THE OHIO DEPARTMENT OF MEDICAID

OHIO MEDICAID PROVIDER AGREEMENT FOR MANAGED CARE ORGANIZATION

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INTRODUCTION

1. **Ohio Department of Medicaid Mission and Goals**

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

        i. Focus on the individual;

        ii. Improve individual and population wellness and health outcomes;

        iii. Create a personalized care experience;

        iv. Support providers in continuously improving care;

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

        vi. Increase program transparency and accountability.

    b. The managed care organization (MCO) must perform its responsibilities and deliver services under this Agreement in a manner consistent with achieving these goals.

2. **Ohio Medicaid Managed Care Program**

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

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

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

            1. All covered services for adult members;

            2. Physical health services for child members; and

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

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

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

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

i. Upon implementation, ODM's Ohio Medicaid Enterprise System (OMES) will serve as a single clearinghouse for all medical (non-pharmacy) claims. All medical claims will be submitted to ODM's OMES, ODM's electronic data interchange (EDI) vendor will apply specified Strategic National Implementation Process (SNIP) level edits, and ODM's OMES will send the claim to the responsible MCO for claims processing and payment.

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

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

3. **Population Health Approach**

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

i. Using data and scientific principles to proactively identify and stratify its members in order to more strategically address member needs;

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

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

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

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

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

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

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

ii. Valuing wellness by investing in and providing preventive, health promotion, and wellness services, and investing in primary care;

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

iv. Recognizing the significance of behavioral health needs to overall health and well being, and emphasizing a strengths-based approach to behavioral health that fully integrates physical and behavioral health care.

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

4. **MCO Service Area**

a. Under this Agreement, the MCO is responsible for providing covered services (see Appendix B, Coverage and Services) to members, described in OAC rule 5160-26-02 and Group VIII-Expansion category as defined in the Ohio Medicaid state plan, residing in the MCO's service area. The MCO's service area includes the following regions:

i. Central/Southeast Region ☒

ii. Northeast Region ☒

iii. West Region ☒

b. The MCO must serve members residing in all counties in each region.

5. **Ohio MCO Regions**

a. Counties are grouped into three regions as identified below.

i. Counties in the Central/Southeast Region

Athens	Franklin	Knox	Meigs	Pike
Belmont	Gallia	Lawrence	Monroe	Ross
Coshocton	Guernsey	Licking	Morgan	Scioto
Crawford	Harrison	Logan	Muskingum	Union
Delaware	Hocking	Madison	Noble	Vinton
Fairfield	Jackson	Marion	Perry	Washington
Fayette	Jefferson	Morrow	Pickaway	

ii. Counties in the Northeast Region

Ashland	Cuyahoga	Huron	Medina	Summit
Ashtabula	Erie	Lake	Mahoning	Trumbull
Carroll	Holmes	Lorain	Richland	Tuscarawas
Columbiana	Geauga	Portage	Stark	Wayne

iii. Counties in the West Region

Adams	Clermont	Hancock	Montgomery	Shelby
Allen	Clinton	Hardin	Ottawa	Van Wert
Auglaize	Darke	Henry	Paulding	Williams
Brown	Defiance	Highland	Preble	Wood
Butler	Fulton	Lucas	Putnam	Wyandot
Champaign	Greene	Mercer	Sandusky	Warren
Clark	Hamilton	Miami	Seneca	

DEFINITIONS AND ACRONYMS

1. **General**

    a. Listed below are definitions of terms and acronyms used in this Agreement. In the event of a conflict between the definition of a term that states that it is "as defined in" a referenced federal or state law and the definition in the referenced law, the definition in the referenced law shall take precedence.

2. **Definitions**

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

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

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

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

Advance Directive – As defined in OAC rule 5160-26-01, written instructions such as a living will or durable power of attorney for health care relating to the provision of health care when an adult is incapacitated.

Adverse Benefit Determination – As defined in OAC rule 5160-26-08.4, a Managed Care Organization's (MCO's):

a. Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

b. Reduction, suspension, or termination of services prior to the member receiving the services previously authorized by the MCO;

c. Denial, in whole or part, of payment for a service (a denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" is not an adverse benefit determination);

d. Failure to provide services in a timely manner as specified in OAC rule 5160-26-03.1;

e. Failure to act within the resolution timeframes specified in this rule; or

f. Denial of a member's request to dispute a financial liability, including cost sharing, co-payments, premiums, deductibles, coinsurance, and other member financial liabilities, if applicable.

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

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

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

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

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

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

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

Care Coordination – A strategy to deliberately organize and support an individual with addressing needs to achieve better health outcomes.

Care Coordination Entity (CCE) – An entity that provides care coordination to a specific population.

Care Coordination Staff – MCO Care Manager, MCO Care Manager Plus, MCO Care Guide, MCO Care Guide Plus, and/or other individuals supporting those roles.

Care Management – A collaborative and team-based, person-centered approach designed to assist members and their support systems in managing medical conditions and social determinants of health more effectively.

Care Management Entity (CME) – As defined in OAC rule 5160-59-03.2, an entity contracted with the OhioRISE Plan that provides behavioral health care management to OhioRISE enrolled members within a catchment area. A single CME serves each catchment area.

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

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

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

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

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

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

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

Cold Call Marketing Activities – Unsolicited personal contact by the MCO with an eligible individual for the purpose of marketing, including door-to-door or telephone contact.

Companion Guide – Document that contains specific electronic data interchange (EDI) instructions required by the receiving payer(s) for use of code values and/or situational segments. Companion guides are a supplement to the X12 Technical Report Type 3 (TR3) Guidelines.

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

Coordinated Services Program (CSP) –In accordance with OAC rule 5160-20-01, a program that requires an individual to obtain services related to the reason for enrollment from an assigned provider. An individual enrolled in CSP is eligible for all medically necessary services covered by Medicaid.

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

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

Cultural Humility – Maintaining a person-centered, interpersonal stance that seeks to understand the aspects of cultural identity that are most important to the individual and recognizes the inherent value of personal history and preferences.

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

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

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

Electronic Health Record (EHR) – A record in digital format that is a systematic collection of electronic health information. EHRs may contain a range of data, including demographics, medical history, medication, and allergies, immunization status, laboratory test results, radiology images, vital signs, personal statistics, such as age and weight, and billing information.

Eligible Individual – Consistent with OAC rule 5160-26-01, any Medicaid recipient who is a legal resident of the managed care service area and is in one of the categories eligible for managed care enrollment as provided in OAC rule 5160-26-02.

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

Emergency Services – As defined in OAC rule 5160-26-01, covered inpatient services, outpatient services, or medical transportation that are provided by a qualified provider and are needed to evaluate, treat, or stabilize an emergency medical condition. Providers of emergency services also include physicians or other health care professionals or health care facilities not under employment or under contractual arrangement with an MCO.

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

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

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

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

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

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

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

Health Equity – Exists when everyone has a fair opportunity to attain their full health potential.

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

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

Healthchek – As defined in OAC rule 5160-1-14, comprehensive preventive health services available to individuals under 21 years of age who are enrolled in Medicaid, otherwise known as early and periodic screening, diagnostic, and treatment (EPSDT) services.

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

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

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

Incident – As defined in OAC rule 5160-44-05, an alleged, suspected, or actual event that is not consistent with the routine care of, and/or service delivery to an individual that may have a negative impact on the health and welfare of the individual. Incidents include, but are not limited to, the following types of events: abuse, neglect, exploitation, misappropriation greater than $500, accidental/unnatural death, and self-harm or suicide attempts requiring medical intervention.

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

Indian Health Care Provider – A health care program operated by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as these terms are defined in Section 4 of the Indian Health Care Improvement Act (25 USC 1603).

Institution for Mental Disease (IMD) – As defined in 42 CFR 435.1010, a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of individuals with mental diseases (including substance use disorders), including medical attention, nursing care, and related services. Whether an institution is an IMD is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for individuals with intellectual disabilities is not an IMD.

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

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

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

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

Marketing – Any communication from the MCO to an eligible individual who is not a member of the MCO that can reasonably be interpreted as intended to influence the individual to select membership in the MCO, or to not select membership in or to terminate membership from another MCO.

Marketing Materials – Items produced in any medium, by or on behalf of the MCO, which can reasonably be interpreted as intended to market to eligible individuals.

Marketing Presentations – A direct interaction between the MCO's marketing representative and an eligible individual, in any setting, unless initiated and requested by the eligible individual.

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

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

Medicaid School Program (MSP) – As defined in Chapter 5160-35 of OAC, a school payment program that allows school districts to receive Medicaid reimbursement for schools that provide school-based therapy services to students who receive Medicaid. The services that Medicaid pays for are part of a student's Individualized Educational Plan (IEP).

