. An indication of which providers are available to members on a self-referral basis;
 - iv. Foreign-language speaking PCPs and specialists and the specific foreign languages spoken;
 - v. How members may obtain directory information in alternate formats that takes into consideration the special needs of eligible individuals including but not limited to, visually-limited, LEP, and LRP eligible individuals, any PCP or specialist practice limitations; and
 - vi. An indication of whether the provider is accepting new members.
- b. Printed Provider Directory. Prior to executing a provider agreement with ODM, the MCOP must develop a printed provider directory that complies with requirements set forth in Section 2.12.5.2 of the Three-Way and is prior-approved by ODM. Once approved, this directory may be regularly updated with provider additions or deletions by the MCOP without ODM prior-approval; however, a copy of the revised directory (or inserts) must be submitted to ODM prior to distribution to members.

On a quarterly basis, the MCOP must create an insert to each printed directory that lists those providers deleted from the MCOP's provider panel during the previous three months.

- c. Internet Provider Directory. The MCOP is required to have an internet-based provider directory available in a format prior approved by ODM. This internet directory must allow members to electronically search for MCOP panel providers based on name, provider type, and geographic proximity. If an MCOP has one internet-based directory for multiple populations, each provider must include a description of which population they serve.

The internet directory may be updated at any time to include providers who are not one of the ODM-required provider types listed on the charts included with this appendix. Providers required by ODM, or by the Three-Way, must be added to the internet directory within one week of submitting the provider to the MCPN. Providers being deleted from the MCOP's panel must be deleted from the internet directory within one week of notification from the provider to the MCOP. Providers being deleted from the MCOP's panel must be posted to the internet directory within one week of notification from the provider to the MCOP of the deletion. These deleted providers must be included in the inserts to the MCOP's printed provider directory referenced above.

MyCare Region	Chore Services	Community Transition	Emergency Response	Home Medical Equipment & Supplies	Home Modifications	Homemaker	Independent Living Assistance	Meals Home Delivered	Nutritional Counseling	Out of Home Respite	Social Work Counseling	Waiver Transportation	Waiver Nursing Agency	Personal Care- Agency
Central	1	5	19	19	8	56	2	9	1	1	2	2	42	124
East Central	2	7	10	10	15	24	2	9	2	1	2	6	22	53
Northeast	1	7	16	6	6	34	0	13	2	2	2	8	28	63
Northeast Central	2	8	5	4	2	10	5	5	3	1	2	2	10	31
Northwest	1	1	3	3	2	4	2	10	2	2	2	2	20	30
Southwest	1	8	10	6	7	16	2	19	4	1	2	4	21	44
West Central	6	4	4	7	8	6	0	8	6	1	2	5	28	41

Nursing Facility-MyCare Provider Panel Analysis

MyCare Region	County	# NF
Central	Delaware	3
Central	Franklin	16
Central	Madison	1
Central	Pickaway	2
Central	Union	1
East Central	Portage	2
East Central	Stark	11
East Central	Summit	14
East Central	Wayne	5
Northeast	Cuyahoga	31
Northeast	Geauga	2
Northeast	Lake	4
Northeast	Lorain	4
Northeast	Medina	4
Northeast Central	Columbiana	5
Northeast Central	Mahoning	7
Northeast Central	Trumbull	7
Northwest	Fulton	2
Northwest	Lucas	12
Northwest	Ottawa	2
Northwest	Wood	4

MyCare Region	County	# NF
Southwest	Butler	7
Southwest	Clermont	4
Southwest	Clinton	1
Southwest	Hamilton	23
Southwest	Warren	6
West Central	Clark	4
West Central	Greene	3
West Central	Montgomery	12
	Grand Total	199

Vision / Dental

Northeast

Cuyahoga	32	85
Geauga	0	1
Lake	2	7
Lorain	3	13
Medina	1	4
Total	38	110

East Central

Portage	0	3
Stark	7	17
Summit	11	23
Wayne	0	3
Total	18	46

Northeast Central

Columbia	0	2
Mahoning	5	11
Trumbull	4	8
Total	9	21

Central

Delaware	3	3
Franklin	20	60
Madison	0	1
Pickaway	1	1
Union	1	1
Total	25	66

Northwest

Fulton	0	2
Lucas	9	26
Ottawa	0	1
Wood	2	2
Total	11	31

Southwest

Butler	4	13
Clermont	1	5
Clinton	1	1
Hamilton	14	34
Warren	2	3
Total	22	56

West Central

Clark	3	6
Greene	3	3
Montgomery	13	23
Total	19	32

MyCare Region	OMHAS Mental Health Providers	OMHAS Alcohol & Drug Providers
Central	18	8
East Central	19	8
Northeast	50	8
Northeast Central	10	6
Northwest	10	6
Southwest	28	8
West Central	19	6

APPENDIX I

PROGRAM INTEGRITY

MCOPs must comply with all applicable state and federal program integrity requirements, including, but not limited to, those specified in 42 CFR 455, 42 CFR 1002 and 42 CFR 438 Subpart H.

1. **Fraud and Abuse Program.** In addition to the specific requirements of OAC rules, 5160-58-01.1 and 5160-26-06, and in accordance with ODM's 1915(c) and 1915(b) CMS-approved waiver, the MCOP must have a program that includes administrative and management arrangements or procedures to guard against fraud and abuse. The MCOP's compliance program must address the following:
 - a. **Compliance Plan.** A mandatory compliance plan including designated staff responsible for administering the plan and include clear goals, milestones or objectives, measurements, key dates for achieving identified outcomes, and explain how the MCOP will determine the compliance plan's effectiveness.
 - b. **Employee education about false claims recovery.** MCOPs must comply with Section 6032 of the Deficit Reduction Act of 2005, regarding employee education and false claims recovery, specifically MCOPs shall:
 - i. Establish and make readily available to all employees, including the MCOP's management, the following written policies regarding false claims recovery:
 1. Detailed information about the federal False Claims Act and other state and federal laws related to the prevention and detection of fraud, waste, and abuse, including administrative remedies for false claims and statements as well as civil or criminal penalties;
 2. The MCOP's policies and procedures for detecting and preventing fraud, waste, and abuse; and
 3. The laws governing the rights of employees to be protected as whistleblowers. In addition, the MCOP shall communicate the following whistleblower fraud and/or abuse reporting contacts to all employees, providers, and subcontractors:
 - a. Ohio Medicaid 1-614-466-0722 or at:
<http://medicaid.ohio.gov/RESOURCES/HelpfulLinks/ReportingSuspectedMedicaidFraud.aspx>;
 - b. Medicaid Fraud Control Unit (MFCU) 1-800-642-2873 or at:
<http://www.ohioattorneygeneral.gov/Individuals-and-Families/Victims/Submit-a-Tip/Report-Medicaid-Fraud>; and

- c. The Ohio Auditor of State (AOS) 1-866-FRAUD-OH or by email at: fraudohio@ohioauditor.gov.
 - ii. Including in any employee handbook the required written policies regarding false claims recovery;
 - iii. Establishing written policies for any MCOP contractors and agents that provide detailed information about the federal False Claims Act and other state and federal laws related to the prevention and detection of fraud, waste, and abuse, including administrative remedies for false claims and statements as well as civil or criminal penalties; the laws governing the rights of employees to be protected as whistleblowers; and the MCOP's policies and procedures for detecting and preventing fraud, waste, and abuse. MCOP must make such information readily available to their subcontractors; and
 - iv. Disseminating the required written policies to all contractors and agents, who must abide by those written policies.
- c. Monitoring for fraud and abuse. MCOPs must specifically address the MCOP's strategies for prevention, detection, investigation, and reporting in at least the following areas:
 - i. Credible allegations of fraud. The MCOP must monitor activities on an ongoing basis to prevent and detect activities involving suspected fraud, embezzlement, and theft (e.g., by staff, providers, contractors) and report promptly as specified in this appendix.
 - ii. Underutilization of services. In order to assure that all Medicaid-covered services are being provided, as required, the following areas must be monitored:
 1. The MCOPs must annually review their prior authorization (PA) procedures to determine if they unreasonably limit a member's access to Medicaid-covered services;
 2. The MCOPs must annually review their appeals process for providers following the MCOP's denial of a prior authorization request to determine if the appeals process unreasonably limits a member's access to Medicaid-covered services;
 3. The MCOPs must monitor, on an ongoing basis, service denials and utilization in order to identify member services which may be underutilized; and
 4. If any underutilized services or limits to a member's access to Medicaid-covered services are identified, the MCOP must immediately investigate and, if indicated, correct the problem(s).

- iii. Claims submission and billing. On an ongoing basis, the MCOP must identify and correct claims submission and billing activities which are potentially fraudulent including, at a minimum, double-billing and improper coding, such as upcoding and unbundling, to the satisfaction of the Ohio Department of Medicaid (ODM).

2. **Reporting MCOP Monitoring of Fraud and Abuse Activities.** Pursuant to OAC rules 5160-58-01.1 and 5160-26-06, the MCOP is required to report annually to ODM a summary of the MCOP's monitoring of credible allegations of fraud and abuse, underutilization of member services, limits to Medicaid-covered services, and suspicious claims submission and billing. The MCOP's report must also identify any proposed changes to the MCOP's compliance plan for the coming year.
- a. Reporting suspected fraud and abuse. MCOPs are required to promptly report all instances of suspected provider fraud and abuse to ODM and member fraud and abuse to ODM's Bureau of Program Integrity, copying the appropriate County Department Job and Family Services (CDJFS).
 - i. Credible allegation of provider fraud. MCOPs must promptly refer suspected cases of provider fraud in the ODM specified form to ODM for investigation and determination of whether a credible allegation of fraud exists. If a credible allegation of fraud exists, at the direction of ODM, the MCOP must immediately suspend all payments to the provider and must immediately suspend the provider in accordance with ORC 5164.36. At the request of ODM staff, ODM's designee, the Ohio Attorney General's Office or federal agencies, the MCOP must produce copies of all MCOP fraud, waste and abuse investigatory files and data (including, but not limited to records of recipient and provider interviews) within thirty calendar days unless otherwise agreed upon by ODM.
 - ii. Credible allegation of member fraud. All suspected member fraud and abuse shall be immediately reported to Bureau of Program Integrity (BPI) at Program_Integrity_County_Referral@medicaid.ohio.gov and a copy reported to the appropriate CDJFS.
 - b. Attestations. The MCOP must respond to ODM-initiated fraud, waste and abuse referrals with attestations in the form specified by ODM within 90 calendar days of referral receipt.
 - c. Monitoring for prohibited affiliations. The MCOP's policies and procedures for ensuring that, pursuant to 42 CFR 438.610, the MCOP will not knowingly have a relationship or prohibited affiliation with individuals debarred by Federal Agencies, as specified in Article XII of the Agreement.
 - d. Provider indictment. If an indictment is issued, charges a non-institutional Medicaid provider or its owner, officer, authorized agent, associate, manager, or employee with committing an offence specified in ORC 5164.37(E), and ODM suspends the provider

agreement held by the non-institutional Medicaid provider, at the direction of ODM, the MCOP must immediately suspend the provider and terminate Medicaid payments to the provider for Medicaid services rendered in accordance with ORC 5164.37(D).

- e. The MCOP must disclose to ODM any information regarding change in ownership and control within 35 days in accordance with 42 CFR 455.104 and 5160-1-17.3.
- f. In accordance with 42 CFR 455.105, the MCOP must submit within 35 days of the date requested by ODM or HHS full and complete information about:
 - i. The ownership of any subcontractor with whom the MCOP has had business transactions totaling more than \$25, 000 during the 12-month period ending on the date of the request.
 - ii. Any significant business transactions between the MCOP and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.
- g. The MCOP must disclose the following information on persons convicted of crimes in accordance with 42 CFR 455.106 who have:
 - i. Ownership or control interest in the provider, or is an agent or managing employee of the provider; and
 - ii. Been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

This information must also be disclosed at any time upon written request by the Medicaid agency. The Medicaid agency may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure referenced in this section.

- h. In accordance with 42 CFR 1002.3(b), MCOPs must notify ODM when the MCOP denies credentialing to a provider for program integrity reasons.
 - i. An MCOP that is not a qualified health maintenance organization must report to ODM a description of certain transactions with parties of interest as outlined in section 1903(m)(4)(A) of SSA [42 U.S.C. 1396b(m)(4)(A)].
3. **Data Certification.** Pursuant to 42 CFR 438.604 and 42 CFR 438.606, MCOPs are required to provide certification as to the accuracy, completeness, and truthfulness of data and documents submitted to ODM which may affect MCOP payment.
- a. MCOPs must submit the appropriate ODM-developed certification concurrently with the submission of the following data or documents:

- i. Encounter Data as specified in Appendix L;
 - ii. Prompt Pay Reports as specified in Appendix J;
 - iii. Cost Reports as specified in Appendix J;
 - iv. Care Management Data as specified in Appendix L; and
 - v. HEDIS IDSS Data/FAR as specified in Appendix L;
 - b. The above MCOP data submissions must be certified by one of the following:
 - i. The MCOP's Chief Executive Officer;
 - ii. The MCOP's Chief Financial Officer; or
 - iii. An individual who has delegated authority to sign for, and who reports directly to, the MCOP's Chief Executive Officer or Chief Financial Officer.
 - c. MCOPs must provide certification as to the accuracy, completeness, and truthfulness of additional submissions.
4. **Explanation of Benefits (EOB) Mailings.** Pursuant to 42 CFR 455.20, MCOPs must have a method for verifying with enrollees whether services billed by providers were received. Therefore, the MCOP is required to conduct a mailing of EOBs to a 95% confidence level (plus or minus 5 percent margin of error) random sample of the MCOP's enrollees once a year. As an option, the MCOP may meet this requirement by using a strategy targeting services or areas of concern as long as they number of mailed EOBs is no less than the number generated by the random sample described above. Any MCOP opting to use a targeted mailing must submit the proposed strategy in writing to ODM, and receive written prior approval from ODM. The EOB mailing must only include those members that have received health care services within the last six months, comply with all state and federal regulations regarding release of personal health information, outline the recent medical services identified as having been provided to the enrollee, and request that the enrollee report any discrepancies to the MCOP. The MCOP must inform its Contract Administrator of the date of the EOB mailing and provide results of the mailing 60 to 90 days after the mailing (i.e., number mailed, number of enrollees reporting discrepancies).
5. **Breaches of Protected Health Information.** The MCOP must report the number of breaches of protected health information (PHI) and specify how many breaches were reported to HHS as required by 45 CFR Part 164.408 (b) and (c). This report must be submitted annually as indicated on the "MCOP Calendar of Required Submissions."
6. **Waiver Integrity Reporting Requirements.** The MCOP must perform unit of service /claims validation for waiver services claims in accordance with Ohio's approved 1915(c) waiver, and

must respond promptly to requests for claims verification in support of Provider Certification and Structural Compliance processes administered by ODM, ODA or their designee.

In accordance with ODM's 1915(c) CMS-approved waiver, the MCOP must report the following information to ODM:

- a. In accordance with ODM's 1915(c) CMS-approved waiver, the MCOP must report semi-annually (January 31 and July 31) or as requested by ODM the number and percent of waiver services claims that have been verified through a review of provider documentation to have been paid in accordance with individuals' waiver service plans. The MCOP must review a representative sample stratified by waiver service type, with a confidence interval of 95% with a margin of error of +/- 5%.
 - b. The MCOP must report semi-annually (January 31 and July 31) or as requested by ODM the number and percent of claims identified in a., above, for which the MCOP recovered payment. The first report is required to be submitted to ODM on July 31, 2015. That report must include verifications that cover the entire period back to the MCOP's MyCare Ohio start-up date.
 - c. The MCOP must report the number of providers and members affected in regards to sub-paragraphs a. and b. above. This information is also due on January 31 and July 31.
 - d. The MCOP must submit to ODM on an annual basis (July 31) a copy of its independently audited annual financial reports. These annual financial reports must be audited in accordance with Generally Accepted Auditing Standards by an independent certified public accountant.
7. **Cooperation with State and Federal Authorities.** The MCOP shall make reasonable efforts to cooperate fully with State and Federal Authorities including:
- a. MCOPs shall cooperate fully in any investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal including providing, upon request, information, access to records, and access to interview MCOP subcontractors, employees and consultants in any manner related to the investigation.
 - b. MCOPs, subcontractors and the MCP's providers, shall, upon request, make available to ODM BPI, ODM BMC and AGO MFCU/OIG any and all administrative, financial and medical records relating to the delivery of items or services for which Ohio Medicaid monies are expended. Such records will be made available at no cost to the requesting entity.

APPENDIX J

FINANCIAL PERFORMANCE FOR MYCARE OHIO PLANS

Pursuant to Section 2.13, Financial Requirements, of the Three-Way Contract, MyCare Ohio Plans (MCOPs) must adhere to the financial measures, standards and reporting requirements contained therein. In addition, MCOPs must adhere to the prompt pay standards set forth in Section 5.1.9.1 of the Three-Way Contract.

Annual and quarterly cost reports must be revised in accordance with the actuaries' observation log or as otherwise instructed by ODM.

APPENDIX K

QUALITY CARE

This appendix establishes program requirements and expectations related to the MyCare Ohio Plan's (MCOP's) responsibilities for developing and implementing a care delivery model, which includes the establishment of a primary care provider for individuals; health promotion and wellness activities; a care management program; and utilization management programs. The MCOP must also develop Quality Assessment and Performance Improvement programs and participate in external quality review activities. These program requirements are applicable to dual benefits (also referred to as "opt in") members and Medicaid only (also referred to as "opt out) members and support the priorities and goals set forth in the Ohio Medicaid Quality Strategy.

1. Care Delivery Model.

- a. Primary Care. In accordance with the Three-Way Contract between the MCOP, CMS and ODM (the Three-Way), Section 2.5.1, the MCOP is required to ensure that each Medicaid only member has a primary care provider who will serve as an ongoing source of primary and preventive care and will perform care coordination activities appropriate to the member's needs.
- b. Health Promotion and Wellness Activities. In accordance with the Three-Way, Section 2.5.2, each MCOP must develop and offer a range of health and wellness programs and informational material that target specific health needs and risk behaviors identified for the MCOP's membership.
- c. Direct Access to Specialists. In accordance with the Three-Way, Section 2.6.1.16, the MCOP must implement a provision for members, specifically those with special health care needs, to directly access a specialist (e.g., for an approved number of visits or a standing referral) as appropriate for the member's condition and health care needs. The MCOP must inform members of their right to directly access a specialist.
- d. Utilization Management Programs. In accordance with the Three-Way, Sections 2.4 and 2.8, and OAC rules 5160-58-01.1 and 5160-26-03.1, the MCOP must implement utilization management programs with clearly defined structures and processes to maximize the effectiveness of the care provided to dual benefits and Medicaid only members. Pursuant to the criteria in ORC 5160.34(C), the MCOP is prohibited from retroactively denying a prior authorization (PA) request as a utilization management strategy. In addition, the MCOP shall permit the retrospective review of a claim that is submitted for a service where PA was required, but not obtained, pursuant to the criteria in ORC 5160.34(B)(9).
 - i. Drug Utilization Management Programs. The MCOP may, pursuant to ORC Section

5167.12, implement strategies for the management of drug utilization for Medicaid covered drugs that are not covered by Medicare Part D. The MCOP may, subject to ODM prior approval, require prior authorization of certain drug classes and place limitations on the type of provider and locations where certain drugs may be administered. The MCOP must establish its PA system so it does not impede member access to medically-necessary Medicaid covered services. The MCOP must comply with the provisions of OAC 5160-58-01.1 regarding the timeframes for PA of covered outpatient drugs. All proposed pharmacy programs and drug utilization management programs, such as PA, step therapy, partial fills, specialty pharmacy, pill-splitting, etc. are subject to ODM review and approval.

- ii. Medicaid Covered Nursing Facility Stays. The MCOP must evaluate the member's need for the level of services provided by a nursing facility. To make this decision, the MCOP must use the criteria for nursing facility-based level of care pursuant to OAC rules 5160-3-08, 5160-3-09 and 5160-1-01. The MCOP must provide documentation of the member's level of care determination to the nursing facility. The MCOP must maintain a written record that the criteria were met, or if not met, the MCOP must maintain documentation that a Notice of Action was issued in accordance with OAC 5160-58-08.4.
 - iii. Nursing Facility Level of Care Determinations. Pursuant to Section 2.5.3.3.5.2 of the Three-Way, the MCOP must request level of care determinations from the local Area Agencies on Aging except in the case of nursing facility stays for which level of care authority is delegated to the MCOP.
- e. The MCOP must utilize ongoing medication reconciliation, employment of advanced practice pharmacy management programs, including medication therapy management, and in-person pharmacy consultation to increase adherence to medication regimens and eliminate contra-indicated drugs.
 - f. Transitions of Care. The MCOP must effectively and comprehensively manage transitions of care between settings in order to prevent unplanned or unnecessary readmissions, emergency department visits, and/or adverse outcomes. The MCOP must at a minimum:
 - i. Identify members who require assistance transitioning between care settings;
 - ii. Develop a method for evaluating risk of readmission in order to determine the intensity and urgency of follow up that is required for the member after the date of discharge;
 - iii. Designate MCOP staff who will regularly communicate with the discharging facility

and inform the facility of the designated MCOP contacts;

- iv. Ensure that timely notification and receipt of admission dates, discharge dates and clinical information is communicated between internal MCOP departments and between care settings, as appropriate;
- v. Participate in discharge planning activities with the facility including making arrangements for safe discharge placement and facilitating clinical hand-offs between the discharging facility and the MCOP;
- vi. Obtain a copy of the discharge/transition plan;
- vii. Arrange for services specified in the discharge/transition plan; and
- viii. Conduct timely follow up with the member and member's providers to ensure post discharge services have been provided.

When an MCOP is contacted by an inpatient facility for the MCOP's member, who is not identified in 1.f.i and 1.f.ii, with a request for assistance with discharge planning, the MCOP must initiate and implement steps 1.f.iii – viii, as applicable, to ensure adequate discharge planning occurs for the member.

The MCOP must ensure that the transition/discharge plan and post-discharge services are integrated into the member's care plan. Upon request, the MCOP may be required to submit the transition of care strategy as prescribed by ODM for approval.

- g. Care Management Program Requirements. Pursuant to the Three-Way, Section 2.5.3, the MCOP must provide care management services to all members, including dual benefits and Medicaid only. In addition, the MCOP must also adhere to the following requirements:
 - i. For Medicaid only members, the MCOP shall coordinate with any Medicare Advantage Plan that is the primary payor of Medicare services, if applicable, in an effort to reduce gaps or duplication of services.
 - ii. The MCOP must also adhere to all operational standards articulated in the approved Ohio Home and Community-Based Services 1915(c) waiver for MyCare Ohio.
 - iii. The MCOP is not required to conduct a new initial comprehensive assessment or annual reassessment if an assessment or reassessment was previously conducted by the current or prior MCOP and one of the following conditions apply:

1. A member remains enrolled with the MCOP; or
 2. A member was previously enrolled with the current MCOP in the prior 90 calendar days; or
 3. A member had an assessment completed with a prior MCOP and the assessment was transferred from the disenrolling MCOP to the enrolling MCOP per Appendix C.
- iv. Updates to the initial assessment must comply with Section 2.5.3.2.3.7 of the Three-Way agreement.
- v. MCOPs are required to develop and implement safeguards, systems, and processes that detect, prevent, and mitigate harm and/or risk factors that could impact an individual’s health, welfare and safety. When the MCOP identifies or becomes aware of risk factors, it must put in place services and supports to mitigate and address the identified issues as expeditiously as the situation warrants. MCOPs will work with ODM to establish monitoring criteria and the associated monetary penalties prior to April 1, 2017. The established criteria and penalties will take effect no later than July 1, 2017.
- h. Care Management Staffing Ratio. ODM will assess MCOP compliance with the staffing ratios established in the Three-Way, Section 2.5.3.3.1.3, and as specified in the ODM Methods for the My Care Ohio Care Management Staffing Ratio. The staffing ratio is defined as one full time equivalent (FTE) per the number of dual benefits and Medicaid only members specified for each risk stratification level below. The staffing ratios must fall within the performance standard ranges for each risk stratification level as specified below:

Risk Stratification Level	Staffing Ratio	Performance Standard
Intensive	1:25 – 1:50	≥.0200
High	1:51 – 1:75	.0196 - .0133
Medium	1:76 – 1:100	.0132 - .0100
Low	1:101 – 1:250	.0099 - .0040
Monitoring	1:251 – 1:350	.00398 and 0029

The staffing ratios will be calculated semiannually for the following measurement periods: July 2014 – December 2014; January 2015 – June 2015; July 2015 – December 2015; January 2016 – June 2016; July 2016 – December 2016; January 2017 – June 2017; and July

2017 – December 2017.

- i. The MCOP must employ a methodology for assigning consistent and appropriate caseloads for care managers that assures health, welfare and safety for members. The MCOP must incorporate the following factors into its caseload assignment methodology:
 - i. Population;
 - ii. Acuity status mix;
 - iii. Care manager qualifications, years of experience, and responsibilities;
 - iv. Provision of support staff; location of care manager (community, MCOP office, provider office);
 - v. Geographic proximity of care manager to members (if community based); and
 - vi. Access to and capabilities of technology/IT systems.

The MCOP must ensure there is a method to periodically evaluate caseload assignments, including identification of circumstances that automatically trigger a review or adjustment of caseload sizes. The MCOP must submit a description of the methodology to ODM as specified and when requested.

- j. Comprehensive Assessment Measures. The MCOP must complete an initial comprehensive assessment and an annual reassessment of medical, behavioral, LTSS and social needs for each MyCare beneficiary as specified in Section 2.5.3.2.3 of the Three-Way Agreement. ODM will assess MCOP compliance with these requirements by using results from the following measures:
 - i. Initial comprehensive assessment:
 1. Measure: The percent of members enrolled in the MCOP who received an initial comprehensive assessment within 90 days of the enrollment effective date.
 2. Measurement periods: January – March 2015; April – June 2015; July – September 2015; October – December 2015, January – March 2016, April – June 2016, July – September 2016, October – December 2016, January – March 2017, April – June 2017.
 3. Minimum Performance Standard: Less than 10 percentage points below the percentage achieved by the highest performing MCOP during the measurement period.
 - ii. Annual reassessment:
 1. Measure: The percent of members enrolled in the MCOP who received an annual reassessment within 365 days of the initial comprehensive assessment completion date.
 2. Measurement periods: July – September 2015; October – December 2015; January – March 2016, April – June 2016, July – September 2016,

October – December 2016, January – March 2017, April – June 2017.

3. Minimum Performance Standard: Less than 10 percentage points below the percentage achieved by the highest performing MCOP during the measurement period.
-
- k. Measures, Measurement Periods and Compliance Determination. ODM reserves the right to revise the measures and measurement periods established in this appendix (and their corresponding periods), as needed due to unforeseen circumstances. Unless otherwise noted, the most recent report or study finalized prior to the end of the contract period will be used in determining the MCOP's performance level for that contract period.

In the event an MCOP's performance cannot be evaluated for a care management program evaluation measure and measurement period established in this appendix, ODM in its sole discretion will deem the MCOP to have met or to have not the standard(s) for that particular measure and measurement period depending on the circumstances involved.

- l. HCBS Waiver Operational Reporting Requirements.
 - i. The MCOP must report the following to ODM on the 15th of July, October, January and April of each calendar year:
 1. Total number of individuals who have a risk agreement by the following categories: drug/alcohol issues, unsafe smoking, and non-compliance with healthcare.
 2. Total number of individuals with behavior support plans by category: mechanical restraints, chemical restraints, physical, seclusion, and restrictive interventions.
 3. Total number of behavior support plans by category as indicated above by authorizing entity: physician, psychologist, county board of developmental disabilities, and other behavioral health professional.
 4. Total number of individuals with behavior support plans for which the MCOP activated the behavioral support plan with an indication of the used restraint or seclusion.
 5. Total number of individuals with behavior support plans for which the MCOP activated the behavioral support plan with an indication of the restrictive intervention used.

- ii. In the event that the MCOP activates the Emergency Response Plan (ERP) pursuant to the Three-Way, Section 2.5.3.3.5.4.6, the MCOP must document the outcomes of the ERP and submit to ODM when requested.

- m. Specialized Recovery Services (SRS) Program. Members who may be eligible to receive Specialized Recovery Services (i.e., recovery management, peer recovery support and individualized placement and support – supported employment), will be assigned a recovery manager who will perform assessments, person-centered planning, and coordination of SRS once determined eligible. Recovery managers will be employed by an Independent Entity, an existing Ohio Home Care Waiver case management agency contracted with ODM. As such, the MCOP is not permitted to perform recovery management services and must contract with at least one Independent Entity in the MyCare Ohio service area.

The MCOP is responsible for the payment of SRS. The MCOP must allow members to maintain current service levels at the time of enrollment for at least 180 days after the initial enrollment effective date with the MCOP. After a beneficiary's transition period concludes, the MCOP may prior authorize SRS in accordance with 42 CFR 438.210.

The MCOP will include the recovery manager as part of the member's MyCare Ohio care management team. The SRS person-centered care plan will be integrated into the member's comprehensive care plan. The MCOP's care manager will adhere to ODM's incident management rule specified in OAC 5160-58-05.3. If an incident is reported to the MyCare care manager for a member receiving SRS, the care manager must inform the recovery manager. Prevention plans will be jointly developed by the MCOP care manager and the recovery manager.

The MCOP will refer a member who is potentially eligible for SRS to its contracted Independent Entity to initiate the SRS eligibility determination process.

2. Quality Assessment and Performance Improvement Program. Each MCOP must implement a Quality Assessment and Performance Improvement (QAPI) program in accordance with the Three-Way, Sections 2.11 that applies to both the dual benefits and Medicaid-only populations.

- a. Each MCOP must develop and implement Performance Improvement Projects (PIP) pursuant to the Three-Way, Section 2.11.3.4. Topics will be selected by ODM. The MCOP must adhere to ODM PIP format, content specifications and timelines for PIP implementation and reporting. All PIP submissions will be reviewed and approved by ODM and CMS. The MCOP must submit the results of each PIP to ODM annually; however, ODM reserves the right to require that MCOPs provide status updates no more frequent than monthly to ODM. The EQRO will assist MCOPs with the development and

implementation of PIPs by providing technical assistance and will annually validate the PIPs.

- i. Initiation of PIPs will begin in the 4th quarter of 2014. No more than two MCOP PIPs will be in an active status per calendar year.
- ii. The MCOP shall actively participate in PIPs facilitated by ODM or the EQRO, or both. This includes but is not limited to:
 1. Attending meetings;
 2. Assigning MCOP staff to the PIP efforts who are subject matter experts in the PIP topic, are familiar with MCOP policies and processes related to the topic, have been trained in quality improvement science and rapid cycle quality improvement approaches, and who have decision making authority;
 3. Responding promptly to data and information requests;
 4. Dedicating resources to test and implement quality improvement interventions;
 5. Establishing internal mechanisms to frequently communicate PIP status updates and results to the MCOP's Medical Director or Quality Improvement Director; and
 6. Maintaining regular communication with ODM or EQRO staff.
- iii. MCOP Medical Directors, Quality Improvement Directors, and at least one MCOP staff assigned to PIP/QIP teams will be required to complete coursework in the application of rapid cycle quality improvement science tools and methods from an ODM approved entity. Content should include topics such as:
 1. The Model for Improvement¹ developed by the Associates in Process Improvement and popularized by the Institute for Healthcare Improvement (IHI)
 2. Edward W. Deming's System of Profound Knowledge
 3. Listening to and incorporating the Voice of the Customer (VOC)
 4. Process mapping/flow charting
 5. SMART Aim development and the use of key driver diagrams¹ for building testable hypotheses
 6. Methods for barrier identification and intervention selection (e.g., root cause analyses, Pareto charts, failure mode and effects analysis, the 5 whys technique)
 7. Selection and use of process, outcome and balancing measures

¹Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009.

8. Testing change through the use of PDS(C)A cycles²
 9. The use of statistical process control, such as the Shewart control chart³
 10. Tools for spread and sustainability planning
- iv. Examples of approved entities offering coaching and/or training in these areas include: the Institute for Healthcare Improvement, the Intermountain Healthcare Leadership Institute, the Cincinnati Children's Hospital Anderson Center for Health System Excellence, the American Society for Quality's Learning Institute, the Deming Institute, and the National Association for Healthcare Quality.
- v. Medical Directors with a substantial role in improvement projects or who are accountable for the QAPI program, along with QI Directors and at least one MCOP staff person involved in each ODM initiated QIP/PIP must submit training curricula to ODM for approval prior to enrollment. Evidence of course completion must be submitted by June 30, 2017. Staff will be exempt from this requirement if one of the following conditions is met:
1. An accredited/certified education course in quality improvement science has been completed since July 1, 2014; or
 2. Satisfactory completion of NCQA CPHQ or ASQ CQIA certification after January 1, 2015. Medical Directors with a substantial role in improvement projects or who are accountable for the QAPI program, as well as Quality Improvement Directors hired after July 1, 2016, must complete the course within six months of the start date unless they have evidence of course completion within the two years prior to their effective start date.
- vi. The MCOP shall integrate results from performance improvement projects into its overall quality assessment and performance improvement program.
- b. Quality Measurement Assessment and Improvement Strategy. The MCOP must measure, analyze, and track performance indicators which reflect Ohio Medicaid's Quality Strategy clinical focus areas (e.g., behavioral health) and other quality initiatives in place to advance the goals of the Quality Strategy. The MCOP must include all measures listed in MyCare Ohio Quality Performance Measures, Standards and Measurement Periods and may also include other measures (e.g., the full NCQA accreditation set) that assist the MCOP in advancing the goals of the Quality Strategy and the Duals Demonstration Project. The MCOP's quality measurement assessment and improvement strategy must include the following:

² Deming WE. *The New Economics for Industry, Government, and Education*. Cambridge, MA: The MIT Press; 2000

³ Revelle JB. *Quality Essentials: A Reference Guide from A to Z*, ASQ Quality Press, 2004.