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

a. Medical necessity for individuals covered by early and periodic screening, diagnosis, and treatment (EPSDT) is defined as procedures, items, or services that prevent, diagnose, evaluate, correct, ameliorate, or treat an adverse health condition such as an illness, injury, disease or its symptoms,

emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability.

b. Medical necessity for individuals not covered by EPSDT is defined as procedures, items, or services that prevent, diagnose, evaluate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability, and without which the person can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort.

c. Conditions of medical necessity are met if all the following apply:

    i. Meets generally accepted standards of medical practice;

    ii. Clinically appropriate in its type, frequency, extent, duration, and delivery setting;

    iii. Appropriate to the adverse health condition for which it is provided and is expected to produce the desired outcome;

    iv. Is the lowest cost alternative that effectively addresses and treats the medical problem;

    v. Provides unique, essential, and appropriate information if it is used for diagnostic purposes; and

    vi. Not provided primarily for the economic benefit of the provider nor for the convenience of the provider or anyone else other than the recipient.

d. The fact that a physician, dentist, or other licensed practitioner renders, prescribes, orders, certifies, recommends, approves, or submits a claim for a procedure, item, or service does not, in and of itself, make the procedure, item, or service medically necessary and does not guarantee payment for it.

e. The definition and conditions of medical necessity articulated in this rule apply throughout the entire Medicaid program. More specific criteria regarding the conditions of medical necessity for particular categories of service may be set forth within ODM coverage policies or rules.

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

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

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

Member Incentive Program – A time-limited monetary or non-monetary reward offered to a member who complies with the intended goals of the MCO's program (e.g., recommended health screenings).

Member Materials – Items developed by or on behalf of the MCO to fulfill MCO program requirements or to communicate to all members or a group of members. Member materials include member education, member appreciation, and member incentive program information. Member health education materials produced by a

source other than the MCO and which do not include any reference to the MCO are not considered to be member materials.

Members with Special Health Care Needs – Individuals, as identified in the MCO's Quality Assurance Performance Improvement (QAPI) program, who have or are at increased risk for chronic, physical, developmental, behavioral, or emotional conditions and who require health and related services of a type or amount beyond that required by individuals generally.

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

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

Mobile Response and Stabilization Services (MRSS) – As provided in OAC rule 5160-27-13, MRSS is a mobile response stabilization service for young people who are experiencing significant behavioral or emotional challenges and their families. The service may be delivered through a face-to-face mobile response to the young person’s home, school, a local emergency department (ED), or another location in the community, including a location preferred by the family. MRSS is available 24 hours a day, 365 days a year.

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

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

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

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

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

Ohio Children’s Initiative Child and Adolescent Needs and Strengths (CANS) – A multiple purpose information integration tool developed for children's services to support decision-making, including level of care and service planning, facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.

CANS is designed to be the output of an assessment process. The Brief and Comprehensive CANS assessments are designed to be the output of a functional assessment process.

Ohio Resilience through Integrated Systems and Excellence (OhioRISE) – A program designed to provide, manage, and coordinate comprehensive behavioral health care for children with serious or complex behavioral health needs who are at risk of involvement or are involved in multiple child-serving systems. Eligibility for OhioRISE and enrollment in the OhioRISE Plan is determined by ODM.

OhioRISE Plan – The prepaid inpatient health plan contracted with ODM to administer the OhioRISE program.

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

Pediatric Recovery Center (PRC) – A facility that has as its primary purpose the provision of residential services for infants affected by substance use and the preservation of families through infant diversion practices and programs. PRC has the same meaning as “residential infant care centers” in section 5103.60 of the Ohio Revised Code.

Pending Member – As defined in OAC rule 5160-26-01, an eligible individual who has selected or been assigned to an MCO but whose MCO membership is not yet effective.

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

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

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

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

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

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

Protected Health Information (PHI) – Information received from or on behalf of ODM that meets the definition of PHI as defined by Health Insurance Portability and Accountability Act (HIPAA) and the regulations promulgated by the United States Department of Health and Human Services, specifically 45 CFR 160.103 and 45 CFR 164.501.

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

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

Provider Agreement – As defined in OAC rule 2160-26-01, a formal agreement between ODM and an MCO for the provision of medically necessary services to Medicaid members.

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

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

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

Provider-Preventable Condition – As defined in 42 CFR 447.26, a condition that meets the definition of a "health care-acquired condition" (a condition occurring in any inpatient hospital setting, identified as a health care-acquired condition by the Secretary under section 1886(d)(4)(D)(iv) of the Act for purposes of the Medicare program identified in the Ohio Medicaid state plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Act; other than Deep Vein Thrombosis /Pulmonary Embolism as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients) or an "other provider-preventable condition" (a condition occurring in any health care setting) that meets the following criteria:

a. Is identified in the Ohio Medicaid state plan;

b. Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;

c. Has a negative consequence for the beneficiary;

d. Is auditable;

e. Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Qualified Community Hub – Central clearinghouse for a network of community care coordination agencies that meets all of the following criteria:

a. Demonstrates to the director of health that it uses an evidenced-based, pay-for-performance community care coordination model (endorsed by the federal agency for health research and quality, the national institutes for health, and the Centers for Medicare and Medicaid Services or their successors) or uses certified community health workers or public health nurses to connect at-risk individuals to health, housing, transportation, employment, education, and other social services;

b. Is a board of health or demonstrates to the director of health that it has achieved, or is engaged in achieving certification from a national hub certification program; and

c. Has a plan specifying how the board of health or community hub ensures that children served by it receive appropriate development screenings as specified in the publication titled "Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents," available from the American academy of pediatrics, as well as appropriate early and periodic screening, diagnostic, and treatment services.

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

QAPI Evaluation Template – The ODM template that MCOs submit annually to demonstrate the content of their QAPI program and evaluate how they have executed ODM's population health management and quality improvement requirements.

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

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

Regional Mobile Response and Stabilization Services Provider (RMP)- Ohio’s regional MRSS provider structure leverages regional and local resources to accelerate the expansion and sustainability of MRSS services. The Regional MRSS Provider (RMP) is responsible for the delivery of high quality in-person MRSS services as defined in rule and practice standards for the entire regional catchment that they are assigned to. RMPs are selected through a state Request for Proposal (RFP) solicitation and are the only entity eligible to bill Medicaid for MRSS services. The RMP is responsible for providing the functions outlined in Ohio Administrative Code and practice standards for the entire coverage area assigned.

Related Entity – Any related party to the MCO by common ownership or control under an oral or written arrangement to perform some of the administrative services under the MCO's contract with ODM. A related party includes but is not limited to agents, managing employees, individuals with an ownership or controlling

interest in the MCO and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or individuals.

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

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

Single Funding Source Manager - A vendor, as designated by ODM, to pool and distribute Medicaid and non-Medicaid funds to Regional Mobile Response and Stabilization Services Providers. The MCO must contract with the Single Funding Source Manager to administer payment to Regional MRSS providers contract with the MCO to provide MRSS to MCO plan members.

Single Pharmacy Benefit Manager (SPBM) – Consistent with OAC rule 5160-26-01, the state pharmacy benefit manager selected under ORC section 5167.24 that is responsible for processing all pharmacy claims for MCO members.

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

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

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

Stratification – A process by which clinicians, providers, and other entities report measures by different groups of members (e.g., male, female, African American, white) or combination of groups to find potential differences in care (e.g., examining a measure of how many members received routine mammography by how many African American women received the recommended care).

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

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

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

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

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

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

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

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

3. **Acronyms**

ABD	Aged, Blind, and Disabled
ADAMH	Alcohol, Drug Addiction, and Mental Health
AMA	American Medical Association
APM	Alternative Payment Model
APRN	Advanced Practice Registered Nurse
ASAM	American Society of Addiction Medicine
CAHP	Consumer Assessment of Healthcare Providers
CANS	Ohio Children's Initiative Child and Adolescent Needs and Strengths
CCE	Care Coordination Entity
CDJFS	County Department of Job and Family Services
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CFT	Child and Family Team
CHIP	Children's Health Insurance Program
CICIP	Care Innovation and Community Improvement Program
CIO	Chief Information Officer
CMC	Comprehensive Maternal Care
CMHSP	Community Mental Health Services Provider
CME	Care Management Entity
CMO	Chief Medical Officer
CMS	Centers for Medicare and Medicaid Services
COA	Certificate of Authority
CPC	Comprehensive Primary Care
CPSE	Claims Payment Systemic Error
CSP	Coordinated Services Program
CY	Calendar Year
eCQM	Electronic Clinical Quality Measure
EDI	Electronic Data Interchange
EHR	Electronic Health Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQRO	External Quality Review Organization
EVV	Electronic Visit Verification