- i. Establishing a measurable goal and benchmark for each performance indicator;
- ii. Measuring performance and comparing the rate for each indicator to the established goal and benchmark (baseline);
- iii. Reviewing data trends to detect improvement, decline or stability in the rates at a frequency no less often than quarterly;
- iv. Identifying opportunities for improvement;
- v. Conducting a root cause analysis to identify factors that may impact the adequacy of rates;
- vi. Developing and quality improvement interventions, using a rapid cycle improvement approach, that will address the root cause of the deficiency;
- vii. Developing a plan to monitor the quality improvement interventions to detect if the changes result in improvement;
- viii. Mechanisms for sustaining and spreading improvement;
- ix. Mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs;
- x. Mechanisms to assess the quality and appropriateness of care furnished to members using long-term services and supports, including assessment of care between care settings and a comparison of services and supports received with those set forth in the member's treatment/service plan, if applicable; and
- xi. Mechanisms to prevent, detect and remediate critical incidents that are based on Ohio's requirements for home and community-based services waiver programs.

The MCOP must ensure that these activities are linked to the MCOP's annual evaluation of the impact and effectiveness of its quality program. Upon request, the MCOP must make the performance indicator tracking and reporting mechanisms available for review by ODM. Annual QAPI submissions are due on or before November 15th.

- 3. External Quality Review.** The MCOP must participate in annual external quality review activities as specified in OAC rules 5160-58-01.1 and 5160-26-07. The review will include but not be limited to the following activities:

- a. Administrative compliance assessment as required by 42 CFR 438.358 and as specified by ODM.
 - b. Non duplication exemption – As allowed by 42 CFR 438.360 and 438.362, an MCOP with accreditation from a national organization approved by the Centers for Medicare and Medicaid services may request to be exempted from certain portions of the administrative compliance assessment. ODM will inform the MCOP when a non-duplication exemption may be requested.
 - c. The EQRO may conduct focused reviews of MCOP performance in the following domains which include, but are not limited to:
 - i. Availability of services
 - ii. Assurance of adequate capacity and services
 - iii. Coordination and continuity of care
 - iv. Coverage and authorization of services
 - v. Credentialing and re-credentialing of services
 - vi. Sub contractual relationships and delegation
 - vii. Enrollee information and enrollee rights
 - viii. Confidentiality of health information
 - ix. Enrollment and disenrollment
 - x. Grievance process
 - xi. Practice guidelines
 - xii. Quality assessment and performance improvement program
 - xiii. Health information systems
 - xiv. Fraud and abuse
 - xv. Encounter data studies
 - xvi. Validation of performance measurement data
 - xvii. Review of information systems
 - xviii. Validation of performance improvement projects
 - xix. Member satisfaction and/or quality of life surveys
4. **Sanctions.** The sanctions for non-compliance with care management, waiver procedural requirements, minimum performance standards, and external quality review activities are listed in the Appendix N of this Provider Agreement.

APPENDIX L

DATA QUALITY

A high level of performance on the data quality standards and requirements established in this appendix is crucial in order for the Ohio Department of Medicaid (ODM) to determine the value of the MyCare Ohio Program and to evaluate MyCare Ohio members' access to and quality of services. Encounter data collected from MyCare Ohio Plans (MCOPs) are used in key performance assessments, such as: the external quality review, clinical performance measures, utilization review, care coordination and care management, and in determining quality withholds. The data will also be used in conjunction with the cost reports in setting the capitation rates. The Encounter Data Volume measures, as specified in this appendix, will be calculated separately per MCOP for the dual benefit members (opt-in population) and those Medicaid-only members (opt-out population) and include all MyCare Ohio members receiving services from the MCOP per these two populations. These measures will be calculated separately for Medicaid and Medicare services for the dual benefit members (opt-in population) and only for the Medicaid services for the Medicaid-only members (opt-out population). All other encounter data quality measures, as specified in this Appendix, will be calculated for each MCOP: Rejected Encounters, Acceptance Rate, Encounter Data Accuracy Study measure (Payment Accuracy), Incomplete Rendering Provider Data, NPI Provider Number Usage Without Medicaid/Reporting Provider Numbers, and Timeliness of Encounter Data Submission.

ODM reserves the right to revise the measures and report periods established in this appendix (and their corresponding compliance periods), as needed, due to unforeseen circumstances. Unless otherwise noted, the most recent report or study finalized prior to the end of the contract period will be used in determining the MCOP's performance level for that contract period.

1. Encounter Data.

For detailed descriptions of the encounter data quality measures below, see *ODM Methods for the MyCare Ohio Encounter Data Quality Measures*.

Each MCOP's encounter data submissions will be assessed for completeness and accuracy per Section 2 of the Three-Way Contract between MCOP, Centers for Medicare and Medicaid Services (CMS) and ODM (Three-Way),. The MCOP is responsible for collecting information from providers and reporting the data to ODM in accordance with program requirements established in Appendix C, *MCOP Responsibilities*. Failure to do so jeopardizes the MCOP's ability to demonstrate compliance with other performance standards.

1.a. Encounter Data Completeness.

1.a.i. Encounter Data Volume.

Measure: The volume measure for each service category, as listed in the tables below, is the rate of utilization (e.g., discharges, visits) per 1,000 member months (MM).

Report Period: The report periods for Calendar Year (CY) 2014 through CY 2017 contract periods are listed in Table 1 below. Fee-For-Service (FFS) Medicaid data will be used as a baseline to set interim data quality standards for Medicaid services for CY 2014 and the first two quarters of CY 2015. Data quality standards for Medicare services and updated data quality standards for Medicaid services will be determined after ODM has collected Medicaid and Medicare encounter data from the MCOPs for at least two quarters. This measure will be used for informational purposes only until February 2017. Beginning in February 2017, this measure will be used to determine compliance.

Table 1. Report Periods for the CY 2014 - CY 2017 Contract Periods.

MCOP Quarterly Report Periods	Data Source (Estimated Encounter Data File Update)	Quarterly Report Estimated Issue	Contract Period
Qtr 1 2014 - Not Applicable	TBD	TBD	CY 2014
Qtr 2: 2014	TBD	TBD	
Qtr 2 and Qtr 3: 2014	TBD	TBD	
Qtr 2 thru Qtr 4:2014	TBD	TBD	
Qtr 2 thru Qtr 4: 2014; Qtr 1 2015	TBD	TBD	CY 2015
Qtr 2 thru Qtr 4: 2014; Qtr 1, Qtr 2: 2015	TBD	TBD	
Qtr 2 thru Qtr 4: 2014; Qtr 1 thru Qtr 3: 2015	TBD	TBD	
Qtr 2 thru Qtr 4: 2014; Qtr 1 thru Qtr 4: 2015	TBD	TBD	
Qtr 2 thru Qtr 4: 2014; Qtr 1 thru Qtr 4: 2015; Qtr 1	TBD	TBD	CY 2016
Qtr 2 thru Qtr 4: 2014; Qtr 1 thru Qtr 4: 2015; Qtr 1, Qtr	TBD	TBD	
Qtr 2 thru Qtr 4: 2014; Qtr 1 thru Qtr 4: 2015; Qtr 1 thru	January 2017	February 2017	
Qtr 2 thru Qtr 4: 2014; Qtr 1 thru Qtr 4: 2015; Qtr 1 thru	April 2017	May 2017	
Qtr 2 thru Qtr 4: 2014; Qtr 1 thru Qtr 4: 2015; Qtr 1 thru	July 2017	August 2017	CY 2017
Qtr 2 thru Qtr 4: 2014; Qtr 1 thru Qtr 4: 2015; Qtr 1 thru	October 2017	November 2017	
Qtr 2 thru Qtr 4: 2014; Qtr 1 thru Qtr 4: 2015; Qtr 1 thru	January 2018	February 2018	
Qtr 2 thru Qtr 4: 2014; Qtr 1 thru Qtr 4: 2015; Qtr 1 thru	April 2018	May 2018	

Qtr1 = January to March; Qtr2 = April to June; Qtr3 = July to September; Qtr 4 = October to December

The dual benefit member (opt-in population) data quality standards for the encounter data volume measure for Medicaid and Medicare services are listed in Tables 2. and 3. below, respectively. The MCOP's utilization rate for each service category listed in Tables 2. and 3. must be equal to or greater than the associated standard established for each service category in Tables 2 and 3, in all quarters of the measurement period.

Table 2. Dual Benefit Members (Opt-In Population) Medicaid Services Standards – Encounter Data Volume.

Category	Measure per 1,000/MM	Standard	Description
Inpatient Hospital	Discharges	TBD	General/acute care, excluding newborns and mental health and chemical
Nursing Facility	Claims	TBD	Nursing facility monthly claims
Emergency Department	Visits	TBD	Includes physician and hospital emergency department
Dental		TBD	Non-institutional and hospital dental visits
Vision		TBD	Non-institutional and hospital outpatient optometry and ophthalmology
Primary and Specialist Care		TBD	Physician/practitioner and
Behavioral Health	Service	TBD	Inpatient and outpatient behavioral encounters
Waiver		TBD	Professional Waiver services
Pharmacy	Prescriptions	TBD	Prescribed drugs

Table 3. Dual Benefit Members (Opt-In Population) Medicare Services Standards – Encounter Data Volume.

Category	Measure per 1,000/MM	Standard	Description
Inpatient Hospital	Discharges	TBD	General/acute care, excluding newborns and mental health and chemical
Nursing Facility	Claims	TBD	Nursing facility monthly claims
Emergency Department	Visits	TBD	Includes physician and hospital emergency department
Primary and Specialist Care		TBD	Physician/practitioner and
Behavioral Health	Service	TBD	Inpatient and outpatient behavioral encounters
Pharmacy	Prescriptions	TBD	Prescribed drugs

The Medicaid-only member (opt-out population) data quality standards for the encounter data volume measure for Medicaid services are listed in Table 4. below. The MCOP’s utilization rate for each service category listed in Table 4. must be equal to or greater than the associated standard established for each service category in Table 4, in all quarters of the measurement period.

Table 4. Medicaid-only (Opt-Out Population) Medicaid Service Standards – Encounter Data Volume.

Category	Measure per 1,000/MM	Standard	Description
Inpatient Hospital	Discharges	TBD	General/acute care, excluding newborns and mental health and chemical
Nursing Facility	Claims	TBD	Nursing facility monthly claims
Emergency Department	Visits	TBD	Includes physician and hospital emergency department
Dental		TBD	Non-institutional and hospital dental visits
Vision		TBD	Non-institutional and hospital outpatient optometry and ophthalmology
Primary and Specialist Care		TBD	Physician/practitioner and
Behavioral Health	Service	TBD	Inpatient and outpatient behavioral encounters
Waiver		TBD	Professional Waiver services
Pharmacy	Prescriptions	TBD	Prescribed drugs

See Appendix N of this Provider Agreement for the sanctions for noncompliance with the standards for this measure.

1.a.ii. Incomplete Rendering Provider Data.

This measure is calculated per MCOP and includes all Ohio MCOP members receiving services from the MCOP. The *Incomplete Rendering Provider Data* measure is calculated to ensure that MCOPs are reporting individual-level rendering provider information to ODM, so that ODM complies with federal reporting requirements. *Measure:* The percentage of rendering providers reported on encounters without individual-level Medicaid and/or Reporting provider numbers as identified in the Medicaid Information Technology System (MITS).

Report Period:

The report periods for CY 2014 through CY 2017 contract periods are listed in Table 1 above. Results for CY 2014 will be informational (reporting only). CY 2014 will be used as a baseline to set interim performance standards for CY 2015. Q1 and Q2 of CY 2015 will be used as a baseline to set performance standards for CY 2017, with additional updates to be determined based on data submitted throughout CY 2015 through CY 2017. MCOPs must meet or exceed the standard in all quarters of the report period. This measure will be used for informational purposes only until February 2017. Beginning in February 2017, this measure will be used to determine compliance.

Data Quality Standard: TBD

See Appendix N of this Provider Agreement for the sanctions for noncompliance with the standards for this measure.

1.a.iii. NPI Provider Number Usage Without Medicaid/Reporting Provider Numbers.

This measure is calculated per MCOP and includes all Ohio MCOP members receiving services from the MCOP. The *NPI Provider Number Usage Without Medicaid/Reporting Provider Numbers* measure is calculated to ensure that providers reported on encounters can be associated with Medicaid and/or Reporting providers in MITS.

Measure: The percentage of institutional (837 I), professional (837 P), and dental (837 D) EDI transactions with an NPI provider number in the billing provider EDI data field that do not have a Medicaid or Reporting Provider Number in MITS.

Report Period:

The report periods for CY 2014 through CY 2017 contract periods are listed in Table 1 above. Results for CY 2014 will be informational (reporting only). CY 2014 will be used as a baseline to set interim performance standards for CY 2015. Q1 and Q2 of CY 2015 will be used as a baseline to set performance standards for CY 2017, with additional updates to be determined based on data submitted throughout CY 2015 through CY 2017. MCOPs must meet or exceed the standard in all quarters of the report period. This measure will be used for informational purposes only until February 2017. Beginning in February 2017, this measure will be used to determine compliance.

Data Quality Standard: TBD

See Appendix N of this Provider Agreement for the sanctions for noncompliance with the standards for this measure.

1.a.iv. Rejected Encounters

Encounters submitted to ODM that are incomplete or inaccurate are rejected and reported back to the MCOPs on the Exception Report. If an MCOP does not resubmit rejected encounters, ODM's encounter data set will be incomplete; therefore, MCOP shall resubmit the required data within the period of time specified by ODM.

These measures are calculated per MCOP and include all Ohio MCOP members receiving services from the MCOP.

1) Measure 1 - Measure 1 only applies to MCOPs that have had MCOP membership for more than one year.

Measure 1: The percentage of encounters submitted to ODM that are rejected

Report Period: Results for CY 2014 will be informational (reporting only). CY 2014 data will be used as a baseline to set data quality standards for CY 2015. For CY 2015 through CY 2017, the report periods will be quarterly. This measure will be used for informational purposes only until February 2017. Beginning in February 2017, this measure will be used to determine compliance.

Data Quality Standard for measure 1: The data quality standard for measure 1 is TBD for each file type in the ODM-specified medium per format.

See Appendix N of this Provider Agreement for the sanctions for noncompliance with the standards for this measure.

2) Measure 2 - Measure 2 only applies to MCOPs that have had MCOP membership for one year or less.

Measure 2: The percentage of encounters submitted to ODM that are rejected.

Report Period: Results for CY 2014 will be informational (reporting only). CY 2014 data will be used as a baseline to set data quality standards for CY 2015. The report period for Measure 2 is monthly. Results are calculated and performance is monitored monthly. The first reporting month begins with the third month of enrollment.

Data Quality Standard for measure 2: The data quality standard for measure 2 is a maximum encounter data rejection rate for each file type in the ODM-specified medium per format as follows:

Third through sixth month with MCOP membership: Not applicable for SFY 2017

Seventh through twelfth month with MCOP membership: Not applicable for SFY 2017

See Appendix N of this Provider Agreement for the sanctions for noncompliance with the standards for this measure.

1.a.v. Acceptance Rate.

This measure only applies to MCOPs that have had MCOP membership for one year or less.

Measure: The rate of encounters that are submitted to ODM and accepted (i.e. accepted encounters per 1,000 member months).

Measurement Period: The measurement period for this measure is monthly. Results are calculated and performance is monitored monthly. The first reporting month begins with the third month of enrollment.

Data Quality Standard: The data quality standard is a monthly minimum accepted rate of encounters for each file type in the ODM-specified medium per format as follows:

Third through sixth month with membership: Not Applicable for SFY 2017

Seventh through twelfth month of membership: Not Applicable for SFY 2017

See Appendix N, *Compliance Assessment System*, for the penalty for noncompliance with the standards for this measure.

1.b. Encounter Data Accuracy.

As with data completeness, MCOPs are responsible for assuring the collection and submission of accurate data to ODM. Failure to do so jeopardizes MCOPs' performance, credibility and, if not corrected, will be assumed to indicate a failure in actual performance.

1.b.i. Encounter Data Accuracy Study.

Measure: This accuracy study will compare the accuracy and completeness of payment data stored in MCOPs' claims systems during the study period to payment data submitted to and accepted by ODM. The measure will be calculated per MCOP. Two levels of analysis will be conducted: one to evaluate encounter data completeness for which two rates will be calculated and one to evaluate payment data accuracy. Payment completeness and accuracy rates will be determined by aggregating data across claim types (i.e., professional, pharmacy, and institutional) and stratifying data by file type (i.e., header and detail). At a minimum, the additional components of analysis will include diagnosis codes and provider information (e.g., rendering provider, billing provider).

Encounter Data Completeness (Level 1):

Omission Encounter Rate: The percentage of encounters in an MCOP's fully adjudicated claims file not present in the ODM encounter data files.

Surplus Encounter Rate: The percentage of encounters in the ODM encounter data files not present in an MCOP's fully adjudicated claims files.

Payment Data Accuracy (Level 2):

Payment Error Rate: The percentage of matched encounters between the ODM encounter data files and an MCOP's fully adjudicated claims files where a payment amount discrepancy was identified.

Rev. 1/2017

Report Period: In order to provide timely feedback on the omission rate of encounters, the report period will be the most recent from when the study is initiated. This study is conducted annually.

Data Quality Standards:

For CY 2015:

For Level 1: An omission encounter rate and a surplus encounter rate of no more than 11% for both claim-level and line-level records.

For Level 2: A payment error rate of no more than 4%.

For CY 2016:

For Level 1: An omission encounter rate and a surplus encounter rate of no more than TBD for both claim-level and line-level records.

For Level 2: A payment error rate of no more than TBD.

For CY 2017:

For Level 1: An omission encounter rate and a surplus encounter rate of no more than TBD for both claim-level and line-level records.

For Level 2: A payment error rate of no more than TBD.

For CY 2018:

For Level 1: An omission encounter rate and a surplus encounter rate of no more than TBD for both claim-level and line-level records.

For Level 2: A payment error rate of no more than TBD.

See Appendix N of this Provider Agreement for the sanctions for noncompliance with the standards for this measure.

1.c. Encounter Data Submission.

Information concerning the proper submission of electronic data interchange (EDI) encounter transactions may be obtained from the ODM website. The website contains Encounter Data Companion Guides for the MyCare Ohio 837 dental, professional and institutional transactions and the NCPDP D.0 pharmacy transactions. Additional Companion Guides for transactions that should be used in conjunction with encounters include the MyCare U277 Unsolicited Claim/Encounter Status Notifications, the MyCare 824 Application Advice and the TA1 Transmission Acknowledgement also available on the website. The Encounter Data Companion Guides must be used in conjunction with the X12 Implementation Guides for MyCare EDI transactions.

Information concerning MyCare Ohio encounter data measures may be obtained from the ODM MyCare Encounter Data Submission Guidelines and Quality Measure Methodology document also located on the ODM website. This document gives additional guidance on the methodologies used to create the measures in Appendix L of this Provider Agreement. This document also provides the MyCare Encounter Data Minimum Number of Encounters required by each plan, the MyCare Encounter Data Submission Schedule and the MyCare Encounter Data Certification Letter guidelines.

1.c.i. Encounter Data Submission Procedure.

The MCOP must submit encounter data files to ODM per the specified schedule and within the allotted amount established in the ODM MyCare Encounter Data Submission Guidelines and Quality Measure Methodology document.

The MCOP must submit a letter of certification, using the form required by ODM, with each encounter data file in the ODM-specified medium per format.

The letter of certification must be signed by the MCOP's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for, and who reports directly to, the MCOP's CEO or CFO.

See Appendix N of this Provider Agreement for the sanctions for noncompliance with these data submission requirements.

1.c.ii. Timeliness of Encounter Data Submission.

ODM recommends submitting MCOP-paid encounters no later than 60 days after the end of the month in which they were paid. ODM currently monitors minimum encounter data claims volume (Section 1.a.i.) and rejected encounters (Section 1.a.iv.) and the standards for these measures are based on encounters being submitted within this time frame. Beginning in March 2015 for claims paid in January 2015, MCOPs must report on encounter data submission lag time on a monthly basis to ODM. Results may be subject to an audit by ODM and/or a vendor representing ODM.

Effective SFY 2016 (July 2015), ODM will evaluate the timeliness of MCOP encounter data submissions.

Measure: The percentage of encounters that are submitted to ODM and accepted within 60 calendar days of the month in which they were paid. (e.g., claims paid by the MCOP in January 2015 would be reported after April 2, 2015).

Measurement Periods: TBD

Data Quality Standard: (effective SFY 2016) TBD

See Appendix N of this Provider Agreement for the sanctions for noncompliance with the standard for this measure.

1.c.iii. Encounter Submissions Per Encounter Schedule.

Measure: The percent of encounters listed in the ODM MyCare Encounter Data Submission Guidelines and Quality Measure Methodology document as the minimum amount for that month that were submitted to ODM and accepted.

Measurement Periods: TBD

Data Quality Standard: The data quality standard is greater than or equal to 100%.

See Appendix N of this Provider Agreement for the sanctions for noncompliance with the standard for this measure.

2. MCOP Self-Reported, Audited HEDIS Data.

2.a. Annual Submission of HEDIS IDSS Data.

The MCOP is required to collect, report, and submit to ODM self-reported, audited HEDIS data for the full set of HEDIS measures reported by the MCOP to NCQA for MyCare Ohio members per *ODM's Specifications for the Collection and Submission of MyCare Ohio Self-Reported, Audited HEDIS Results*. The self-reported, audited HEDIS data are due to ODM no later than five business days after the NCQA due date.

See Appendix N of this Provider Agreement for the sanctions for noncompliance with this data submission requirement.

2.b. Annual Submission of Final HEDIS Audit Report (FAR).

The MCOP is required to submit to ODM its FAR that contains the audited results for the full set of HEDIS measures reported by the MCOP to NCQA for MyCare Ohio members. This must include all HEDIS measures referenced in Appendix M. The FAR is due to ODM no later than five business days after the NCQA due date.

See Appendix N of this Provider Agreement for the sanctions for noncompliance with this data submission requirement.

Note: ODM will review each MCOP's FAR in order to determine if any data collection or reporting issues were identified. In addition, ODM will evaluate any issues that resulted in the assignment of an audit result of "Not Report" (i.e., NR) for any measure. ODM reserves the right to pursue corrective action based on this review (see Appendix N of this Provider Agreement).

2.c. Data Certification Requirements for HEDIS IDSS Data and Final HEDIS Audit Report.

In accordance with 42 CFR 438.600, *et seq.*, each MCOP must submit a signed data certification letter to ODM attesting to the accuracy and completeness of its audited HEDIS IDSS data submitted to ODM. Each MCOP must also submit to ODM a signed data certification letter attesting to the accuracy and completeness of its final HEDIS audit report (FAR) submitted to ODM.

Each data certification letter is due to ODM on the same days that the respective HEDIS IDSS data/ FAR are submitted to ODM. Additional specifications regarding the data certification letters will be made available in future technical guidance.

See Appendix N of this Provider Agreement for the sanctions for noncompliance with these data

3. Care Management Data.

The MCOP must submit care management data in accordance with the *MyCare Ohio Care Management Data Submission Specifications*.

In accordance with 42 CFR 438.600—438.606, each MCOP must submit the ODM required signed data certification letter to ODM attesting to the accuracy and completeness of care management data submitted to ODM.

Care management data files and the data certification letters are due on the 10th calendar day of each month.

See Appendix N of this Provider Agreement for the sanctions for noncompliance with these data submission requirements.

4. Appeals and Grievances Data.

Pursuant to OAC rule 5160-58-08.4, the MCOP is required to submit appeal and grievance activity to ODM as directed. ODM requires appeal and grievance activity to be submitted at least monthly in an electronic data file format pursuant to the *Appeal File and Submission Specifications* and *Grievance File and Submission Specifications*.

The appeal data file and the grievance data file must include all appeal and grievance activity, respectively, for the previous month, and must be submitted by the ODM-specified due date. These data files must be submitted in the ODM-specified format and with the ODM-specified filename in order to be successfully processed.

MCOPs who fail to submit their monthly electronic data files to the ODM by the specified due date or who fail to resubmit, by no later than the end of that month, a file which meets the data quality requirements will be subject to sanctions as provided in Appendix N of this Provider agreement.

5. Utilization Management Data.

Pursuant to OAC rules 5160-58-01.1 and 5160-26-03.1, the MCOP is required to submit information on prior authorization requests as directed by ODM. ODM requires information on prior authorization requests to be submitted at least bi-weekly in electronic data file formats pursuant to the *Utilization Management Tracking Database: Prior Authorization File and Submission Specifications* document.

6. Health Outcomes Survey (HOS) Data.

The MCOP is required to collect, report, and submit to ODM HOS data for the full set of HOS measures reported to CMS by the MCOP for applicable MyCare Ohio members per CMS' *Reporting Requirements for 2016 HEDIS, HOS and CAHPS Measures*.

See Appendix N of this Provider Agreement for the sanctions for noncompliance with this data submission requirement.

7. Nursing Facility 100-Day Threshold and Discharge Data.

7.a. Timely Submission of Nursing Facility 100-day Threshold and Discharge Data.

MCOPs are required to collect, report, and submit nursing facility 100-day threshold and discharge data as specified in the *MyCare Ohio Rules for Reporting the Institutional 100-Day Requirement*. Individual member records must be submitted within 30 business days of the NF LOC (100-day threshold) date and date of discharge, and in every case, NF LOC (100-day threshold) dates must be submitted in accordance with dates specified by ODM to comply with the MEMA timeframes specified in Appendix E.

The individual member records 100-day threshold and discharge dates must be complete and accurate as compared with associated medical records and in accordance with the *MyCare Ohio Rules for Reporting the Institutional 100-Day Requirement*.

The MCOP must also submit a letter of certification, using the form required by ODM, with each nursing facility admission and discharge data submission file. ODM will use a sample of the NF LOC data to determine compliance.

See Appendix N of this Provider Agreement for the sanctions for noncompliance with this data submission requirement.

8. MyCare Ohio Quarterly Enrollment Files.

Accurate and complete MCOP enrollment records are a critical component of determining accurate rates for measures where member enrollment is used as the basis for calculating rates. In order to ensure the most accurate and complete enrollment records possible for each MCOP, ODM is creating quarterly enrollment files to be sent to the MCOPs for the purpose of enrollment verification. Details regarding specifications for these enrollment files can be found in *ODM's MyCare Ohio Plan Quarterly Enrollment Data File Specifications*.

Effective July 2016, MCOPs may voluntarily submit to ODM on a quarterly basis addition and deletion files for member enrollment spans. These file submissions must be accompanied by a data certification letter, using the form required by ODM. Specifications for submitting the addition and deletion files, and instructions for submitting the associated data certification letter, are provided in *ODM's MyCare Ohio Plan Addition and Deletion Enrollment Data File Specifications*.

As this file submission is voluntary, no penalty will be assessed for failure to submit the required data certification letter, however, ODM will not utilize any MCOP files submitted under this section that are not accompanied by the associated data certification letter.

9. Biannual Submission of Provider Preventable Conditions Data.

Pursuant to 42 CFR 438.3(g), MCOPs must identify the occurrence of all provider preventable conditions (PPCs). MCOPs shall report identified PPCs, regardless of the provider's intention to bill for that event, to ODM on a biannual basis, beginning January 1, 2018, in a form specified by ODM.

APPENDIX M

QUALITY MEASURES AND STANDARDS

The Ohio Department of Medicaid (ODM) has established Quality Measures and Standards to evaluate MyCare Ohio Plan (MCOP) performance in key program areas (i.e., access, clinical quality, consumer satisfaction). The selected measures align with specific priorities, goals, and focus areas of the ODM Quality Strategy. Each measure has a Minimum Performance Standard. Failure to meet a Minimum Performance Standard will result in the assessment of a noncompliance penalty. See Appendix N of this Provider Agreement for sanctions for noncompliance with the performance standards. Certain measures are also used to determine the Medicaid quality withhold amount that an MCOP may earn back for a contract year per Appendix O, *Quality Withholds*, and/or per Section 4 of the Three-Way Contract between the MCOP, CMS and ODM (the Three-Way).

The measures utilized for performance evaluation are derived from national measurement sets (e.g., HEDIS, AHRQ, HOS, CAHPS, MDS, CMS, etc.), widely used for evaluation of Medicaid/Medicare managed care industry data, or are Ohio-specific measures designed to monitor goals associated with rebalancing initiatives which provide greater access to home and community based services, as an alternative to facility-based long-term care. Each measure applies to dual benefit members (opt-in population) and/or to Medicaid-only members (opt-out population). Performance measures and standards are subject to change based on the revision or update of applicable national measures, methods, benchmarks, or other factors as deemed relevant.

The performance measures listed in this Appendix are not intended to limit the assessment of other indicators of performance for quality improvement activities. MCOP performance based on multiple measures will be assessed and reported to the MCOPs and others, including Medicare and Medicaid consumers.

1. Quality Measures and Standards.

MCOPs are evaluated on measures separately for dual benefit members (opt-in population) and Medicaid-only members (opt-out population) using statewide population-specific results that include all regions in which the MCOP has membership. Results for each measure are calculated per MCOP and will either include all of the MCOP's Ohio dual benefit members (opt-in population) and/or Medicaid-only (opt-out population) per the criteria specified by the methodology for the given measure. Separate minimum performance standards may be established for the dual benefit population and the Medicaid-only population.

MCOP performance is assessed using ODM calculated performance measurement data, CMS calculated performance measurement data, and results submitted to ODM and CMS by the MCOPs. The measures in this appendix are calculated in accordance with *CMS' Reporting Requirements for HEDIS, HOS, and CAHPS Measures*, and *The Ohio Department of Medicaid's MyCare Rebalancing and Long Term Care Measures Methods*.

1.a. Measures, Measurement Sets, Standards, and Measurement Years.

Appendix M
 MyCare Ohio
 Quality Measures and Standards
 Page 2 of 7

The measures and accompanying Minimum Performance Standards and measurement years for the SFY 2016, SFY 2017, SFY 2018, and SFY 2019 contract periods are listed in Table 1. below. Each measure’s corresponding measurement set and applicable consumer population is also provided. For sanctions associated with noncompliance with the performance standards for these measures, see Appendix N of this Provider Agreement.

Table 1. SFY 2016, SFY 2017, SFY 2018, and SFY 2019 Performance Measures, Measurement Sets, Standards, and Measurement Years

Quality Strategy: Population Stream	Measure	Measurement Set	Applicable Population	SFY 2016 Minimum Perf. Std.	SFY 2016 Measurement Year	SFY 2017 Minimum Perf. Std.	SFY 2017 Measurement Year	SFY 2018 Minimum Perf. Std.	SFY 2018 Measurement Year	SFY 2019 Minimum Perf. Std.	SFY 2019 Measurement Year
Behavioral Health	Follow-Up After Hospitalization for Mental Illness - 30 Day Follow Up**	NCQA/HEDIS	Dual Benefits Members (Opt-In)	N/A	N/A	≥ 41.2%	CY 2016	≥56.0%	CY 2017	TBD	CY 2018
Behavioral Health	Follow-Up After Hospitalization for Mental Illness - 7 Day Follow Up	NCQA/HEDIS	Dual Benefits Members (Opt-In)	≥ 23.0%	CY 2015	N/A	N/A	N/A	N/A	N/A	N/A
Behavioral Health	Anti-depressant Medication Management	NCQA/HEDIS	Dual Benefits Members (Opt-In)	N/A	N/A	Effective Acute Phase Treatment: ≥ 62.8%	CY 2016	Effective Acute Phase Treatment: ≥ 64.1%	CY2017	TBD	CY 2018
					Effective Continuation Phase Treatment: ≥ 47.4%	Effective Continuation Phase Treatment: ≥ 48.4%					
Chronic Conditions	Controlling High Blood Pressure **	NCQA/HEDIS	Dual Benefits Members (Opt-In)	≥ 58.9%	CY 2015	≥ 47.0%	CY 2016	≥53.0%	CY 2017	TBD	CY 2018

Appendix M
 MyCare Ohio
 Quality Measures and Standards
 Page 3 of 7

Chronic Conditions	Comprehensive Diabetes Care - HbA1c Control (<8.0%)	NCQA/HEDIS	Dual Benefits Members (Opt-In)	N/A	CY 2015	≥ 58.3%	CY 2016	≥55.8%	CY 2017	TBD	CY 2018
Chronic Conditions	Part D Medication Adherence for Diabetes Medications **	CMS	Dual Benefits Members (Opt-In)	≥ 73.0%	CY 2015	≥ 69.0%	CY 2016	≥ 73.0%	CY 2017	TBD	CY 2017
Healthy Adults	Annual Flu Vaccine**	CAHPS	Dual Benefits Members (Opt-In)	≥ 69.0%	CY 2015 (Survey conducted in CY 2016)	≥ 63.0%	CY 2016 (Survey conducted in CY 2017)	≥69.0 %	CY 2017 (Survey conducted in CY 2018)	TBD	CY 2018
Healthy Adults	Fall Risk Management – Managing Fall Risk **	NCQA/HEDIS/HOS	Dual Benefits Members (Opt-In)	≥ 55.0%	CY 2015 (Survey conducted in CY 2016)	≥ 53.0%	CY 2016 (Survey conducted in CY 2017)	≥55.0%	CY 2017 (Survey conducted in CY 2018)	TBD	CY 2018
Healthy Adults	Breast Cancer Screening	NCQA/HEDIS	Dual Benefits Members (Opt-In)	N A	CY 2015	≥ 66.0%	CY 2016	≥66.3%	CY 2017	TBD	CY 2018