FDR	First Tier, Downstream, and Related Entities
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
HCBS	Home and Community-Based Service
HIC	Health Insuring Corporation
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
IMD	Institution for Mental Disease
IMS	Incident Management System
LISW	Licensed Independent Social Worker
LPCC	Licensed Professional Clinical Counselor
LSW	Licensed Social Worker
MAGI	Modified Adjusted Gross Income
MAT	Medication Assisted Treatment
MCE	Managed Care Entity
MCO	Managed Care Organization
MFCU	Medicaid Fraud Control Unit
MHPAEA	Mental Health Parity and Addiction Equity Act
MISP	Maternal and Infant Support Program
MPS	Minimum Performance Standards
MRSS	Mobile Response and Stabilization Services
MSP	Medicaid School Program
NAIC	National Association of Insurance Commissioners
NCQA	National Committee for Quality Assurance
NPI	National Provider Identifier
OAC	Ohio Administrative Code
ODI	Ohio Department of Insurance
ODM	Ohio Department of Medicaid
OMHAS	Ohio Department of Mental Health and Addiction Services
OMES	Ohio Medicaid Enterprise System
ORC	Ohio Revised Code
PCP	Primary Care Provider
PDSA	Plan-Do-Study-Act
PHI	Protected Health Information
PHMS	Population Health Management Strategy
PII	Personal Identifiable Information
PIP	Performance Improvement Project
PMPM	Per Member Per Month
PRC	Pediatric Recovery Center
QAPI	Quality Assessment and Performance Improvement
QI	Quality Improvement
RFP	Request for Proposal
RHC	Rural Health Clinic
RMP	Regional Mobile Response and Stabilization Services Providers
SDOH	Social Determinants of Health
SFTP	Secure File Transfer Protocol
SFY	State Fiscal Year
SIU	Special Investigative Unit

SPBM	Single Pharmacy Benefit Manager
SUD	Substance Use Disorder
TMR	Targeted Medication Review
TPL	Third Party Liability
UPDL	Unified Preferred Drug List
UM	Utilization Management
US	United States
USC	United States Code

BASELINE PROVIDER AGREEMENT

This Provider Agreement (hereinafter "Agreement") is entered into this first day of July, 2025, at Columbus, Franklin County, Ohio, between the state of Ohio, the Ohio Department of Medicaid, (hereinafter referred to as ODM) whose principal office is located in the City of Columbus, County of Franklin, state of Ohio, and _____, Managed Care Organization (MCO), an Ohio corporation, whose principal office is located in the city of_____, County of _____, state of Ohio.

The MCO 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 must operate as prescribed by Chapter 5167 of the ORC, Chapter 5160-26 of the Ohio Administrative Code (OAC), and other applicable portions of the OAC as amended from time to time. Upon request, the MCO must submit to ODM any data submitted to ODI to establish the MCO has adequate provisions against the risk of insolvency as required under 42 Code of Federal Regulations (CFR) 438.116 and to ensure that neither members nor ODM shall be liable for any MCO debts, including those that remain in the event of MCO insolvency or the insolvency of any subcontractors.

The MCO is an entity eligible to enter into this Agreement in accordance with 42 CFR 438.3 and is engaged in the business of providing the comprehensive services described in 42 CFR 438.2 through the managed care program for the Medicaid-eligible population described in OAC rule 5160-26-02 along with any other Medicaid-eligible populations authorized by the Centers for Medicare and Medicaid Services (CMS) and described in the Ohio Medicaid state plan.

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

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

ARTICLE I – GENERAL

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

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

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

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

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

ARTICLE II – TIME OF PERFORMANCE

A. Upon approval by the Director of ODM, this Agreement is in effect from the date executed through June 30, 2026, unless this Agreement is terminated pursuant to Article VIII of the Baseline Provider Agreement on or prior to the Agreement expiration date, or otherwise renewed or amended pursuant to Article IX of the Baseline Provider Agreement. Termination of this Agreement does not relieve the MCO of any ongoing obligations as set forth in this Agreement, including those obligations associated with the transition plan described in Appendix O, MCO Termination and Non-Renewal.

ARTICLE III – REIMBURSEMENT

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

Payment for behavioral health services for members under the age of 21 not enrolled in the OhioRISE Plan will be made pursuant to the methodology specified in Appendix M, Rate Methodology.

Delivery (childbirth) payments for Modified Adjusted Gross Income (MAGI) member childbirth deliveries will be made pursuant to the methodology specified in Appendix L, Payment and Financial Performance.

B. Other than as noted above, the amounts paid by ODM in accordance with this Agreement represent a full risk arrangement and the total obligation of ODM to the MCO for the costs of medical care and services provided. Any savings or losses remaining after costs have been deducted from the premium will be wholly retained by the MCO subject to any remittance as may be required by ODM in accordance with 42 CFR 438.8(j).

C. ODM may establish financial incentive programs for the MCO based on performance.

ARTICLE IV – RELATIONSHIP OF PARTIES

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

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

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

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

ARTICLE V – CONFLICT OF INTEREST; ETHICS LAWS

A. In accordance with 42 CFR 438.58, the safeguards specified in Section 27 of the Office of Federal Procurement Policy Act (41 USC 423), and other applicable federal requirements, an officer, member, or employee of the MCO, the Director of ODM, or other ODM employee who exercises any functions or responsibilities in connection with the review or approval of this Agreement or provision of services under this Agreement must not, prior to the completion of such services or reimbursement, acquire any interest, personal or otherwise, direct or indirect that is incompatible or in conflict with or would compromise in any manner or degree the discharge and fulfillment of their functions and responsibilities with respect to carrying out of such services. For purposes of this article, "members" does not include individuals whose sole connection with the MCO is the receipt of services through a health care program offered by the MCO.

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

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

D. The MCO must ensure that 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, immediately discloses their interest to ODM in writing. Thereafter, the MCO must ensure that they must not participate in any action affecting the services under this Agreement unless ODM determines in its sole discretion that, in the light of the personal interest disclosed, their participation in any such action would not be contrary to the public interest. The MCO must provide written disclosure of such interest to ODM.

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

ARTICLE VI – NON-DISCRIMINATION OF EMPLOYMENT

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

   a. Title VII of the Civil Rights Act of 1964 (Pub. L. 88-352);
   b. Title VI of the Civil Rights Act of 1964 (42 USC 2000d, et seq.);
   c. The Americans with Disabilities Act of 1990 (42 USC 12101, et seq.) and Section 504 of the Rehabilitation Act of 1973; and
   d. The Age Discrimination Act of 1975 (42 USC 6101, et seq.).

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

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

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

ARTICLE VII – RECORDS, DOCUMENTS, DATA, AND INFORMATION

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

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

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

C. The MCO must not withhold records, documents, data, or other information the MCO deems as proprietary from ODM. Proprietary information is information that: (a) if made public, would put the MCO at a disadvantage in the marketplace and trade of which the MCO is a part; and (b) meets the definition of "trade secret" as defined in ORC section 1333.61(D). The MCO must prominently mark the top or bottom of each individual record containing information the MCO deems proprietary as "proprietary," regardless of media type (e.g., CD-ROM, Excel file), prior to its release to ODM, unless otherwise specified by ODM. If the MCO fails to mark a record as proprietary, the MCO waives any claim that the record is proprietary and ODM may not hold the record confidential. Upon request from ODM, the MCO must notify ODM in writing and within the timeframe specified by ODM of the specific proprietary information contained in the record, the nature of the proprietary information, the legal basis that supports that the information is proprietary, and the specific harm or injury that would result from disclosure.

Except as stated in this Agreement, ODM will not share or otherwise disclose proprietary information received from the MCO to any third party without the express written authorization of the MCO. Notwithstanding the forgoing, ODM is permitted to share or disclose (without a subpoena, grand jury subpoena, or court order) proprietary information to CMS, the U.S. Department of Health and Human Services Office of Inspector General, the Ohio Auditor of State, the Ohio Attorney General, the Medicaid Fraud Control Unit (MFCU), and/or ODM-contracted entities who perform rate setting or other duties connected to the administration of the Ohio Medicaid program and who agree to be bound by the standards of confidentiality in this Agreement. In addition, notwithstanding the forgoing, ODM is also permitted to share or disclose proprietary information in response to court orders, subpoenas, and grand jury subpoenas. Prior to disclosure of proprietary information required by court order, subpoena, or grand jury subpoena (unless otherwise ordered by a court), ODM will promptly notify the MCO in writing of the order and the proprietary information that would be released.

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

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

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

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

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

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

ARTICLE VIII – TERMINATION AND NON-RENEWAL

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

B. ODM may terminate this Agreement as a result of ODM's procurement of managed care organizations pursuant to ORC section 5167.10. The MCO must comply with the termination and non-renewal requirements as specified in Appendix O, MCO Termination and Non-Renewal. The termination of this Agreement due to ODM's procurement of managed care organizations shall not be considered a termination or non-renewal for purposes of the MCO's application for future procurements.

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

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

E. In the event of termination or non-renewal under this article, the MCO must transfer all data and records to ODM within the time period and in a file format as specified by ODM relating to cost, work performed, supporting documentation for invoices submitted to ODM, and copies of all materials produced under or pertaining to this Agreement.

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

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

H. If the MCO terminates or does not renew this Agreement for a specific region or regions, the MCO must comply with the requirements of Appendix O, MCO Termination and Non-Renewal. If the MCO terminates or does not renew this Agreement for a specific region or regions, ODM may terminate or not renew this Agreement with the MCO for all regions. ODM, at its discretion, may use the MCO's termination or non-renewal of this Agreement as a factor in any future procurement process.