Appendix M
 MyCare Ohio
 Quality Measures and Standards
 Page 4 of 7

Quality Strategy: Population Stream	Measure	Measurement Set	Applicable Population	SFY 2016 Minimum Perf. Std.	SFY 2016 Measurement Year	SFY 2017 Minimum Perf. Std.	SFY 2017 Measurement Year	SFY 2018 Minimum Perf. Std.	SFY 2018 Measurement Year	SFY 2019 Minimum Perf. Std.	SFY 2019 Measurement Year
Integrating Care	Plan All Cause Readmissions – Observed Readmissions (Num/Den)	NCQA/HEDIS	Dual Benefits Members (Opt-In)	N/A	CY 2015	≤ 11.0%	CY 2016	≤11.0%	CY 2017	TBD	CY 2018
	Adults' Access to Preventive/Ambulatory Health Services	NCQA/HEDIS	Dual Benefits Members (Opt-In)	≥ 94.6%	CY 2015	≥ 94.0%	CY 2016	≥93.8%	CY 2017	TBD	CY 2018
	Getting Appointments and Care Quickly Composite*	CAHPS	Dual Benefits Members (Opt-In)	N/A	CY 2015 (Survey conducted in CY 2016)	≥ 74.0%	CY 2016 (Survey conducted in CY 2017)	≥73.0%	CY 2017 (Survey conducted in CY 2018)	TBD	CY 2018
	Satisfaction with Customer Service Composite*	CAHPS	Dual Benefits Members (Opt-In)	N/A	CY 2015 (Survey conducted in CY 2016)	≥ 85.0%	CY 2016 (Survey conducted in CY 2017)	≥86.0%	CY 2017 (Survey conducted in CY 2018)	TBD	CY 2018

Appendix M
 MyCare Ohio
 Quality Measures and Standards
 Page 5 of 7

	Care for Older Adults - Medication Review, 66 & Older	NCQA/HEDIS	Dual Benefits Members (Opt-In)	≥ 71.0%	CY 2015	≥ 60.0%	CY 2016	≥57.0%	CY 2017	TBD	CY 2018
	Care for Older Adults - Functional Status Assessment, 66 & Older	NCQA/HEDIS	Dual Benefits Members (Opt-In)	≥ 59.0%	CY 2015	≥ 54.0%	CY 2016	≥56.0%	CY 2017	TBD	CY 2018
	Care for Older Adults - Pain Assessment, 66 & Older	NCQA/HEDIS	Dual Benefits Members (Opt-In)	≥ 60.0%	CY 2015	≥ 62.0%	CY 2016	≥59.0%	CY 2017	TBD	CY 2018
Improving and Rebalancing Long-TermCare	Nursing Facility Diversion Measure* **	Ohio-Specific	Dual Benefits Members (Opt-In) and Medicaid-Only Members (Opt-Out)	≥5% decrease from CY 2013 (baseline year)	CY 2015	TBD	CY 2016	TBD	CY 2017	TBD	CY 2018
	Long Term Care Rebalancing Measure	Ohio-Specific	Dual Benefits Members (Opt-In) and Medicaid-Only Members (Opt-Out)	≥5% increase from CY 2013 (baseline year)	CY 2015	TBD	CY 2016	TBD	CY 2017	TBD	CY 2018
	Long Term Care Overall Balance Measure**	Ohio-Specific	Dual Benefits Members (Opt-In) and Medicaid-Only Members (Opt-Out)	≥5% decrease from CY 2013 (baseline year)	CY 2015	TBD)	CY 2016	TBD	CY 2017	TBD	CY 2018
	Percent of residents whose need for help with daily activities has increased	RTI International/MDS	Dual Benefits Members (Opt-In) and Medicaid-Only Members (Opt-Out)	≤ 15.2%	CY 2015	≤ 15.2%	CY 2016	TBD	CY 2017	TBD	CY 2018
	Percent of residents who were	RTI International/MDS	Dual Benefits Members (Opt-In)	≤ 2.1%	CY 2015	≤ 2.1%	CY 2016	TBD	CY 2017	TBD	CY 2018

physically restrained		and Medicaid-Only Members (Opt-Out)									
Percent of residents experiencing on or more falls with a major injury	RTI International/MDS	Dual Benefits Members (Opt-In) and Medicaid-Only Members (Opt-Out)	≤ 3.6%	CY 2015	≤ 3.6%	CY 2016	TBD	CY 2017	TBD	CY 2018	
Percent of residents with urinary tract infection	RTI International/MDS	Dual Benefits Members (Opt-In) and Medicaid-Only Members (Opt-Out)	≤ 5.8%	CY 2015	≤ 5.8%	CY 2016	TBD	CY 2017	TBD	CY 2018	
Percent of high-risk residents with pressure ulcers	RTI International/MDS	Dual Benefits Members (Opt-In) and Medicaid-Only Members (Opt-Out)	≤ 5.6%	CY 2015	≤ 5.6%	CY 2016	TBD	CY 2017	TBD	CY 2018	
Percent of residents who have/had a catheter inserted and left in their bladder	RTI International/MDS	Dual Benefits Members (Opt-In) and Medicaid-Only Members (Opt-Out)	≤ 3.0%	CY 2015	≤ 3.0%	CY 2016	TBD	CY 2017	TBD	CY 2018	

* Quality withhold measure for Demonstration Year 1 (CY 2014 and CY 2015).

** Quality withhold measure for Demonstration Years 2 (CY 2016) and 3 (CY 2017). Note: the Plan All Cause Readmissions rate included in the draft Medicare-Medicaid Quality Withhold Technical Notes (DY 2&3) is the Observed Readmissions rate.

2. Notes.

2.a. Measures and Measurement Periods.

ODM reserves the right to revise the measures and measurement periods referenced in this Appendix (and their corresponding compliance periods), as needed, due to unforeseen circumstances. Unless otherwise

noted, the most recent report or study finalized prior to the end of the contract period will be used in determining an MCOP's performance level for that contract period.

2.b. Performance Standards – Compliance Determination.

In the event that an MCOP's performance cannot be evaluated for a performance measure and/or a measurement period referenced in this appendix, ODM will deem the MCOP to have met or to have not met the standard(s) for that particular measure and measurement period depending on the circumstances involved (e.g., if a HEDIS measure was assigned an audit result of "Not Report" on the MCOP's Final Audit Report and the "Not Report" designation was determined to be the result of a material bias caused by the MCOP, ODM would deem the MCOP to have not met the standard(s) for that measure and measurement period).

2.c. Performance Standards – Retrospective Adjustment.

ODM will implement the use of a uniform methodology, as needed, for the retrospective adjustment of any Minimum Performance Standard referenced in this Appendix, except for the CAHPS measure standards. This methodology will be implemented at ODM's discretion when all three of the following criteria are met.

- The methodology for the standard's associated measure is revised. Note, for HEDIS measures, ODM will not adjust performance measure standards retrospectively due to procedural changes such as revisions to medical record hybrid review timelines.
- For the year in which the methodology is revised, the performance results for all Ohio MCOPs all increase or all decrease when compared to the standard-setting year. Note, this excludes MCOPs without results for both years.
- For the year in which the methodology is revised, the performance results for three or more MCOPs each change by at least three percentage points (e.g., increase from 56.0% to 59.0%) when compared to the standard-setting year.

For a comprehensive description of the standard adjustment methodology, see *ODM's MyCare Ohio Methods for the Retrospective Adjustment of Quality and Withhold Measure Standards*.

APPENDIX N

COMPLIANCE ASSESSMENT SYSTEM

I. General Provisions of the Compliance Assessment System.

- A. The Compliance Assessment System (CAS) sets forth sanctions that may be assessed by the Ohio Department of Medicaid (ODM) against the MyCare Ohio Plan (MCOP) if the MCOP is found to have violated the Three-Way Contract between ODM, CMS and the MCOP, this Provider Agreement, or applicable law. It does not in any way limit ODM from requiring Corrective Action Plans (CAPs) and program improvements, or from imposing any of the sanctions specified in OAC rule 5160-26-10 (applicable to MyCare Ohio pursuant to OAC rule 5160-58-01.1) or any other additional compliance actions, including the proposed termination, amendment, or nonrenewal of this Provider Agreement.
- B. As stipulated in OAC rule 5160-26-10, regardless of whether ODM imposes a sanction, the MCOP is required to initiate corrective action for any MCOP program violation or deficiency as soon as the violation or deficiency is identified by the MCOP or ODM. The MCOP is required to report to ODM when it becomes aware of any violation that could impair a member's ability to obtain correct information regarding services, impair member rights, affect the ability of the MCOP to deliver covered services, or affect the member's ability to access covered services.
- C. If ODM determines that an MCOP has violated any of the requirements of sections 1903(m) or 1932 of the Social Security Act that are not specifically identified within this Provider Agreement, ODM may (1) require the MCOP to permit any of its members to disenroll from the MCOP without cause, or (2) suspend any further new member enrollments to the MCOP, or both.
- D. Program violations that reflect non-compliance from the previous compliance term will be subject to remedial action under CAS at the time that ODM first becomes aware of this non-compliance.
- E. ODM retains the right to use its discretion to determine and apply the most appropriate compliance action based on the severity of the non-compliance, a pattern of repeated non-compliance, and number of beneficiaries affected. In instances where the MCOP is able to document, to the satisfaction of ODM, that the violation and precipitating circumstances were beyond its control and could not reasonably have been foreseen (e.g. a construction crew severs a phone line, a lightning strike disables a computer system, etc.), ODM may in its discretion utilize alternative methods (i.e. a remediating plan) in lieu of the imposition of sanctions/remedial actions as defined in section II of this appendix.

A Remediation Plan is a structured activity or process implemented by the MCP to improve identified deficiencies related to compliance with applicable rules, regulations or contractual requirements. All remediation plans must be submitted in the manner specified by ODM. Failure to comply with, or meet the requirements of a remediation plan may result in the imposition of progressive sanctions/remedial actions outlined in Section II.

- F. ODM will issue all notices of non-compliance in writing to the identified MCOP contact.
- G. Actions recommended or issued by the Contract Management Team (CMT) as defined in the Three-Way Contract in no way limit ODM's authority to impose sanctions and remedial actions under this Provider Agreement. ODM will take into consideration any sanctions or actions taken by the CMT when deciding whether and what type of sanctions/remedial actions to take for violations of this Provider Agreement.

II. Types of Sanctions/Remedial Actions. ODM may impose sanctions/remedial actions, including, but not limited to, the items listed below.

A. ODM Initiated Corrective Action Plans (CAPs)

A CAP is a structured activity, process or quality improvement initiative implemented by the MCOP to improve identified operational and clinical quality deficiencies. All CAPs must be submitted in the manner specified by ODM.

MCOPs may be required to develop CAPs for any instance of non-compliance with applicable rules, regulations or contractual requirements; CAPs are not limited to actions taken in this appendix. All CAPs requiring ongoing activity on the part of an MCOP to ensure its compliance with a program requirement will remain in effect until the plan has provided sufficient evidence that it has fulfilled the requirements of the CAP to the satisfaction of ODM. All CAPs requiring implementation of quality improvement initiatives will remain in effect for at least twelve months from the date of implementation.

Where ODM has determined the specific action which must be implemented by the MCOP or if the MCOP has failed to submit a CAP, ODM may require the MCOP to comply with an ODM- developed or "directed" CAP.

Where a sanction is assessed for a violation in which an MCOP has previously been assessed a CAP (or any sanction or any other related written correspondence), the MCOP may be assessed escalating sanctions.

B. Financial Sanctions

B.1. Financial Sanctions Assessed Due to Accumulated Points

On the effective date of the Three-Way between CMS, ODM and the MCOP, the MCOP shall begin with 0 points. Points will accumulate over a rolling 12-month schedule. Points more than 12

months old will expire.

No points will be assigned for a violation if an MCOP is able to document that the precipitating circumstances were completely beyond its control and could not reasonably have been foreseen (e.g., a construction crew severs a phone line, a lightning strike disables a computer system, etc.). In cases where an MCOP-contracted healthcare provider is found to have violated a program requirement (e.g., failing to provide adequate contract termination notice, marketing to potential members, inappropriate member billing), ODM may assess points unless to the satisfaction of ODM: (1) the MCOP can document that it provided sufficient notification or education to providers of applicable program requirements and prohibited activities; and (2) the MCOP took immediate and appropriate action to correct the problem and to ensure that it will not reoccur. ODM will review repeated incidents and determine whether the MCOP has a systemic problem. If ODM determines that a systemic problem exists, further sanctions or remedial actions may be assessed against the MCOP.

B.1.2.1. _____ 5 Points

ODM may at its discretion assess five points for any instance of non-compliance with applicable rules, regulations or contractual requirements. Instances of non-compliance can include, but are not limited to those that (1) impair a member's or potential enrollee's ability to obtain accurate information regarding MCOP services, (2) violate a care management process, (3) impair a member's or potential enrollee's ability to obtain correct information regarding services or (4) infringe on the rights of a member or potential enrollee. Examples of five point violations include, but are not limited to the following:

- Failure to provide accurate provider panel information.
- Failure to provide member materials to new members in a timely manner.
- Failure to comply with appeal, grievance, or state hearing requirements, including the failure to notify a member of his or her right to a state hearing when the MCOP proposes to deny, reduce, suspend or terminate a Medicaid-covered service.
- Failure to staff a 24-hour call-in system with appropriate trained medical personnel.
- Failure to meet the monthly call-center requirements for either the member services or the 24-hour call-in system lines.
- Provision of false, inaccurate or materially misleading information to ODM, health care providers, the MCOP's members, or any eligible individuals.
- Use of unapproved marketing or member materials.
- Failure to appropriately notify ODM, or members, of provider panel terminations.
- Failure to update website provider directories as required.
- Failure to comply with an open remediation plan or CAP or a CAP closed in the last 12 months.
- Failure to meet provider network performance standards.
- A violation of a care management process specified in Section 2.5.3 of the Three- Way, or Appendix K of the Provider Agreement that does not meet the standards for a 10 point violation. Examples include but are not limited to the failure to:
 - Ensure that staff performing care management functions are operating within their professional scope of practice, are appropriately responding to a

- member's care management needs, or are complying with the state's licensure/credentialing requirements;
- Adequately assess an individual's needs including the evaluation of mandatory assessment domains;
- Update an assessment upon a change in health status, needs or significant health care event;
- Develop or update a care plan that appropriately addresses assessed needs of a member;
- Monitor the care plan;
- Complete a care gap analysis that identifies gaps between recommended care and care that is received by a member;
- Update the care plan in a timely manner when gaps in care or change in need are identified;
- Coordinate care for a member across providers, specialists, and team members, as appropriate;
- Adhere to a documented communication plan, including the contact schedule for in-person visits and telephone calls;
- Make reasonable attempts to obtain a discharge/transition plan from an inpatient facility; conduct timely follow up with the member and provider, as appropriate; or arrange for services specified in the discharge/transition plan; or
- Adhere to home and community-based services (HCBS) waiver service coordination and operational requirements in the Three-Way, Section 2.5.3.3.5.4, and the Ohio approved HCBS 1915(c) waiver for MyCare Ohio.

B.1.2.2. 10 Points

ODM may assess ten points when an MCOP fails to meet a program requirement that could, as determined by ODM: (1) affect the ability of the MCOP to deliver, or a member to access, covered services; (2) place a member at risk for a negative health outcome; or (3) jeopardize the safety and welfare of a member. Examples include, but are not limited to, the following:

- Discrimination among members on the basis of their health status or need for health care services (this includes any practice that would reasonably be expected to encourage termination or discourage selection by individuals whose medical condition indicates probable need for substantial future medical services).
- Failure to assist a member in accessing needed services in a timely manner after receiving a request from the member.
- Failure to provide medically-necessary Medicare or Medicaid covered services to members.
- Failure to process prior authorization requests within the prescribed time frames.
- Repeated failure to comply with an open remediation plan or CAP or a CAP closed in the last twelve months.
- The imposition of premiums or charges on members that are in excess of the premiums or charges permitted under the MyCare Ohio demonstration project.
- Misrepresentation or falsification of information that the MCOP furnishes to ODM.

- Misrepresentation or falsification of information that the MCOP furnishes to a member, potential member, or health care provider.
- Failure to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR 422.208 and 422.210.
- Violation of a care management process, including HCBS 1915(c) waiver operations, as specified in the Three-Way, Section 2.5.3 or the Provider Agreement Appendix K.

B.1.2.3. Progressive Sanctions Based on Accumulated Points

Progressive sanctions will be based on the number of points accumulated at the time of the most recent incident. A CAP or other sanction may be imposed in addition to the fines listed below. The designated fine amount will be assessed when the number of accumulated points falls within the ranges specified below:

0 -15 Points	CAP + No fine
16-25 Points	CAP + \$5,000 fine
26-50 Points	CAP + \$10,000 fine
51-70 Points	CAP + \$20,000 fine
71-100 Points	CAP + \$30,000 fine
100+ Points	Proposed Provider Agreement Termination

B.2 Specific Pre-Determined Sanctions

B.2.1. Adequate network-minimum provider panel requirements

Any deficiencies in an MCOP's provider network specified the Provider Agreement or the Three-Way may result in the assessment of a \$1,000 nonrefundable fine for each category (dental, vision, waiver providers etc.) and for each county/zip code. Compliance will be assessed at least quarterly.