I. The MCO understands that availability of funds to fulfill the terms of this Agreement is contingent on appropriations made by the Ohio General Assembly and the United States government for funding the Medicaid program. If sufficient funds are not available from the Ohio General Assembly or the United States government to make payments on behalf of a specific population (e.g., Aged, Blind, and Disabled; Modified Adjusted Gross Income; or Group VIII-Expansion) to fulfill the terms of this Agreement, the obligations, duties, and responsibilities of the parties with respect to that population will be terminated, except as specified in Appendix O, MCO Termination and Non-Renewal, as of the date funding expires. If the Ohio General Assembly or the United States government fails at any time to provide sufficient funding for ODM or

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

ARTICLE IX – AMENDMENT AND RENEWAL

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

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

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

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

E. This Agreement may be renewed each fiscal year after June 30, 2026, upon satisfactory performance hereunder, appropriation of funds by the Ohio General Assembly, and at the sole discretion of ODM. ODM will issue a notice to the MCO if ODM decides to renew this Agreement. The MCO must not obligate resources in anticipation of a renewal until such notice is provided and includes direction to begin obligating resources to the renewal year.

ARTICLE X – LIMITATION OF LIABILITY

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

agencies against these claims, regardless of whether those legal fees, fees, costs, or expenses are incurred by the MCO or the state of Ohio, ODM, or other Ohio agencies. In any such litigation or claim, ODM, the state of Ohio, and its agencies have the right to choose their own legal counsel and any experts and consultants, subject only to the requirement that legal, expert, and consulting fees must be reasonable.

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

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

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

ARTICLE XI – CHANGE IN ORGANIZATIONAL STRUCTURE

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

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

C. ODM may approve the MCO's proposal, without or with conditions, which may include but are not limited to allowing for an open enrollment for MCO members or a capping enrollment under this Agreement.

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

ARTICLE XII – ASSIGNMENT

A. The MCO may not transfer Medicaid members to another MCO without the prior written approval of ODM. Even with ODM's prior written approval, ODM reserves the right to offer such members the choice of MCOs outside the normal open enrollment process and implement an assignment process as ODM determines is appropriate. The MCO must submit any member transfer request to ODM for ODM's approval 120 calendar days prior to the desired effective date. ODM will use reasonable efforts to respond to any such request for

approval within the 120-calendar day period. Failure of ODM to act on a request for approval within the 120-calendar day period does not act as an approval of the request. ODM may require a receiving MCO to successfully complete a readiness review process before the transfer of members under this Agreement.

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

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

ARTICLE XIII – CERTIFICATION MADE BY THE MCO

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

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

C. The MCO certifies that neither the MCO nor any principals of the MCO (e.g., a director, officer, partner, or person with beneficial ownership of more than 5% of the MCO's equity) is presently debarred, suspended, proposed for debarment, declared ineligible, or otherwise excluded from participation in transactions by any federal agency. The MCO 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 MCO also certifies that the MCO 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 MCO's contractual obligation with ODM. This certification is a material representation of fact upon which reliance was placed when this Agreement was entered into. Federal financial participation (FFP) is not available for amounts expended for providers excluded by Medicare, Medicaid, or State

Children's Health Insurance Program (SCHIP), except for emergency services. If it is ever determined that the MCO knowingly executed this certification erroneously, then, in addition to any other remedies, this Agreement will be terminated pursuant to Article VIII of the Baseline Provider Agreement, and ODM must advise the secretary of the appropriate federal agency of the knowingly erroneous certification.

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

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

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

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

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

I. The MCO must ensure that the MCO, its officers, employees, members, any subcontractors, and any independent contractors (including all field staff) associated with this Agreement comply with all state and federal laws regarding a smoke-free and drug-free workplace. The MCO will make a good faith effort to ensure that all MCO officers, employees, members, and subcontractors will not purchase, transfer, use, or possess illegal drugs or alcohol, or abuse prescribed drugs in any way while performing their duties under this Agreement.

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

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

L. The MCO must comply with the Federal Acquisition Regulation for Combating Trafficking in Persons, 48 CFR Part 22 Subpart 22.17, in which "the United States Government has adopted a zero-tolerance policy regarding trafficking in persons." The provisions found in 48 CFR Part 52 Subpart 52.2, specifically Subpart 52.222-50, are hereby incorporated into this Agreement by reference. ODM reserves the right to

immediately and unilaterally terminate this Agreement if any provision in this section is violated and ODM may implement Section 106(g) of the Trafficking Victims Protection Act of 2000, as amended (22 USC 7104), see 2 CFR Part 175.

M. The MCO must comply with Executive Order 2019-12D. A copy of Executive Order 2019-12D can be found at https://governor.ohio.gov/wps/portal/gov/governor/media/executive-orders/2019-12d. This Executive Order prohibits the use of public funds to purchase services provided outside of the United States except under certain circumstances. Such services include the use of offshore programming or call centers. Additionally, the MCO shall not transfer personal health information to any location outside the United States or its territories. Pursuant to 42 CFR 438.602(i), no MCO claim paid to any provider, out-of-network provider, subcontractor, or financial institution located outside of the United States is considered in capitation rates.

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

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

ARTICLE XIV – CONSTRUCTION

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

ARTICLE XV – INCORPORATION BY REFERENCE

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

B. Appendices A through R and any additional appendices are hereby incorporated by reference as part of this Agreement having the full force and effect as if specifically restated herein. Appendix O, MCO Termination

and Non-Renewal, and any other applicable obligations set forth in this Agreement will survive the termination or non-renewal of this Agreement.

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

D. In accordance with the terms and conditions of Request for Applications (RFA) Number ODMR-2021-0024, the MCO is bound by the responses the MCO has submitted through that process. Accordingly, the MCO's responses to RFA Number ODMR-2021-0024 are incorporated by reference in this Agreement and have the full force and effect as if specifically restated herein.

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

ARTICLE XVI – NOTICES

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

ARTICLE XVII – HEADINGS

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

B. The parties have executed this Agreement on this _____ day of _____, 2025. This Agreement is hereby accepted and considered binding in accordance with the terms and conditions set forth in the preceding statements.

MCO NAME:

BY: _____ DATE: _____
PRESIDENT & CEO
ADDRESS: _____

THE OHIO DEPARTMENT OF MEDICAID:

BY: _____ DATE: _____
MAUREEN M. CORCORAN, DIRECTOR
50 West Town Street, Suite 400, Columbus, Ohio 43215

APPENDIX A – GENERAL REQUIREMENTS

1. General Administrative Requirements

a. Inclusive Agreement

i. The MCO acknowledges and agrees that the RFA Number ODMR-2021-0024, all attachments, written addenda to the RFA, the MCO's accepted proposal, the questions and answers posted during the inquiry period of the RFA Number ODMR-2021-0024 are hereby incorporated into this Agreement.

b. Certificate of Authority

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

c. National Committee for Quality Assurance Accreditation

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

ii. The MCO must hold and maintain or must obtain NCQA Health Plan accreditation, for the MCO's Ohio Medicaid line of business. If the MCO does not have NCQA Health Plan accreditation for the MCO's Ohio Medicaid line of business as of the effective date of this Agreement, the MCO must achieve NCQA Health Plan accreditation within 18 months of the effective date of this Agreement.

iii. The MCO must achieve and maintain a minimum status of "Accredited." If the MCO receives a "Provisional" or "Denied" status from NCQA, the MCO will be subject to sanctions as specified in Appendix N, Compliance Actions.

iv. ODM will assess MCO compliance annually, based on the MCO's accreditation status posted on the NCQA "Report Cards" webpage (https://reportcards.ncqa.org/) as of November 1 of each year.

v. For the purposes of determining whether the MCO meets this accreditation requirement, ODM will only accept the use of the NCQA Corporate Survey Process to the extent deemed allowable by NCQA.

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

d. Model Agreements with the OhioRISE Plan and SPBM

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

1. The content of the written agreements must include but not be limited to:

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

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

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

d. Data and information exchange requirements and timeframes;

e. Confidentiality and privacy requirements; and

f. Problem resolution protocols.

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

e. MCO Implementation and Readiness Review Activities

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

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

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

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

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

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

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

3. Terminate this Agreement; or

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

vi. During the implementation and readiness period, members currently enrolled in an ODM managed care plan will be given the opportunity to choose an MCO. ODM will prepare and send/deliver the materials associated with this initial opportunity for choice. The MCO must obtain ODM prior approval of marketing processes, practices, and communications related to member choice of an MCO as required in Appendix E, Marketing and Member Materials.

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

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

ix. During the course of this Agreement, the MCO must participate in ODM-conducted readiness reviews prior to MCO implementation of significant operational or program changes (e.g., service changes, information technology (IT) system modifications,

transportation vendor), as determined by ODM. At ODM's sole discretion, ODM may retain expert consultants at the MCO's expense to verify readiness of significant MCO-initiated operational or program changes. The MCO must demonstrate to ODM's satisfaction that the MCO will continue to be able to meet the requirements in this Agreement prior to implementing the change.

f. Local Presence

i. *Administrative Office*

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

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

ii. *Member and Provider Call Center*

1. The MCO must have its member and provider call centers for this Agreement located in the state of Ohio. In-state requirements do not apply to the MCO's medical advice line or after-hours system to route emergent and crisis behavioral health calls.

iii. *Out-of-State Functions*

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

2. MCO must bear any additional costs borne by ODM associated with ODM conducted on-site audits or other oversight activities for out-of-state MCO functions.

g. Contract Communications

i. *Key Contacts*

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

2. The MCO must designate and identify contact staff for specific program areas upon ODM's request.

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

ii. *Communication Process*

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

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

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

    c. The MCO is prohibited from contacting entities that contract with ODM, unless necessary to fulfill the requirements under this Agreement or when specifically instructed by ODM.

    d. Under the terms of this Agreement, the MCO must meet all program requirements, regardless of delegation of functions. The MCO must ensure that its subcontractors communicate with ODM as requested by ODM. ODM may meet with MCO subcontractors at any time and does not need to have approval of the MCO to do so.