ODM may assess additional sanctions (e.g. CAPs, points, fines) if (1) an MCOP violates any other provider panel requirements contained within either the Three-Way or Medicaid provider agreement or (2) an MCOP's member has experienced problems in accessing necessary services because of non-compliance by a provider within the MCOP's panel.

B.2.2. Late Submissions

B.2.2.1 Submission of data and documentation to ODM

All submissions, data and documentation submitted by an MCOP must be received by ODM within the specified deadline and must represent the MCOP in an honest and forthright manner. If the MCOP fails to provide ODM with any required submission, data or documentation, (with the exception of incident management documentation referenced in B.2.2.2) ODM may assess a nonrefundable fine of \$100 per day, unless the MCOP requests and is granted an extension by ODM. Assessments for late submissions will be done monthly.

B.2.2.2. Submission of incident management documentation to ODM or PCG

If an MCOP fails to provide the requested information to ODM or PCG, in accordance with the defined ODM "MyCare Ohio Incident Escalation Procedure," ODM may assess a nonrefundable fine of \$1,000 per incident record, per day until the requested information is provided.

B.2.2.3 Extension requests

With the exception of incident management documentation, if an MCOP is unable to meet a program deadline or data/documentation submission deadline, the MCOP must submit a written request to its Contract Administrator for an extension of the deadline, as soon as possible, but no later than 3 PM, EST, on the date of the deadline in question. Requests for extensions should only be submitted where unforeseeable circumstances have made it impossible for the MCOP to meet a deadline stipulated by ODM and will not be approved for incident management documentation. All such requests will be evaluated upon this standard. ODM may assess a compliance action against an entity, unless written approval for an extension of the deadline has been granted.

B.2.3. Non-compliance with Claims Adjudication Requirements

If ODM finds that an MCOP is unable to (1) electronically accept and adjudicate claims to final status, or (2) notify providers of the status of their submitted claims, ODM may assess the MCOP with a monetary sanction of \$20,000 per day for the period of non-compliance. Additionally, the MCOP may be assessed 5 points per incident of non-compliance.

B.2.4 Non-compliance with Financial Performance Measures and/or the Submission of Financial Statements

If the MCOP fails to meet any financial performance measure set forth in Sections 2.13 or 4.2.6 of the Three-Way or fails to submit to the Ohio Department of Insurance (ODI) financial statements by the due date set by ODI, then ODM may impose upon the MCOP a CAP, or a freeze on the enrollment of new members, or both. The MCOP shall submit financial statements to ODM by ODI's originally specified due date unless ODM grants an extension to the MCOP in writing.

B.2.5 Non-compliance with Reinsurance Requirements

If ODM determines that (1) an MCOP has failed to maintain reinsurance coverage as set forth in 2.13.4. of the Three-Way, (2) an MCOP's deductible exceeds \$100,000 without approval from ODM, or (3) an MCOP's reinsurance for non-transplant services covers less than 80% of inpatient costs in excess of the deductible incurred by one member for one year without approval from ODM, then ODM may require the MCOP to pay a monetary sanction to ODM. The amount of the sanction will be the lesser of (1) 10% of the difference between the estimated amount of what the MCOP

would have paid in premiums for the reinsurance policy if it had been in compliance and what the MCOP actually paid while it was out of compliance or (2) \$50,000.

If ODM determines that an MCOP's reinsurance for transplant services covers less than 50% of inpatient costs incurred by one member for one year, ODM may subject the MCOP to a CAP.

B.2.6 Non-compliance with Prompt Payment

ODM may impose progressive sanctions on an MCOP that does not comply with the prompt pay requirements as specified in 42 CFR 447.46 and Section 5.1.9 of the Three-Way.

- The first instance of non-compliance during a rolling 12-month period: ODM may assess a refundable fine equal to the greater of, one quarter of one percent of the amount calculated in accordance with section B.3.2. of this appendix, or 25% of the total dollar amount of clean claims not paid within the timeframes outlined in 42 CFR 447.46 and Section 5.1.9 of the Three-Way. The refundable fine amount will be returned to the MCOP if ODM determines the MCOP is in full compliance with the prompt pay standards within the five consecutive reporting periods following the report period for which the refundable fine was issued.
- The second instance of non-compliance during a rolling 12-month period: ODM may assess a nonrefundable fine equal to the greater of, one half of one percent of the amount calculated in accordance with section B.3.2. of this appendix, or 50% of the total dollar amount of clean claims not paid within the timeframes outlined in 42 CFR 447.46 and Section 5.1.9 of the Three-Way.
- Subsequent violations during a rolling 12-month period may result in an enrollment freeze of not less than three months duration or until the MCP has come back into compliance.

B.2.7. Non-compliance with Clinical Laboratory Improvement Amendments (CLIA)

If an MCOP fails to comply with CLIA requirements as specified by ODM, then ODM may impose a nonrefundable fine in the amount of a \$1,000 for each documented violation.

B.2.8. Non-compliance with Abortion and Sterilization Hysterectomy Requirements

If an MCOP fails to comply with abortion and sterilization requirements as specified by ODM, then ODM may impose a nonrefundable fine in the amount of \$2,000 for each documented violation. Additionally, MCOPs must take all appropriate action to correct each violation documented by ODM.

B.2.9. Refusal to Comply with Program Requirements

If ODM has instructed an MCOP that it must comply with a specific program requirement and the MCOP refuses, such refusal constitutes documentation that the MCOP is no longer operating in the best interests of the MCOP's members or the state of Ohio, and ODM may move to terminate or non-renew the MCOP's provider agreement.

B.2.10. Data Reporting Requirements and Data Quality Measures

ODM reserves the right to withhold an assessment of non-compliance under section B.2.10. due to unforeseeable circumstances.

B.2.10.1 Data Reporting Requirements

B.2.10.1.1. Annual Submission of MCOP Self-Reported, Audited HEDIS Data Performance is monitored annually. If an MCOP fails to submit its self-reported, audited HEDIS data as specified by ODM, the MCOP will be considered non-compliant with the standards for all of the self-reported, audited HEDIS performance measures in *MyCare Ohio Quality Performance Measures, Standards and Measurement Periods* referenced in Appendix M of the Provider Agreement for the corresponding contract period. In addition, the MCOP will be disqualified from receiving all or a portion of the quality withholds as specified in the Three-Way and in Appendix O of the Provider Agreement for the corresponding contract period.

B.2.10.1.2 Annual Submission of Final HEDIS Audit Report (FAR)

Performance is monitored annually. If an MCOP fails to submit its FAR as specified by ODM, the MCOP will be considered non-compliant with the standards for all of the self-reported, audited HEDIS performance measures in *MyCare Ohio Quality Performance Measures, Standards and Measurement Periods* referenced in Appendix M of the Provider Agreement for the corresponding contract period. In addition, the MCOP will be disqualified from receiving all or a portion of the quality withholds as specified in the Three-Way and in Appendix O of the Provider Agreement for the corresponding contract period.

ODM will review each MCOP's FAR in order to determine if any data collection or reporting issues were identified. In addition, ODM will evaluate any issues that resulted in the assignment of an audit result of "Not Report" (i.e., NR) for any measure. An MCOP may be required to submit to ODM requested documentation to account for an NR audit designation. Based on its review of an MCOP's FAR and any NR audit designations assigned, ODM may impose corrective action (such as requiring the MCOP to implement a corrective action plan to resolve data collection and/or reporting issues).

B.2.10.1.3. Data Certification Requirements for HEDIS IDSS Data and HEDIS Audit Report

Performance is monitored annually. If an MCOP fails to submit a required data certification letter to ODM within the required time frame, CMS or ODM may impose a nonrefundable fine of \$100 per day, unless the MCOP requests and is granted an extension by ODM.

B.2.10.1.4. Annual Submission of MCOP Health Outcomes Survey (HOS) Results Performance is monitored annually beginning with the 2016 HOS survey. If an MCOP fails to submit its HOS data as specified by ODM, the MCOP will be considered non-compliant with the standards for all of the HOS performance measures in *MyCare Ohio Quality Performance Measures, Standards and Measurement Periods* referenced in Appendix M of the Provider Agreement for the corresponding contract period. In addition, the MCOP will be disqualified from receiving all or a portion of the quality withholds as specified in the Three-Way and in Appendix O of the Provider Agreement for the corresponding contract period.

B.2.10.1.5. Complete and Accurate Submission of Nursing Facility 100-Day Threshold and Discharge Data

The nursing facility admission and discharge data set may be subject to an audit or review for completeness and accuracy by ODM, or a vendor contracted by ODM. Any overpayments made by ODM to the MCOP as a result of inaccurate or incomplete nursing facility 100-day threshold or discharge data submitted by the MCOP will result in ODM recouping the

overpayment(s).

B.2.10.2. Data Quality Measures

The MCOP must submit to ODM, by the specified deadline and according to specifications set by ODM, all required data files and requested documentation needed to calculate each measure listed below. If an MCOP fails to comply with this requirement for any measure listed below, the MCOP will be considered noncompliant with the standard(s) for that measure. Data quality report periods, measures, standards and requirements are specified in Appendix L of the Provider Agreement and *ODM Measures for the MyCare Ohio Encounter Data Quality Measures*.

Sanctions for non-compliance are assessed for each MCOP as described for each measure.

B.2.10.2.1 Encounter Data Volume

Performance is monitored once every quarter for the entire measurement period for each of the following populations and service combinations: 1) Medicaid and Medicare services for dual benefit members; and 2) Medicaid services for Medicaid-only members. Sanctions for non-compliance will be assessed separately, by population and service combination. For each population (i.e., dual benefit members vs. Medicaid-only members) and service combination (i.e., Medicaid vs. Medicare), if the standard is not met for every service category in all quarters of the measurement period, the MCOP will be determined to be noncompliant for the measurement period.

ODM may issue a CAP for all instances of non-compliance with this measure that are NOT consecutive. ODM may issue a series of progressive sanctions for consecutive instances of non-compliance. The first time an MCOP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If an MCOP is determined to be noncompliant with the standard in a second, consecutive quarter, ODM may impose a monetary sanction of two percent of the amount calculated in accordance with section B.3.2. of this appendix. If an MCOP is determined to be noncompliant with the standard in a third, consecutive quarter, ODM may impose a new member enrollment freeze.

A monetary sanction issued under this section will be returned to the MCOP if ODM determines the MCOP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the monetary sanction was issued. A new member enrollment freeze issued under this section will be lifted after ODM determines the MCOP is in full compliance with this program requirement.

B.2.10.2.2. Rejected Encounters

Performance is monitored once every quarter for Measure 1 and once every month for Measure 2 in Appendix L of the Provider Agreement. Compliance determination with the standard applies only to the measurement period under consideration and does not include performance in previous measurement periods. Files in the ODM-specified medium per format that are totally rejected will not be considered in the determination of non-compliance. If the standard is not met for every file type, the MCOP will be determined to be noncompliant for the measurement

period.

ODM may issue a CAP for all instances of non-compliance with this measure that are NOT consecutive. ODM may issue a series of progressive sanctions for consecutive instances of non-compliance. The first time an MCOP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If an MCOP is determined to be noncompliant with the standard in a second, consecutive measurement period, ODM may impose a monetary sanction of two percent of the amount calculated in accordance with section B.3.2. of this appendix. If an MCOP is determined to be noncompliant with the standard in a third, consecutive measurement period, ODM may impose a new member enrollment freeze. Special consideration may be made for MCOPs with less than 1,000 members.

A monetary sanction issued under this section will be returned to the MCOP if ODM determines the MCOP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the monetary sanction was issued. A new member enrollment freeze issued under this section will be lifted after ODM determines the MCOP is in full compliance with this program requirement.

B.2.10.2.3. Acceptance Rate

Performance is monitored once every month. Compliance determination with the standard applies only to the month under consideration and does not include performance in previous months. If the standard is not met for every file type, the MCOP will be determined to be noncompliant for the measurement period.

ODM may issue a CAP for all instances of non-compliance with this measure that are NOT consecutive. ODM may issue a series of progressive sanctions for consecutive instances of non-compliance. The first time an MCOP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If an MCOP is determined to be noncompliant with the standard in a second, consecutive measurement period, ODM may impose a monetary sanction of two percent of the amount calculated in accordance with section B.3.2. of this appendix. If an MCOP is determined to be noncompliant with the standard in a third, consecutive measurement period, ODM may impose a new member enrollment freeze. Special consideration may be made for MCOPs with less than 1,000 members.

A monetary sanction issued under this section will be returned to the MCOP if ODM determines the MCOP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the monetary sanction was issued. A new member enrollment freeze issued under this section will be lifted after ODM determines the MCOP is in full compliance with this program requirement.

B.2.10.2.4. Encounter Data Accuracy Measure

The first time an MCOP is determined to be noncompliant with the standard for either level 1 or level 2 for this measure, the MCOP must implement a CAP which identifies interventions and a timeline for resolving data quality issues related to payments. Additional reports to ODM addressing targeted areas of deficiencies and progress implementing data quality improvement activities may be required. Upon all subsequent measurements of performance, if an MCOP is

again determined to be noncompliant with the standard for either level 1 or level 2 for this measure, ODM may impose a monetary sanction of one percent of the amount calculated in accordance with section B.3.2. of this appendix.

A monetary sanction issued under this section will be returned to the MCOP if ODM determines the MCOP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the monetary sanction was issued.

B.2.10.2.5. Incomplete Rendering Provider Data

Performance is monitored once every quarter for all measurement periods. If the standard is not met in all quarters of the measurement period, the MCOP may be determined to be noncompliant for the measurement period.

ODM may issue a CAP for all instances of non-compliance with this measure that are NOT consecutive. ODM may issue a series of progressive sanctions for consecutive instances of non-compliance. The first time an MCOP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If an MCOP is determined to be noncompliant with the standard in a second, consecutive quarter, ODM may impose a monetary sanction of two percent of the amount calculated in accordance with section B.3.2. of this appendix. If an MCOP is determined to be noncompliant with the standard in a third, consecutive quarter, ODM may impose a new member enrollment freeze.

A monetary sanction issued under this section will be returned to the MCOP if ODM determines the MCOP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the monetary sanction was issued. A new member enrollment freeze issued under this section will be lifted after ODM determines the MCOP is in full compliance with this program requirement.

B.2.10.2.6. NPI Provider Number Usage without Medicaid/Reporting Provider Numbers

Performance is monitored once every quarter for all measurement periods. If the standard is not met in all quarters of the measurement period, the MCOP may be determined to be noncompliant for the measurement period.

ODM may issue a CAP for all instances of non-compliance with this measure that are NOT consecutive. ODM may issue a series of progressive sanctions for consecutive instances of non-compliance. The first time an MCOP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If an MCOP is determined to be noncompliant with the standard in a second, consecutive quarter, ODM may impose a monetary sanction of two percent of the amount calculated in accordance with section B.3.2. of this appendix. If an MCOP is determined to be noncompliant with the standard in a third, consecutive quarter, ODM may impose a new member enrollment freeze.

A monetary sanction issued under this section will be returned to the MCOP if ODM determines the MCOP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the monetary sanction was issued. A new member enrollment freeze issued under this section will be lifted after ODM determines the MCOP is in full compliance with this program requirement.

B.2.10.2.7 Encounter Submissions per ODM MyCare Encounter Data Submission Guidelines and Quality Measure Methodology document. is monitored once every month. If the standard is not met for the measurement period, the MCOP will be noncompliant for the measurement period.

ODM will issue a series of progressive sanctions for all instances of non-compliance. The first time an MCOP is determined to be noncompliant with the standard for this measure, ODM may impose a monetary sanction of one percent of the amount calculated in accordance with section B.3.2. of this appendix. If an MCOP is determined to be noncompliant with the standard in any subsequent month, consecutive or non-consecutive, ODM will impose a monetary sanction of two percent of the amount calculated in accordance with section B.3.2. of this appendix.

A monetary sanction issued under this section will be returned to the MCOP if ODM determines the MCOP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the monetary sanction was issued.

B.2.10.2.8. Timeliness of Encounter Data Submission

Performance is monitored once every month. If the standard is not met for the measurement period, the MCOP will be noncompliant for the measurement period.

Effective SFY 2016 (July 2015), ODM will issue a series of progressive sanctions for all instances of non-compliance. The first time an MCOP is determined to be noncompliant with the standard for this measure, ODM may impose a monetary sanction of one percent of the amount calculated in accordance with section B.3.2. of this appendix. If an MCOP is determined to be noncompliant with the standard in any subsequent month, consecutive or non-consecutive, ODM will impose a monetary sanction of two percent of the amount calculated in accordance with section B.3.2. of this appendix.

A monetary sanction issued under this section will be returned to the MCOP if ODM determines the MCOP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the monetary sanction was issued.

B.2.11. Quality Measures

The MCOP must submit to ODM, by the specified deadline and according to ODM specifications, all required data files and requested documentation needed to assess the quality measures specified any quality measure listed in Appendix M of the Provider Agreement, the MCOP will be considered noncompliant with the standard(s) for that measure.

ODM reserves the right to withhold an assessment of non-compliance under this section due to unforeseeable circumstances.