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

iii. *Timeframes for Responding to Requests for Information*

1. Unless otherwise stated in this Agreement or in the request for information from ODM, the MCO must respond to requests for information within the following timeframes:

a. Within 24 hours for requests regarding member health, safety, and welfare;

b. Within two business days for requests regarding member access to services;

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

d. Ten business days for requests regarding policy research queries, coding, rate change inquiries, and all other requests for information.

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

iv. *Electronic Communications*

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

v. *Meeting Attendance*

1. The MCO must prepare for and send appropriate staff representatives to participate in all meetings and events when ODM requires MCO attendance and participation. Meetings may include but are not limited to technical assistance sessions, performance and compliance, systems configuration, provider network decisions, and policy and program development.

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

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

vi. *Program Input from MCO*

1. The MCO must respond on a timely basis to Ohio Medicaid managed care program input opportunities, including:

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

   b. Commenting on Ohio Medicaid managed care program policy and procedural changes; and

   c. Reviewing Ohio Medicaid managed care program updates and discussing program issues with ODM staff.

vii. *Performance and Compliance Feedback*

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

h. Program Modifications

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

2. Eligibility, Enrollment, Transfers, and Enrollment Termination

a. Managed Care Eligibility and Enrollment

i. Pursuant to OAC rule 5160-26-02, the MCO must comply with managed care program eligibility and enrollment requirements.

b. Auto-Assignment Algorithm

i. Eligible individuals and members who do not exercise their right to choose an MCO and those who are not assigned to an MCO based on family continuity will be assigned to the MCO through an ODM-approved auto-assignment algorithm.

ii. ODM's auto-assignment algorithm will account for specified lower and upper limits of MCO member enrollment.

1. ODM will establish a lower limit of MCO enrollment. Should the MCO fall below the lower limit of MCO member enrollment, auto-assignment will be adjusted to favor the MCO until the MCO meets the lower limit.

2. An upper limit of MCO enrollment will be established based upon the number of ODM-contracted MCOs in each region. Upon reaching the

upper limit, ODM will stop the auto-assignment of members to the MCO until the MCO's membership drops below the upper limit.

iii. ODM's auto-assignment algorithm will work in conjunction with Quality Based Assignment percentages where MCOs are awarded a percentage of unassigned enrollees based upon the MCO's performance relative to other ODM-contracted MCOs.

1. Percentages will be allocated by region and by three population categories (i.e., Aged, Blind, and Disabled [ABD], Covered Families and Children, and Group VIII- Expansion).

2. To preserve equal allocation of the Quality Based Assignments within the regional and auto-assignment for ABD, Covered Families and Children, and Group VIII-Expansion populations, exact percentage allocations shall not be guaranteed through the assignment processes, but will be adhered to as strictly as possible.

iv. MCOs are not entitled to an equal share or particular number of auto-assigned members, nor to a grouping of members with equivalent medical expenses. ODM's algorithm may auto-assign members in different numbers and with different expenses. Because these members are new and their relative risk is unknown, ODM will make no warranty relative to the members' risk profiles. The auto-assignment process will be used only to equitably distribute members in relatively comparable risk categories among ODM-contracted MCOs.

v. Member choice and family continuity will not be impacted by an auto-assignment adjustment or stoppage.

vi. ODM may change the auto-assignment algorithm at any time during the term of this Agreement in response to MCO-specific performance and quality considerations or when ODM determines it is in the best interest of the state, the program, or members.

c. <u>OhioRISE Eligibility and Enrollment</u>

i. ODM will enroll individuals who meet the eligibility criteria in OAC rule 5160-59-02 into the OhioRISE Program. The OhioRISE Plan is designed to provide comprehensive, coordinated behavioral health care for children with serious or complex behavioral health needs involved in, or at risk for involvement in, multiple child-serving systems. ODM, at its discretion, may include additional children and youth in the OhioRISE Plan membership.

ii. Members enrolled in the OhioRISE Plan will remain enrolled in the MCO for services not provided by the OhioRISE Plan. The MCO must cover and provide services for OhioRISE enrolled members as specified in Appendix B, Coverage and Services.

iii. ODM will enroll individuals in the OhioRISE Plan in accordance with the effective dates described in OAC rules 5160-59-02 and 5160-59.02.1.

iv. ODM will notify the MCO of OhioRISE Plan enrollments and disenrollments on the Health Insurance Portability and Accountability Act (HIPAA) 834C daily enrollment files.

d. Managed Care Day One

i. Eligible individuals are enrolled in managed care beginning the first day of the month in which Medicaid eligibility is determined.

ii. The MCO must pay for all medically necessary covered services provided during the first month of managed care enrollment for members identified on the HIPAA 834C daily enrollment file as being determined Medicaid eligible.

e. MCO Membership Acceptance, Documentation, and Reconciliation

i. *Medicaid Consumer Hotline Contractor*

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

ii. *Monthly Remittance Advice*

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

iii. *Enrollment and Monthly Capitation Reconciliation*

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

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

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

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

5. ODM will not accept MCO reconciliation requests for enrollment and/or payment beyond the last day of the 18th month after the capitation/enrollment month.

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

7. ODM will not accept newborn reconciliations beyond the last day of the month in which the newborn turns 15 months of age where the MCO has not submitted a Medicaid billing ID as part of the reconciliation process.

iv. *Change in Member Circumstance*

1. In accordance with 42 CFR 438.608, the MCO must notify ODM no later than 30 calendar days after being notified of the date of death of a member. The MCO must notify ODM within one business day of becoming aware of changes in the member's address, phone number, email address, or other relevant contact information.

2. The MCO's notifications must follow ODM prescribed submission guidelines, and be provided in the format prescribed by ODM.

v. *Termination of Enrollment*

1. Pursuant to OAC rule 5160-26-02.1, the MCO must comply with managed care program termination of enrollment requirements.

vi. *MCO-Initiated Nursing Facility Disenrollment requests*

1. Excluding Group VIII-Expansion, pursuant to OAC rule 5160-26-02.1, the MCO must submit MCO-initiated nursing facility disenrollment requests for Modified Adjusted Gross Income (MAGI) and ABD in the format specified by ODM. See disenrollment table below.

Table A.1 Disenrollment Requests

Month of Nursing Facility Admission	Next Two Consecutive Months	Earliest Disenrollment Date
January	February & March	March 31
February	March & April	April 30
March	April & May	May 31
April	May & June	June 30
May	June & July	July 31
June	July & August	August 31
July	August & September	September 30
August	September & October	October 31

Month of Nursing Facility Admission	Next Two Consecutive Months	Earliest Disenrollment Date
September	October & November	November 30
October	November & December	December 31
November	December & January (next CY)	January 31 (next CY)
December	January & February (next CY)	Last Day of February (next CY)

2. If a member is admitted to a nursing facility while enrolled with the MCO and the MCO disenrollment request is submitted after the Earliest Disenrollment Date, the member will be disenrolled as of the last calendar day of the submission month.

3. When a member is admitted to a nursing facility while enrolled with one MCO, then changes to a different MCO:

    a. If the admission date is three months or less prior to the initial enrollment month, the MCO must align the disenrollment request with the Disenrollment Requests table dates.

    b. If the admission date is more than three months prior to the initial enrollment month, the MCO must submit the disenrollment request during the initial enrollment month to disenroll the member the last calendar day of the month prior to the initial enrollment.

4. If a member is admitted to a nursing facility prior to being enrolled with the MCO and was admitted under fee-for-service Medicaid, the MCO must submit a disenrollment request during the initial enrollment month to disenroll the member the last calendar day of the month prior to the initial enrollment. Otherwise, the member will be disenrolled as of the last calendar day of the submission month.

5. In instances where the initial enrollment month is accompanied by an enrollment span with a start reason of First Month Enrollment due to Day 1 Managed Care enrollment, the First Month Enrollment span will also be removed. For example, if HIPAA 834 contains a 1/1/2022 to 1/31/2022 enrollment with a First Month Enrollment start reason and a 2/1/2022 to 12/31/2299 enrollment with assignment start reason then:

    a. The MCO submits a nursing facility disenrollment request on 2/12/2022, which is prior to 2/28/2022. Both the initial enrollment of 2/1/2022 and First Month Enrollment of 1/1/2022 will be deleted.

    b. The MCO submits a nursing facility disenrollment request on 3/15/2022, which is after 2/28/2022. The First Month Enrollment of 1/1/2022 to 1/31/2022, the initial enrollment of 2/1/2022 through the month of submission (3/31/2022) will be covered by the MCO.

6. In all cases, the MCO is responsible for coverage of services and payment through the disenrollment date.

vii. *Change in Enrollment During Hospital/Inpatient Facility Stay*

1. *General*

   a. The MCO must comply with change in enrollment requirements pursuant to OAC rule 5160-26-02.

2. *Responsibilities of Disenrolling MCO*

   a. When the MCO learns of a currently hospitalized member's intent to disenroll through the Consumer Contact Record or the HIPAA 834, the disenrolling MCO must notify the hospital/inpatient facility and treating providers as well as the enrolling MCO, if applicable, of the change in enrollment.

   b. The disenrolling MCO must notify the hospital/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.

   c. The disenrolling MCO must not request or require that a disenrolled member be discharged from the hospital/inpatient facility for transfer to another hospital/inpatient facility.

   d. Should a discharge and transfer to another hospital/inpatient facility be medically necessary, the disenrolling MCO must notify the treating providers to work with the enrolling MCO or ODM as applicable to facilitate the discharge, transfer, and authorization of services as needed.

3. *Responsibilities of Enrolling MCO*

   a. When the enrolling MCO learns through the disenrolling MCO, through ODM, or other means that a new member previously enrolled with another MCO was admitted prior to the effective date of enrollment and remains an inpatient on the effective date of enrollment, the enrolling MCO must contact the hospital/inpatient facility.

   b. The enrolling MCO must verify that it is responsible for all medically necessary covered services from the effective date of MCO membership, including professional charges related to the inpatient stay.

c. The enrolling MCO must inform the hospital/inpatient facility that the admitting/disenrolling MCO remains responsible for the hospital/inpatient facility charges through the date of discharge.

d. The enrolling MCO must work with the hospital/inpatient facility to facilitate discharge planning and authorize services as needed.

e. When the MCO 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 MCO must notify the hospital/inpatient facility and treating providers that the MCO is responsible for the professional charges effective on the date of enrollment, and must work to ensure discharge planning provides continuity using MCO-contracted or authorized providers.

f. Except as provided below regarding members under the age of 21 admitted for an inpatient behavioral health stay, if a member is admitted to a hospital prior to the first day of Medicaid eligibility and retroactive eligibility does not apply, the MCO is responsible for reimbursement of the inpatient hospital claim for the days the member is enrolled in the MCO. The days prior to Medicaid eligibility would be considered non-covered days, and the claim should be processed for payment based upon partial eligibility.

viii. *Change in Enrollment for Behavioral Health Services due to an Inpatient Behavioral Health Admission*

1. Members under the age of 21 admitted to a hospital for an inpatient behavioral health stay with a primary diagnosis of mental illness or substance use disorder will be enrolled in the OhioRISE Plan upon notification of the psychiatric inpatient admission in the Ohio Children's Initiative CANS IT system. OhioRISE Plan enrollment will be effective the date of the inpatient hospital behavioral health admission as specified above in this appendix.

2. The OhioRISE Plan will notify the inpatient behavioral health facility that it is responsible for coverage of the stay, work with the facility to facilitate discharge planning, and authorize services as needed.

3. If the MCO receives an inpatient psychiatric authorization request for a member under the age of 21, the MCO must notify the hospital within one business day of receiving the request that the request will be denied because it is covered by another payer and provide relevant information for submission to the OhioRISE Plan. The MCO must notify the OhioRISE Plan of the admission and assist the OhioRISE Plan with care coordination and discharge planning as specified in Appendix D, Care Coordination.

4. MCOs must deny inpatient behavioral health claims with a principal diagnosis and reimbursement APR-DRG within the behavioral health

range as specified in the OhioRISE Mixed Services Protocol for an OhioRISE eligible member because it is covered by another payer. MCOs must notify the facility and the OhioRISE Plan of the claim denial. If the MCO does not notify the OhioRISE Plan within 30 calendar days of claim receipt, the MCO will be responsible for claims payment to the facility for admit through discharge for this member and be subject to penalty as specified in Appendix N, Compliance.

ix. *Just Cause Requests*

1. Pursuant to OAC rule 5160-26-02.1, the MCO must assist in resolving member-initiated just cause disenrollment requests.

x. *Newborn Notifications*

1. The MCO must comply with the following notification and enrollment requirements for newborns, unless otherwise notified by ODM:

    a. In order to encourage the timely enrollment of newborns, the MCO must provide notification of the birth to the County Department of Job and Family Services within the earlier of five business days of birth or immediately upon learning of the birth.

    b. The MCO must provide the mother's name, social security number, eligibility system case number, 12-digit recipient ID, county of eligibility, and the newborn's name, gender, and date of birth in the format specified by ODM.

    c. The MCO must send the information to the County Department of Job and Family Services again at 60 calendar days from the date of birth if the MCO has not received confirmation by ODM of a newborn's MCO membership via the HIPAA 834 file.

    d. If the MCO does not receive newborn information from the County Department of Job and Family Services within two weeks after the 60-day submission, the MCO must follow established reconciliation procedures in this appendix.

xi. *Eligible Individuals*

1. If an eligible individual, as defined in OAC rule 5160-26-01, contacts the MCO, the MCO must provide member-required, MCO-specific, managed care program information.

2. The MCO 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 MCO must provide an assurance that all MCOs must cover all medically necessary Medicaid-covered health care services and assist members with transitioning their health care services.

xii. *Pending Member*

1. If a pending member (i.e., an eligible individual subsequent to MCO selection or assignment to an MCO, but prior to their membership effective date) contacts the selected MCO, the MCO must provide any membership information requested, including how to access services as an MCO member and assistance in determining whether the eligible individual's current services require prior authorization.

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

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

xiii. *Direct Member Reimbursement*

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

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

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

f. Medicaid Managed Care Quarterly Enrollment Files

i. ODM will send quarterly files to the MCO for enrollment verification.

ii. Details regarding specifications for these enrollment files can be found in ODM's Medicaid Managed Care Organization Quarterly Enrollment Data File Specifications.

iii. On a quarterly basis, the MCO may voluntarily submit to ODM addition and deletion files for member enrollment spans. The MCO may submit a data certification letter with these file submissions, using the form required by ODM.

iv. Specifications for submitting the addition and deletion files and instructions for submitting the associated data certification letter are provided in ODM's Medicaid Managed Care Organization Addition and Deletion Enrollment Data File Specifications.

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

g. Notification of Voluntary Membership for Indians

i. In compliance with the terms of the Ohio Medicaid state plan amendment for the managed care program, the MCO must inform Indians who are members of federally recognized tribes that MCO membership is voluntary. Except as permitted under 42 CFR 438.50(d)(2), federally recognized tribal members are not required to select an MCO in order to receive their Medicaid health care benefits.

ii. The MCO must inform these members of steps to take if they do not wish to be a member of an MCO.

iii. In accordance with 42 CFR 438.14, the MCO must provide access to an Indian Health Care Provider to any enrolled Indian.

3. Privacy Compliance Requirements

a. General

i. The MCO must safeguard confidential information in accordance with state and federal requirements, including but not limited to: the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191); 45 CFR parts 160 and 164, 42 CFR 431, Subpart F; 42 CFR Part 2; 42 CFR Part 457; 42 CFR Part 438; and ORC sections 5101.26, 5101.27, *the Family Educational Rights and Privacy Act (20 U.S.C. § 1232g; 34 CFR Part 99);* and 5160.45 through 5160.481.

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

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

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

b. Data Security Agreement with Board of Pharmacy

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

c. Reporting of Disclosures

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

d. Mitigation Procedures

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

e. Incidental Costs

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

f. System Access Requests

i. The MCO must follow ODM access processes to obtain, maintain, and remove access to all state systems. The MCO must immediately notify ODM when an individual with access to a state system leaves employment. The MCO must cooperate with ODM access audits.

4. Member Requirements

a. Availability of Services

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

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

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

iv. The MCO's population-specific efforts must align with the requirements in Appendix C, Population Health and Quality.

v. The MCO must participate in ODM's population-specific initiatives as requested by ODM.

b. Member Information

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

ii. The MCO must develop and implement a written plan or policy governing accessibility and accommodations for persons with LEP and persons with disabilities. The plan shall require training of pertinent staff on the process. The plan must be made available for review by ODM at ODM's request.

iii. The MCO must provide written notice of nondiscrimination (i.e., that the MCO may not discriminate on the basis of race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, ancestry, genetic information, health status, or need for health services in the receipt of health services) to members.

iv. The MCO must provide written information to members describing how to request language or disability accommodations and how to file a grievance with both the MCO and the HHS Office of Civil Rights.

v. The MCO must comply with the following information requirements for eligible individuals and members, in accordance with applicable federal and state law, including 42 CFR §438.10 and OAC rules 5160-26-03.1, 5160-26-05, and 5160-26-05.1:

1. *Oral Interpretation*

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

2. *Written Translation*

    a. The MCO must make written translation available, in each prevalent non-English language in its service area, as identified by ODM, for written member materials that are critical to obtaining service.

3. *Written Materials*

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

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

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

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

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

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

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

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

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

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

iii. The determination of whether the MCO materials comply with member material requirements is in the sole discretion of ODM.