For each measure and population (i.e., dual benefit members and Medicaid-only members) as specified in *MyCare Ohio Quality Performance Measures, Standards and Measurement Periods* as referenced in Appendix M of the Provider Agreement, one rate is calculated. Each rate

per specified population has an associated Minimum Performance Standard. When an MCOP fails to meet a Minimum Performance Standard listed in *MyCare Ohio Quality Performance Measures, Standards and Measurement Periods* as referenced in Appendix M of the Provider Agreement, for a measure and specified population for which non-compliance sanctions are applicable, the MCOP will be assessed a sanction for non-compliance with the standard. ODM has established uniform non-compliance sanctions for these standards.

A series of progressive sanctions may be issued for consecutive instances of non-compliance with the standard established for a given rate and population. For example, two rates, corresponding to the dual benefit member population and Medicaid-only member population, are calculated for the *Long-Term Care Overall Balance* measure. An MCOP failing to meet the standard established for the dual benefit member population rate in three consecutive measurement periods would be subject to progressive sanctions. However, an MCOP failing to meet the standard established for the dual benefit member population rate in one measurement period and the Medicaid-only member population in the next would not be subject to progressive sanctions, as these only apply to the standard established for the same rate and population.

For the standard established for each rate and specified population listed in *MyCare Ohio Quality Performance Measures, Standards and Measurement Periods* as referenced in Appendix M of the Provider Agreement, for measures for which non-compliance sanctions are applicable, an MCOP may be assessed sanctions for instances of non-compliance as follows:

- The first instance, or subsequent but nonconsecutive instance, of non-compliance: ODM may impose a monetary sanction in the amount of one quarter of one percent of the MCOP's average monthly net premium for the twelve months prior to the month in which the compliance action is issued to the MCOP. If the MCOP is determined to be in full compliance with this program requirement within the following five consecutive report periods, the monetary sanction will be returned.
- The second consecutive instance of non-compliance: ODM may impose a monetary sanction in the amount of one quarter of one percent of the MCOP's average monthly net premium for the twelve months prior to the month in which the compliance action is issued to the MCOP. This monetary sanction non-refundable.
- The third consecutive, and any additional consecutive, instance of non-compliance: ODM may impose a monetary sanction in the amount of one half of one percent of the MCOP's average monthly net premium for the twelve months prior to the month in which the compliance action is issued to the MCOP. The monetary sanction is nonrefundable.
- In addition, if ODM determines that an MCOP is noncompliant with greater than 50% of the applicable quality standards listed in *MyCare Ohio Quality Performance Measures, Standards and Measurement Periods* referenced in Appendix M of the Provider Agreement, for which non-compliance sanctions are applicable, for two consecutive contract years, ODM may terminate the MCOP's Provider Agreement.

B.2.12. Quality Care

ODM reserves the right to withhold an assessment of non-compliance under this section due to unforeseeable circumstances.

B.2.12.1. Administrative Compliance Assessment

Compliance with administrative standards is performed by the external quality review organization, as specified by ODM. For each documented instance of non-compliance with an administrative standard, the MCOP may be required to submit a CAP as specified by ODM to remedy the identified deficiency.

B.2.12.2. Care Management Data Submission

The MCOP must submit to ODM all required care management data as specified in ODM's *MyCare Ohio Care Management Data Submission Specifications*. If an MCOP fails to comply with the timely submission requirement, then ODM may impose a nonrefundable fine of \$100 per day, unless the MCOP requests and is granted an extension by ODM.

B.2.12.3. Care Management Data Certification Requirements

If an MCOP fails to submit a required Care Management data certification letter to ODM within the required time frame, ODM may impose a nonrefundable fine of \$100 per day, unless the MCOP requests and is granted an extension by ODM.

B.2.12.4. HCBS Waiver Operational Reporting Requirements

The MCOP must submit to ODM all required HCBS waiver operational reporting requirements as specified by ODM or CMS or both. If an MCOP fails to submit a required reporting to ODM within the required time frame, CMS or ODM may impose a nonrefundable fine of \$100 per day, unless the MCOP requests and is granted an extension by ODM.

B.2.12.5. Care Management Staffing Ratio

ODM may assess sanctions on the MCOP for instances of non-compliance with the care management staffing ratio standards specified in Appendix K.1.g.ii. of the Provider Agreement as follows:

- First instance, or subsequent but nonconsecutive instance, of non-compliance: ODM may impose a monetary sanction in the amount of one quarter of one percent of the MCOP's average monthly net premium for the twelve months prior to the month in which the compliance action is issued to the MCOP. If the MCOP is determined to be in full compliance with this program requirement within the following five consecutive report periods, the monetary sanction will be returned.
- Second consecutive instance of non-compliance: ODM may impose a monetary sanction in the amount of one quarter of one percent of the MCOP's average monthly net premium for the twelve months prior to the month in which the compliance action is issued to the MCOP. This amount is nonrefundable.
- Third consecutive, and any additional consecutive, instance of non-compliance: ODM may impose a monetary sanction in the amount of one half of one percent of the MCOP's average monthly net premium for the twelve months prior to the month in which the compliance action is issued to the MCOP. This amount is nonrefundable.
- In addition, upon a fourth consecutive instance of non-compliance: ODM may terminate the MCOP's Provider Agreement.

B.2.12.6. Comprehensive Assessment Measures

For the standard established for each measure listed in Appendix K, an MCOP may be assessed

sanctions for instances of non-compliance as follows:

- First instance, or subsequent but non-consecutive instance, of non-compliance: ODM may impose a monetary sanction in the amount of one quarter of one percent of the MCOP's average monthly net premium for the twelve months prior to the month in which the compliance action is issued to the MCOP. This amount is nonrefundable.
- Second consecutive instance of non-compliance: ODM may impose a monetary sanction in the amount of one half of one percent of the MCOP's average monthly net premium for the twelve months prior to the month in which the compliance action is issued to the MCOP. This amount is nonrefundable.
- Third consecutive, and any additional consecutive, instance of non-compliance: ODM may impose a monetary sanction in the amount of three-quarters of one percent of the MCOP's average monthly net premium for the twelve months prior to the month in which the compliance action is issued to the MCOP. This amount is nonrefundable.
- Fourth consecutive instance of non-compliance: ODM may terminate the MCOP's provider agreement.

B.2.12.7.Maintenance of National Committee for Quality Assurance Health Plan Accreditation

For the standard established in Section 2.2.4 of the Three-Way, ODM may assess the following sanctions for non-compliance:

If the MCOP receives a Provisional accreditation status, the MCOP will be required to complete a resurvey within 12 months of the accreditation decision. If the resurvey results in a Provisional or Denied status, ODM will consider this a material breach of the provider agreement and may terminate the provider agreement with the MCOP.

If the MCOP receives a Denied accreditation status, then ODM will consider this a material breach of the provider agreement and may terminate the provider agreement with the MCOP.

B.2.13. Non-compliance with Provision of Transportation Services

If the MCOP fails to comply with the transportation requirements specified in Appendix C of this Agreement, or if an MCOP fails to transport a member to a pre-scheduled appointment on time, which results in a missed appointment, when providing Medicaid-covered transportation services and when members must travel more than 30 miles to receive services, ODM may impose a nonrefundable fine in the amount of \$1,000 for each violation. ODM may assess additional sanctions (e.g., CAPs, points, fines) as provided for in section II of this appendix for any violation of the Medicaid-covered transportation services and applicable requirements.

B.3. Fines

Refundable or nonrefundable fines may be assessed separately or in combination with other sanctions/remedial actions. The total fines assessed in any one month will not exceed 15% of one month's payments from ODM to the MCOP. Unless otherwise stated, all fines are nonrefundable.

B.3.1. Refundable and nonrefundable monetary sanctions/assurances must be paid by the MCOP to ODM within thirty calendar days of receipt of the invoice by the MCOP, or as otherwise

directed by ODM in writing. In addition, per ORC Section 131.02, payments owed to the State not received within forty-five calendar days will be certified to the Attorney General's (AG's) office. The AG's Office will assess the appropriate collection fee for MCOP payments certified to the AG's Office.

B.3.2. For monetary sanctions calculated in accordance with this section, ODM will use the MCOP's average monthly net premium for the twelve months prior to the month in which the compliance action is issued to the MCOP.

B.3.3. Unless otherwise specified, any monies collected through the imposition of a refundable fine will be returned to the MCOP (minus any applicable collection fees owed to the AG's Office if the MCOP has been delinquent in submitting payment) after it has demonstrated full compliance with the particular program requirement, as determined by ODM.

B.3.4. An MCOP is required to submit a written request for refund to ODM at the time it believes is appropriate before a refund of monies will be considered.

B.3.5. Refundable monetary sanctions issued under sections B.2.10., B.2.11., and B.2.12. of this appendix will be returned to the MCOP in the event ODM replaces or eliminates the sanction's applicable measure(s) from the Provider Agreement for the measurement period immediately following the measurement period for which the sanction was assessed.

B.4. New Enrollment Freezes

Notwithstanding any other sanction or point assessment that ODM may impose on the MCOP under this Provider Agreement, ODM may prohibit an MCOP from receiving new enrollment through consumer initiated selection or the assignment process if any of the following occur: (1) the MCOP has accumulated a total of 51 or more points during a rolling 12-month period; (2) the MCOP has failed to fully implement a plan of correction within the designated time frame; (3) circumstances exist that potentially jeopardize the MCOP's members' access to care, as solely determined by ODM; or (4) the MCOP is found to have a pattern of repeated or ongoing non-compliance, as solely determined by ODM. Examples of circumstances that ODM may consider as jeopardizing member access to care include, but are not limited to, the following:

- The MCOP has been found by ODM to be noncompliant with the prompt payment or the non-contracting provider payment requirements;
- The MCOP has been found by ODM to be noncompliant with the provider panel requirements specified in Appendix H of the Provider Agreement;
- The MCOP has refused to comply with a program requirement after ODM has directed the MCOP to comply with the specific program requirement;
- The MCOP has received notice of proposed or implemented adverse action by the ODI; or
- The MCOP has failed to provide adequate provider or administrative capacity.

Payments provided for under the Provider Agreement will be denied for new enrollees, when and for so long as, payments for those enrollees are denied by CMS in accordance with the requirements in 42 CFR 438.730.

B.4.1. New Member Enrollment freezes issued under section B.2.10 of this appendix may be lifted in the event ODM replaces or eliminates the sanction's applicable measure(s) from the Provider Agreement for the measurement period immediately following the measurement period for which the sanction was assessed.

B.4.2. Unless otherwise specified, new enrollment freezes issued under this appendix may be lifted after the MCOP is determined to be in full compliance with the applicable program requirement, and the violations or deficiencies are resolved to the satisfaction of ODM.

B.5. Reduction of Assignments

ODM has discretion over how member auto-assignments are made. ODM may reduce the number of assignments an MCOP receives to assure program stability within a region, or upon a determination that the MCOP lacks sufficient capacity to meet the needs of the increased enrollment volume. ODM may determine that an MCOP has demonstrated a lack of sufficient capacity under circumstances that include, but are not limited to the following:

- The MCOP has failed to maintain an adequate provider network;
- The MCOP has failed to provide new member materials by the member's effective date;
- The MCOP has failed to meet the minimum call center requirements;
- The MCOP has failed to meet the minimum performance standards for members with special health care needs; or
- The MCOP has failed to provide complete and accurate data files regarding appeals or grievances, or its care management program.

B.6. Death or Injury to Member

ODM may immediately terminate or suspend this Agreement if an MCOP's failure to perform, or properly perform, any of the requirements in this Agreement results in the death of or serious injury to, an MCOP's member, as determined by ODM.

III. Request for Reconsiderations.

Unless otherwise specified below, an MCOP may seek reconsideration of any sanction or remedial action imposed by ODM including CAPs (when a CAP is required for the first violation in a series of progressive compliance actions), points, fines, and member enrollment freezes.

MCOPs may not seek reconsideration of:

- An action by ODM that results in changes to the auto-assignment of members.
- The imposition of directed CAPs as defined in II of this appendix.

The MCOP must submit a request for reconsideration on the form required by ODM, in accordance with the following procedure:

A. An MCOP must submit a request for reconsideration either by email to the designated Contract

Administrator (CA), or by overnight mail to ODM's Bureau of Managed Care (BMC). The request for reconsideration must be received by ODM no later than the tenth business day after the date that the MCOP receives notice of the imposition of the remedial action by ODM. If ODM imposes an enrollment freeze based on access to care concerns, the enrollment freeze will be imposed concurrent with initiating notification to the MCOP.

B. A request for reconsideration must explain in detail why the specified sanction should not be imposed. At a minimum, the reconsideration must include: the proposed action being contested; the basis for requesting reconsideration; and any supporting documentation. In considering an MCOP's request for reconsideration, ODM will review only the written material submitted by the MCOP.

C. ODM will take reasonable steps to make a final decision, or request additional information, within ten business days after receiving the request for reconsideration. If ODM requires additional time, the MCOP will be notified in writing.

D. If ODM approves a reconsideration request, in whole, the associated sanctions or remedial actions will be rescinded. The MCOP will not be required to submit a CAP.

E. If ODM approves, in part, the MCOP's reconsideration request, the sanction, remedial action and/or the points associated with the incident may be rescinded or reduced, at the discretion of ODM. The MCOP may still be required to submit a CAP if ODM, in its discretion, believes that a CAP is still warranted under the circumstances.

F. If ODM denies the MCOP's reconsideration request, any CAP, sanction, remedial action, and/or points outlined in the original notice of non-compliance will be assessed.

APPENDIX O QUALITY

WITHHOLDS

Dual Benefit Members Quality Withhold Policies and Measures

Section 4 of the Three-Way Contract between MCOP, CMS and ODM (the Three-Way) specifies the Quality Withhold policies and measures for the dual benefit members (opt-in population). For the dual benefit members (opt-in population), the quality withhold methodology is specified in *CMS' Medicare-Medicaid Capitated Financial Alignment Model Quality Withhold Technical Notes (DY 1)* for Demonstration Year 1.

Medicaid-Only Quality Withhold Policies and Measures

ODM will withhold a percentage of the MCOP's Medicaid-only (opt-out population) capitation rate. The withheld amounts will be repaid subject to the MCOP's performance consistent with established quality thresholds. ODM will evaluate the MCOP's performance according to the specified metrics required in order to determine whether the MCOP will earn back the quality withhold for a given year. Table 1, below identifies the withhold measure and standards for the Medicaid-only members (opt-out population) for Demonstration Year 1. This measure will be for a one percent (1%) withhold. Because Demonstration Year 1 crosses calendar and contract years, the MCOP will be evaluated to determine whether it has met required withhold requirements at the end of both Calendar Year (CY) 2014 and CY 2015. For Demonstration Years 2 and 3, the MCOP will be evaluated to determine whether it has met withhold requirements at the end of CY 2016 and CY 2017, respectively. Consistent with such evaluations, the withheld amounts will be repaid separately for each calendar year. The quality withhold will increase to two percent (2%) in Demonstration Year 2 and three percent (3%) in Demonstration Year 3. Table 2, below identifies the withhold measures and standards for the Medicaid-only members (opt-out population) for Demonstration Years 2 and 3.

Table 1. Quality Withhold Measures and Standards for Demonstration Year 1 for Medicaid-Only Members – Contract Period/Measurement Year

		Demonstration Year 1	
Measure	Source	SFY 2015/CY 2014 Min Perf Standard	SFY 2016/ CY 2015 Min Perf Standard
Nursing Facility Diversion Measure	State-defined measure	5% decrease from CY 2013 (baseline year)	5% decrease from CY 2013 (baseline year)

Table 2. Quality Withhold Measures and Standards for Demonstration Years 2 and 3 for Medicaid-Only Members – Contract Period/Measurement Year

Appendix O
 MyCare Ohio
 Quality Withholds
 Page 2 of 2

		Demonstration Year 2	Demonstration Year 3
Measure	Source	SFY 2017/ CY 2016 Min Perf Standard	SFY 2018/ CY 2017 Min Perf Standard
Nursing Facility Diversion Measure	State-defined measure	TBD	TBD
Long Term Care Overall Balance Measure	State-defined measure	TBD	TBD

For Medicaid-only members (opt-out population), additional specifications regarding the quality withholds, including more detailed specifications, required thresholds and other information regarding the methodology will be made available in future technical guidance.

APPENDIX P

TERMINATION/NONRENEWAL

1. PLAN-INITIATED TERMINATIONS/NONRENEWALS

If a MyCare Ohio Plan (MCOP) provides notice of the termination/nonrenewal of this Provider Agreement to ODM, pursuant to Article VIII of this MCOP Provider Agreement (Agreement) or Section 5.5 of the Three-Way Contract (Three-Way) between United States Department of Health and Human Services Centers for Medicare and Medicaid Services, ODM and the MCOP, the MCOP will be required to comply with the following:

a. Fulfill Existing Duties and Obligations

The MCOP agrees to fulfill all duties and obligations as required under Chapter 5160-58 of the Ohio Administrative Code (OAC) and any agreements related to the provision of services for the Medicaid population during periods of time when the MCOP was under contract with ODM. Such duties and obligations include, but are not limited to, the submission by the MCOP of any previously reported appeals and grievances data which were unresolved for the Medicaid population after the termination/nonrenewal date, resolution of provider and consumer complaints for the Medicaid population served by the MCOP for the MCOP provider agreement time periods, and provision of data to support audits related to the Medicaid population served by the MCOP for the MCOP's provider agreement time periods.

b. Refundable Monetary Assurance

The MCOP will be required to submit a refundable monetary assurance. This monetary assurance will be held by ODM until such time that the MCOP has submitted all outstanding monies owed, data files, and reports, including, but not limited to, grievance, appeal, encounter and cost report data related to time periods through the final date of service under the MCOP's provider agreement. The monetary assurance must be in an amount of either \$50,000 or 5% of the capitation amount paid by ODM in the month the termination/nonrenewal notice is issued, whichever is greater.