4. *Contracting for Translation, Oral Interpretation, and Sign Language*

a. If, in accordance with OAC rule 5160-26-05.01, the MCO is financially responsible for providing oral translation, oral interpretation, or sign language services to members while receiving services from a network provider, the MCO must give preference to contracting with local agencies to provide such services.

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

5. *Centralized Communication Database Special Communication Needs*

a. The MCO must collect and use information regarding:

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

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

b. The MCO's database must include all MCO member primary language information, as well as all other special communication needs information for MCO members, as indicated above, when identified by any source, including ODM, the SPBM, the OhioRISE Plan, ODM's consumer hotline, MCO staff, providers, and members.

c. This information regarding special communication needs must be readily available to MCO staff and be used in coordinating communication and services to members, including the selection of a PCP who speaks the primary language of a limited English proficiency member when such a provider is available.

d. Unless otherwise specified by a member, the MCO must ensure that the special communication needs identified by a member (e.g., large print) are applied to subsequent communications with the member so that a member does not have to repeatedly request the accommodation.

e. The MCO must share information on member-specific communication needs with its providers (e.g., PCPs, subcontractors, and Third Party Administrators) as applicable.

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

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

h. The MCO and the SPBM may exchange information, upon request, regarding the special communication needs of the MCO's members.

c. Member Services

i. *Member Services Telephone System*

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

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

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

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

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

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

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

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

ii. *Member Services Responsibilities*

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

    a. Reminding members calling member services of upcoming Medicaid recertification dates when the recertification date is within 90 calendar days;

    b. Accessing Medicaid-covered services;

    c. Obtaining or understanding information on the MCO's policies and procedures;

    d. Understanding the requirements and benefits of the MCO;

    e. Resolving of concerns, questions, and problems;

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

    g. Obtaining information on state hearing rights;

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

    i. Identifying which members are receiving services through the Medicaid School Program (MSP) and identifying any care coordination supports that may be needed;

    j. Appealing to or filing directly with the ODM Office of Civil Rights any complaints of discrimination on the basis of race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, health status, or need for health services in the receipt of health services; and

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

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

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

2. In the event the MCO's member services center receives a call about a matter that is the responsibility of the SPBM or OhioRISE Plan during

normal business hours, the MCO must make a warm transfer to the SPBM's or OhioRISE Plan's member services center. If the call is received after hours or the contact is made other than by phone (e.g., email or fax), the MCO must provide the relevant information to the SPBM or OhioRISE Plan as expeditiously as possible, but no more than one business day from receipt of the contact.

3. In the event the Consumer Contact Record does not identify a member-selected PCP for each assistance group member or if the member-selected PCP is not available, the MCO must:

    a. Select a PCP for each member based on the PCP assignment methodology that is prior-approved by ODM;

    b. Simultaneously notify each member with an MCO-selected PCP of the ability within the first month of initial MCO membership to change the

    c. MCO-selected PCP effective on the date of contact with the MCO; and

    d. Explain that PCP change requests after the initial month of MCO membership must be processed according to the procedures outlined in the MCO member handbook.

iii. *Member Services Hours of Operation*

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

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

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

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

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

6. The MCO must have an after-hours system to route emergent and crisis behavioral health calls directly to Ohio Department of Mental Health and Addiction Services' (OMHAS') statewide crisis line, 988, outside of the MCO's member services hours of operation. The MCO must collaborate with ODM and OMHAS to ensure OMHAS' statewide crisis line will have access to deploy Mobile Response and Stabilization Services (MRSS) providers when necessary.

iv. *Medical Advice Line*

1. The MCO must provide member access to medical advice and direction through a centralized 24 hours per day, seven days a week (24/7) toll-free call-in system, available nationwide. The medical advice line must be available every day of the year.

2. The MCO must staff its medical advice line with appropriately trained medical professionals. For the purposes of meeting this requirement, ODM defines "trained medical professionals" as physicians, physician assistants, licensed practical nurses, and registered nurses.

v. *Member Call Center Performance Standards*

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

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

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

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

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

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

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

i. the call center representative needs to review documentation; or

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

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

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

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

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

4. The MCO must report performance standards more frequently if required by ODM.

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

d. Member Rights

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

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

e. Advance Directives

i. The MCO must:

1. Maintain written policies and procedures that meet the requirements for advance directives as set forth in 42 CFR Part 489 Subpart I;

2. Maintain written policies and procedures concerning advance directives with respect to all adult members receiving medical and/or behavioral health care by or through the MCO to ensure the MCO:

a. Provides written ODM-approved information to all adult members concerning:

i. The member's rights under state law to make decisions concerning their medical and/or behavioral health care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;

ii. The MCO'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;

iii. Any changes in state law regarding advance directives as soon as possible, but no later than 90 calendar days after the proposed effective date of the change; and

iv. The right to file complaints concerning noncompliance with the advance directive requirements with ODM.

b. Provides for education of staff concerning the MCO's policies and procedures on advance directives;

c. Provides for community education regarding advance directives directly or in concert with other providers or entities;

d. Requires that the member's medical record documents whether or not the member has executed an advance directive; and

e. Does not condition the provision of care or otherwise discriminate against a member based on whether the member has executed an advance directive.

f. <u>MCO Member and Family Advisory Council</u>

i. The MCO must convene an MCO Member and Family Advisory Council (council) at least quarterly in each region that the MCO serves. The MCO must offer meeting attendance in person, by phone, or by webinar.

ii. The MCO, through council support and activities, must engage members in such a way as to elicit meaningful input into the MCO's population health and quality improvement (QI) strategies, and strengths and challenges with serving members.

iii. The MCO must ensure that the composition of the council is diverse and representative of the MCO's current membership throughout the region with respect to the members' race, ethnic background, primary language, age, Medicaid eligibility category (Group VIII -Expansion, MAGI, and ABD), and health status.

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

v. The MCO must report the following Member and Family Advisory Council Report to ODM as specified in Appendix P, Chart of Deliverables:

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

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

3. Improvement recommendations developed by each regional council; and

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

5. Grievance and Appeal System

a. General

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

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

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

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

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

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

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

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

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

b. State Hearing Process

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

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

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

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

    a. In this event, the MCO must attempt to contact the member to initiate the MCO appeal process unless the timeframe for a member to file an appeal with the MCO has been exhausted in accordance with OAC rule5160-26-08.4.

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

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

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

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

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

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

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

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

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

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

6. If applicable, the date of the resolution.

d. Grievance and Appeal System Reporting

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

ii. The MCO must submit the Quarterly Grievance and Appeal Summary Report to ODM as specified in Appendix P, Chart of Deliverables. As part of the MCO's report submission, the MCO must include the analysis of individual and aggregate outliers and trends and identify the MCO's actions taken in response.

6. Provider Requirements

a. Provider Services

i. *General*

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

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

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

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

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

ii. *Provider Services Hours of Operation*

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

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

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

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

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

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

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

iii. *Provider Call Center Performance Standards*

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

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

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

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

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

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

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

i. the call center representative to review documentation; or

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

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

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

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

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

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

iv. *Provider Representatives*

1. The MCO, for each region, must designate provider representatives with the training and knowledge to promptly and accurately respond to inquiries and resolve problems raised by providers of all types.

v. *Provider Training*

1. The MCO must ensure providers and subcontractors receive training on applicable program requirements and all necessary MCO operational requirements.

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

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

4. The MCO must maintain records of trainings that occur along with an attendee listing for each training.

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

6. The MCO must make upcoming provider trainings publicly available, including on its website, and must maintain records of past training and related information for at least two years. If the provider training and related information is updated in the two year time period, the previous version should still remain for the two years.

b. Provider Feedback

i. The MCO must have the administrative capacity to offer feedback to individual providers on the provider's adherence to evidence-based practice guidelines, and positive and negative care variances from standard clinical pathways that may impact outcomes or costs.

ii. The MCO must use this information to guide MCO activities, such as performance improvement projects for providers that include incentive programs, or the development of QI programs.

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

c. Notification of MCO Policy Changes

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

d. Provider Manual

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

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

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

iv. The MCO must post the provider manual on its website.

e. Billing Guides

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

1. Collaborate with ODM when developing billing guides to minimize the complexity of conducting business with the State Medicaid agency.

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

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

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

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

f. Information for ODM-Designated Providers

i. The MCO must share specific information with federally qualified health centers (FQHCs)/rural health clinics (RHCs), qualified family planning providers, hospitals, and if applicable, certified nurse midwives, certified nurse practitioners, and free-standing birth centers as defined in OAC rule 5160-18-01 within the MCO's service area and in bordering regions, if appropriate, based on member utilization information.

ii. The information must be shared within the first month after the MCO has been awarded a Medicaid provider agreement for a specific region and annually thereafter.