The MCOP must remit the monetary assurance in the specified amounts via separate electronic fund transfers (EFT) payable to *Treasurer of State, State of Ohio (ODM)*. The MCOP must contact its Contract Administrator to verify the correct amounts required for the monetary assurance and obtain an invoice number prior to submitting the monetary assurance. Information from the invoices must be included with each EFT to ensure monies are deposited in the appropriate ODM Fund account. In addition, the MCOP must send copies of the EFT bank confirmations and copies of the invoices to their Contract Administrator.

If the monetary assurance is not received as specified above, ODM may withhold the MCOP's next month's capitation payment until such time that ODM receives documentation that the monetary assurance has been received by the Treasurer of State. If within one year of the date of issuance of the invoice, an MCOP does not submit all outstanding monies owed and required submissions, including, but not limited to, grievance, appeal, encounter and cost report data related to time periods through the final date of service under the MCOP's provider agreement, the monetary assurance will not be refunded to the MCOP.

c. Withhold Amount

Any withhold amount in the managed care program performance payment fund will be retained by ODM.

d. Final Accounting of Amounts Outstanding

The MCOP must submit to ODM a final accounting list of any outstanding monies owed by ODM no later than six months after the termination/nonrenewal date. Failure by the MCOP to submit a list of outstanding items will be deemed a forfeiture of any additional compensation due to the MCOP. ODM payment will be limited to only those amounts properly owed by ODM.

e. Monetary Sanctions

All previously collected refundable monetary sanctions shall be retained by ODM.

f. Data Files

In order to assist members with continuity of care, the terminating MCOP must create data files to be shared with each newly enrolling MCOP. The data files must be provided in a consistent format specified by ODM and may include information on the following: care management, prior authorizations, inpatient facility stays, PCP assignments, pregnant members, and any other information as specified by ODM. The timeline for providing these files will be at the discretion of ODM. The terminating MCOP will be responsible for ensuring the accuracy and data quality of the files.

g. Notification

- i. Provider Notification - The MCOP must notify contracted providers at least 55 days prior to the effective date of termination. The provider notification must be approved by ODM prior to distribution.
- ii. Member Notification – Unless otherwise notified by ODM, the MCOP must notify its members regarding its provider agreement termination at least 45 days

in advance of the effective date of termination. The member notification must be approved by ODM prior to distribution.

- iii. Prior Authorization Re-Direction Notification - The MCOP must create two notices to assist members and providers with prior authorization requests received and/or approved during the last month of membership. The first notice is for prior authorization requests for services to be provided after the effective date of termination; this notice will direct members and providers to contact the enrolling MCOP. The second notice is for prior authorization requests for services to be provided before and after the effective date of termination. The MCOP must utilize ODM model language to create the notices and receive approval by ODM prior to distribution. The notices will be mailed to the provider and copied to the member for all requests received during the last month of MCOP membership.

2. ODM-INITIATED TERMINATIONS FOR CAUSE

- a. If ODM initiates the proposed termination, nonrenewal or amendment of this agreement pursuant to OAC rules 5160-58-01.1 and 5160-26-10 by issuing a proposed adjudication order pursuant to O.R.C. 5164.38, and the MCOP submits a valid appeal of that proposed action pursuant to O.R.C. Chapter 119, the MCOP's provider agreement will be extended through the issuance of an adjudication order in the MCOP's appeal under ORC Chapter 119.

During this time, the MCOP will continue to accrue points and be assessed penalties for each subsequent compliance assessment occurrence/violation under Appendix N of the provider agreement. If the MCOP exceeds 69 points, each subsequent point accrual will result in a \$15,000 nonrefundable fine.

Pursuant to OAC rules 5160-58-01.1 and 5160-26-10, if ODM has proposed the termination, nonrenewal, denial or amendment of a provider agreement, ODM may notify the MCOP's members of this proposed action and inform the members of their right to immediately terminate their membership with that MCOP without cause. If ODM has proposed the termination, nonrenewal, denial or amendment of a provider agreement and access to medically-necessary covered services is jeopardized, ODM may propose to terminate the membership of all of the MCOP's members. The appeal process for reconsideration of the proposed termination of members is as follows:

- All notifications of such a proposed MCOP membership termination will be made by ODM via certified or overnight mail to the identified MCOP contact.
- An MCOP notified by ODM of such a proposed MCOP membership termination will have three working days from the date of receipt to request reconsideration.
- All reconsideration requests must be submitted by either facsimile transmission or

overnight mail to the Director, Ohio Department of Medicaid, and received by 3PM Eastern Time on the third working day following receipt of the ODM notification of termination. The address and fax number to be used in making these requests will be specified in the ODM notification of termination document.

- The MCOP will be responsible for verifying timely receipt of all reconsideration requests. All requests must explain in detail why the proposed MCOP membership termination is not justified. The MCOP's justification for reconsideration will be limited to a review of the written material submitted by the MCOP.
- A final decision or request for additional information will be made by the Director within three working days of receipt of the request for reconsideration. Should the Director require additional time in rendering the final reconsideration decision, the MCOP will be notified of such in writing.
- The proposed MCOP membership termination will not occur while an appeal is under review and pending the Director's decision. If the Director denies the appeal, the MCOP membership termination will proceed at the first possible effective date. The date may be retroactive if the ODM determines that it would be in the best interest of the members.

b. Fulfill Existing Duties and Obligations

The MCOP agrees to fulfill all duties and obligations as required under OAC Chapter 5160-58 and any provider agreements related to the provision of services for the Medicaid population during periods of time when MCOP was under contract with ODM. Such duties and obligations include, but are not limited to, the submission by the MCOP of any previously reported appeals and grievances data which were unresolved for the Medicaid population after the termination/nonrenewal date, resolution of provider and consumer complaints for the Medicaid population served by the MCOP for the MCOP provider agreement time periods, and provision of data to support audits related to the Medicaid population served by the MCOP for the MCOP's provider agreement time periods.

c. Refundable Monetary Assurance

The MCOP will be required to submit a refundable monetary assurance. This monetary assurance will be held by ODM until such time that the MCOP has submitted all outstanding monies owed, data files, and reports, including, but not limited to, grievance, appeal, encounter and cost report data related to time periods through the final date of service under the MCOP's provider agreement. The monetary assurance must be in an amount of either \$50,000 or 5% of the capitation amount paid by ODM in the month the termination/nonrenewal notice is issued, whichever is greater.

The MCOP must remit the monetary assurance in the specified amounts via separate electronic fund transfers (EFT) payable to *Treasurer of State, State of Ohio (ODM)*. The MCOP must contact its Contract Administrator to verify the correct amounts required for the monetary assurance and obtain an invoice number prior to submitting the monetary assurance. Information from the invoices must be included with each EFT to ensure monies are deposited in the appropriate ODM Fund account. In addition, the MCOP must send copies of the EFT bank confirmations and copies of the invoices to its Contract Administrator.

If the monetary assurance is not received as specified above, ODM will withhold the MCOP's next month's capitation payment until such time that ODM receives documentation that the monetary assurance has been received by the Treasurer of State. If within one year of the date of issuance of the invoice, the MCOP does not submit all outstanding monies owed and required submissions, including, but not limited to, grievance, appeal, encounter and cost report data related to time periods through the final date of service under the MCOP's provider agreement, the monetary assurance will not be refunded to the MCOP.

d. Withhold Amount

Any withhold amount in the managed care program performance payment fund will be retained by ODM.

e. Monetary Sanctions

All previously collected refundable monetary sanctions shall be retained by ODM.

f. Final Accounting of Amounts Outstanding

The MCOP must submit to ODM a final accounting list of any outstanding monies owed by ODM no later than six months after the termination/nonrenewal date. Failure by the MCOP to submit a list of outstanding items will be deemed a forfeiture of any additional compensation due to the MCOP. ODM payment will be limited to only those amounts properly owed by ODM.

In order to assist members with continuity of care, the terminating MCOP must create data files to be shared with each newly enrolling MCOP. The data files must be provided in a consistent format specified by ODM and may include information on the following: care management, prior authorizations, inpatient facility stays, PCP assignments, pregnant members and any other information as specified by ODM. The timeline for providing these files will be at the discretion of ODM. The terminating MCOP will be responsible for ensuring the accuracy and data quality of the files.

h. Notification

- i. Provider Notification - The MCOP must notify contracted providers at least 55 days prior to the effective date of termination. The provider notification must be approved by ODM prior to distribution.
- ii. Prior Authorization Re-Direction Notification - The MCOP must create two notices to assist members and providers with prior authorization requests received and/or approved during the last month of membership. The first notice is for prior authorization requests for services to be provided after the effective date of termination; this notice will direct members and providers to contact the enrolling MCOP. The second notice is for prior authorization requests for services to be provided before and after the effective date of termination. The MCOP must utilize ODM model language to create the notices and receive approval by ODM prior to distribution. The notices will be mailed to the provider and copied to the member for all requests received during the last month of MCOP membership.

3. TERMINATION OR MODIFICATION OF THIS PROVIDER AGREEMENT DUE TO LACK OF FUNDING

Should this Agreement terminate or be modified due to a lack of available funding as set forth in the Baseline of this Agreement, the MCOP has no right to appeal the selection process under ORC Chapter 119 pursuant to ORC 5164.38 and will be required to comply with the following:

a. Fulfill Existing Duties and Obligations

The MCOP agrees to fulfill all duties and obligations as required under OAC Chapter 5160-58 and any provider agreements related to the provision of services for the Medicaid populations during periods of time when the MCOP was under contract with ODM. Such duties and obligations include, but are not limited to, the submission by the MCOP of any previously reported appeals and grievances data which were unresolved for the Medicaid populations, resolution of provider and consumer complaints for the Medicaid population served by the MCOP for the MCOP provider agreement time periods, and provision of data to support audits related to the Medicaid populations

served by the MCOP for the MCOP's provider agreement time periods.

b. Refundable Monetary Assurance

The MCOP will be required to submit a refundable monetary assurance should the Provider Agreement terminate. This monetary assurance will be held by ODM until such time that the MCOP has submitted all outstanding monies owed, data files, and reports, including, but not limited to, grievance, appeal, encounter and cost report data related to time periods through the final date of service under the MCOP's provider agreement. The monetary assurance must be in an amount of either \$50,000 or 5% of the capitation amount paid by ODM in the month the termination notice is issued, whichever is greater.

The MCOP must remit the monetary assurance in the specified amounts via separate electronic fund transfers (EFT) payable to *Treasurer of State, State of Ohio (ODM)*. The MCOP must contact its Contract Administrator to verify the correct amounts required for the monetary assurance and obtain an invoice number prior to submitting the monetary assurance. Information from the invoices must be included with each EFT to ensure monies are deposited in the appropriate ODM Fund account. In addition, the MCOP must send copies of the EFT bank confirmations and copies of the invoices to its Contract Administrator.

If the monetary assurance is not received as specified above, ODM will withhold the MCOP's next month's capitation payment until such time that ODM receives documentation that the monetary assurance has been received by the Treasurer of State. If within one year of the date of issuance of the invoice, an MCOP does not submit all outstanding monies owed and required submissions, including, but not limited to, grievance, appeal, fines or sanctions, encounter and cost report data related to time periods through the final date of service under the MCOP's provider agreement, the monetary assurance will not be refunded to the MCOP.

c. Withhold Amount

Any withhold amount in the managed care program performance payment fund will be awarded by ODM in accordance with the pay-for-performance system set forth in Appendix O for the current provider agreement year.

d. Monetary Sanctions

Previously collected refundable monetary sanctions directly and solely related to the termination or modification of this Agreement shall be returned to the MCOP.

e. Final Accounting of Amounts Outstanding

The MCOP must submit to ODM a final accounting list of any outstanding monies owed by ODM no later than six months after a termination/nonrenewal date of this Agreement.

Failure by the MCOP to submit a list of outstanding items will be deemed a forfeiture of any additional compensation due to the MCOP. ODM payment will be limited to only those amounts properly owed by ODM.

f. Data Files

In order to assist members with continuity of care, the MCOP must create data files if requested by ODM. The data files must be provided in a consistent format specified by ODM and may include information on the following: care management, prior authorizations, inpatient facility stays, PCP assignments, pregnant members and any other information as specified by ODM. The timeline for providing these files will be at the discretion of ODM. The MCOP will be responsible for ensuring the accuracy and data quality of the files.

g. Provider Notification

The MCOP must notify contracted providers within 30 days of notice from ODM of the effective date of termination or modification of this Agreement. The provider notification must be approved by ODM prior to distribution.

APPENDIX Q

PAYMENT REFORM

On January 9, 2013, Governor John Kasich's Advisory Council on Health Care Payment Reform adopted the Catalyst for Payment Reform (CPR) principles as part of a comprehensive strategy to prioritize and coordinate multi-payer health care payment innovation activities in Ohio. The Ohio Department of Medicaid (ODM) is committed to reforming the health care delivery system by designing and implementing systems of payment that signal powerful expectations for improved health care delivery.

1. **Payment Innovation and Reform.** Improving the delivery of health care including its quality, efficiency, safety, patient-centeredness, coordination, and outcomes requires significant changes in existing payment structures and methodologies as well as the environment in which payments are made. The following principles have been adopted by Ohio Medicaid:
 - a. Payment reforms should promote health by rewarding the delivery of quality, cost effective and affordable care that is patient-centered and reduces disparities.
 - b. Health care payments should encourage and reward patient-centered care that coordinates services across the spectrum of providers and care setting while tailoring health care service to the individuals patient's needs.
 - c. Payment policies should encourage alignment between public and private sectors to promote improvement, innovations and meeting national health priorities, and to maximize the impact of payment decisions of one sector on the other.
 - d. Decisions about payment should be made through independent processes that are guided by what serves the patient and helps society as a whole, and payment decisions must balance the perspectives of consumers, purchasers, payers, physicians and other health care providers.
 - e. Payment policies should foster ways to reduce expenditure on administrative processes (e.g., claims payment and adjudications).
 - f. Reforms to payment should balance the need for urgency against the need to have realistic goals and timelines that take into account the need to change complex systems and geographic and other variations.

2. **ODM's Expectations.** ODM expects MCOPs to support and advance initiatives to develop a health care market where payment is increasingly designed to improve and reflect effectiveness and efficiency with which providers deliver care. In addition, ODM supports the development of MCOP members that are engaged in managing their health, selecting their providers, and maintaining sensitivity to the cost and quality of services they seek. The MCOP must use its best efforts to ensure that these commitments and initiatives apply to the benefits offered and services delivered under this provider agreement. MCOPs shall achieve progress in the following areas:
 - a. **Value-Oriented Payment.** The MCOP shall design and implement payment methodologies with its network providers that are designed either to cut waste or reflect value. For the purposes of this Provider Agreement, payments that cut waste are those that by their design reduce unnecessary payment and unnecessary care (e.g. elective cesarean deliveries). Value is defined as the level of the quality of care for the amount of money paid to the provider. Payments designed to reflect value are those that are tied to provider performance so that they may rise or fall in a predetermined fashion commensurate with different levels of performance assessed against standard measures.
 - b. **Market Competition and Consumerism.** The MCOP shall design contracting methodologies and payment options and administer the benefit package to members in a manner that enhances competition among providers and reduces unwarranted price and quality variation. To stimulate provider competition further, the MCOP shall establish programs to engage MCOP members to make informed choices and to select evidence-based, cost-effective care.
 - c. **Transparency.** The MCOP shall participate in ODM initiatives to design and implement member-accessible comparisons of provider information including quality, cost, and patient experience, among providers in the plan's network. The MCP shall contribute to the program design, provide data as specified by ODM, and publish results in accordance with standards established by the Department.
3. **Obligations of MCOPs.** MCOPs shall implement payment strategies that tie payment to value or reduce waste. Examples of strategies include the following:
 - a. Pay providers differentially according to performance (and reinforce with benefit design);
 - b. Design approaches to payment that cut waste while not diminishing quality, including reducing unwarranted payment variation;

- c. Design payments to encourage adherence to clinical guidelines. At a minimum, the MCOP must address policies to discourage elective deliveries before 39 weeks;
 - d. Develop payment strategies to reduce unwarranted price variation, such as reference or value pricing (e.g. analysis of price variation among network providers by procedure and service types, pilot value pricing programs, encouragement of member value-based pricing information , center of excellence pricing, and rebalance payment between primary and specialty care).
4. **Reporting.** The MCOP must submit a quarterly progress report as specified by ODM that addresses progress towards meeting the obligations as outlined in II above.