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

a. The information's purpose;

b. Claims submission information, including the MCO's Medicaid provider number for each region (this information must only be provided to out-of-network FQHCs/RHCs, qualified family planning

providers, certified nurse midwives, certified nurse practitioners, and hospitals). Claims submission information must include 30 calendar day advance notice to providers of any new edits or system changes related to claims adjudication or payment key processing;

c. The MCO's prior authorization and referral procedures;

d. A picture of the MCO ID card (front and back);

e. Contact numbers for obtaining information for eligibility verification, claims processing, referrals, prior authorization, post-stabilization care services, and if applicable, information regarding the MCO's behavioral health administrator; and

f. A listing of the MCO's laboratories and radiology providers.

g. Provider Claim Resolution

i. Provider Claim Inquiry Resolution

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

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

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

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

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

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

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

ii. *Provider Claim Inquiry Resolution Tracking and Reporting*

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

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

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

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

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

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

i. Inquiry Category

ii. Claim Number;

iii. Received Date; and

iv. Provider type.

iii. *Provider Claim Dispute Resolution Process*

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

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

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

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

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

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

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

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

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

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

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

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

i. When required, the written notice must include:

    i. The nature of the dispute;

    ii. The claim dispute tracking number;

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

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

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

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

j. Reprocess and pay disputed claims, when the resolution determines they were paid/denied incorrectly, within 30 calendar days of the written notice of the resolution unless a system fix is needed then additional time is allotted; and

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

iv. *Provider Claim Dispute Resolution Tracking and Reporting*

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

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

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

2. The MCO must evaluate the effectiveness of the claim dispute resolution system and identify opportunities to improve the provider experience.

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

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

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

      i. Dispute Category;

      ii. Claim Number;

      iii. Received Date;

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

      v. Provider type; and

      vi. Resolution date.

h. External Medical Review

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

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

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

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

ii. Decisions subject to external medical review include an adverse benefit determination in response to a service authorization request or claim payment denial due to lack of medical necessity. Service authorization requests and claim payments that are denied for reasons other than lack of medical necessity and for which no clinical review was completed by the MCO are not subject to external medical review. If a plan incorrectly denies without a medical necessity review, they cannot prevent a provider from using the EMR process.

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

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

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

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

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

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

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

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

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

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

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

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

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

x. The MCO must comply with the written decision from the entity identified by ODM to perform external medical reviews. For reversed service authorization decisions, the MCO must authorize the services promptly and as expeditiously as the member's health condition requires, but no later than 72 hours from when the MCO receives the external medical review decision.

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

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

xiii. The MCO must periodically evaluate the effectiveness of the external medical review process and identify opportunities to improve the provider experience.

xiv. The MCO must use information collected from the external medical review process to improve service authorization decision-making.

i. Provider Web Portal Complaints

i. The MCO must check ODM's Provider Web portal (hereinafter referred to as HealthTrack) complaint inbox daily for updates and new complaints assigned to them.

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

a. Conducting outreach to the provider through an in-person visit, a phone call, or an email. If attempting to make contact via phone and the appropriate person is unavailable, the MCO must leave a voicemail.

b. Outreach must include that the complaint was received and that the MCO will respond by the assigned due date; and

c. Documenting the MCO's initial contact with the provider in HealthTrack within six business days of the submission of the complaint to include the following information:

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

ii. A call reference number if applicable;

iii. The method(s) of contact;

iv. The person that made the contact; and

v. The name of the individual(s) contacted.

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

a. Provider contact must include:

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

   ii. The assigned MCO provider representative's contact information;

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

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

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

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

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

   ii. The method or methods of contact;

   iii. The name of the individual or individuals contacted;

   iv. The findings shared with the provider;

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

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

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

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

   ii. Document the MCO's outreach to the provider in HealthTrack, including the date of the provider contact, the name(s) of the individual(s) contacted, the requested

extension date, and the justification for the delay in resolution.

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

7. MCO Website Requirements

a. General

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

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

iii. The MCO must have a mobile version of MCO website content.

iv. The MCO must ensure that all information is located on the MCO's website in a manner that members and providers can easily find and navigate to and from the MCO's home page.

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

vi. The MCO must post a listing of the regions and counties the MCO serves, unless the MCO serves the entire state, in which case the MCO must indicate it serves the entire state.

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

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

ix. The MCO's website must have a link to the OhioRISE Plan and information about the OhioRISE Plan that includes:

1. A description of the OhioRISE Plan and MCO responsibilities;

2. OhioRISE eligibility requirements;

3. Process for referring children/families for a CANS assessment;

4. A list of CANS providers; and

5. The general timeframe for a CANS assessment and OhioRISE eligibility determination.

x. The MCO must post all Healthchek information on its website as specified in Appendix B, Coverage and Services.

xi. The MCO must post prominent, easily understood information on its website for members and providers regarding the optimization of pregnancy outcomes.

1. The MCO must include information for providers, trusted messengers (i.e., community health workers), and members about the prevention of preterm birth by linking to the Ohio Perinatal Quality Collaborative's information about best practices at https://www.opqc.net/prematurity-prevention?adlt=strict..

2. The MCO must include a link to the official ODM notification of pregnancy and risk assessment form (PRAF 2.0) located at https://progesterone.nurtureohio.com/login with a statement encouraging network providers to complete and submit the form to assist pregnant women in maintaining Medicaid eligibility and connecting to needed services and supports (e.g., home visiting).

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

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

xiv. The MCO must include additional information on its website as determined necessary by ODM.

b. Online Member Website

i. *Member Information*

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

2. The MCO member website must also include the following information, which must be accessible to members and the general public without any log-in restrictions:

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

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

c. The ODM-approved MCO member handbook, Quick Guide, SPBM insert, recent newsletters, and announcements:

    i. The MCO's online version of its member handbook must offer hyperlinks from the table of contents to the applicable section or topic.

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

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

f. Information about the MCO's member incentive programs;

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

    i. Change of address (County);

    ii. Grievance and appeal form;

    iii. Change of PCP;

    iv. Authorized representative;

    v. Advanced Directive; and

    vi. Any other forms the MCO requires the member to complete.

h. A list of services requiring prior authorization;

i. A 30-calendar days' advance notice of changes to the list of all services requiring prior authorization:

    i. The MCO must provide a hard copy of the notification of any Prior Authorization changes upon request.

j. The toll-free telephone number for the 24/7 medical advice call-in system specified in this appendix; and

k. Contact information and links to schedule non-emergency transportation assistance, including an explanation of the available services, and to contact member services for transportation services complaints.

3. The MCO must ensure that toll-free member services, 24/7 call-in systems, statewide and local behavioral health crisis response, and transportation scheduling telephone numbers are easily identified on

either the MCO's website home page or a page that is a direct link from a contact button on the home page.

ii. *Secure Member Portal*

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

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

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

    c. Request a change in PCP.

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

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

    a. The member's redetermination date;

    b. Authorized services;

    c. The member's current PCP;

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

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

    f. Community resources; and

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

c. Online Provider Website

i. *Secure Provider Portal*

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

    a. Access relevant member information to:

        i. View member eligibility and enrollment, including information when members are enrolled in OhioRISE;

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

iii. Access claims and utilization history.

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

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

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

ii. *Publicly-Available Provider Page*

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

a. The MCO's provider services contact information for provider issues;

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

c. Links to policies and prominent alerts that notify providers of changes to MCO coverage processes and policies:

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

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

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

e. Instructions for submitting claims and prior authorizations to the MCO and ODM-supplied provider instruction regarding submitting claims through the OMES;

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

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

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

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

j. The MCO must make information regarding upcoming provider trainings publicly available on its website for easy accessibility.

8. Staffing Requirements

a. General Requirements

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

ii. The MCO must provide ODM with an MCO Organizational and Functional Chart that identifies key staff, organizational staff and reporting lines as specified in Appendix P, Chart of Deliverables. This chart must also include work telephone numbers and work email addresses for all key staff. Personal phone numbers and email addresses should not be included.

iii. Prior to the implementation of this Agreement, the MCO must ensure ODM-identified key and organizational staff are in place within the timeframe established by ODM as part of the readiness review requirements in this appendix.

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

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

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

b. Key Staffing Requirements

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

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

iii. An MCO key staff member may occupy a similar position under the MCO's MyCare Ohio line of business, but may not occupy a position for any other line of business (e.g., commercial plan), unless the MCO receives prior written approval from ODM stating otherwise.

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

1. MCO notification must include the name of interim or permanent staff fulfilling the position responsibilities, and the individual's experience and credentials demonstrating minimum key staff requirements under this Agreement are met, and the individual's contact information.

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

c. Key Staff

i. *Administrator/Chief Executive Officer/Chief Operating Officer*

1. The Administrator/Chief Executive Officer (CEO)/Chief Operating Officer (COO) must fulfill the responsibilities of the position to oversee the entire operation of the MCO and have clear local authority over the general administration and implementation of all requirements set forth in this Agreement. The Administrator/CEO/COO must devote sufficient time to the MCO's operations to ensure adherence to program requirements and timely responses to ODM.

ii. *Medical Director/Chief Medical Officer*

1. The Medical Director/Chief Medical Officer (CMO) must be a physician with a current, unencumbered license through the Ohio State Medical Board. The Medical Director must have at least three years of training in a medical specialty.

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

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

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

c. Developing, implementing, and interpreting medical policies and procedures, including service authorization, claims review,

discharge planning, and medical reviews performed through the MCO's grievance and appeal system;

d. Leading the administration of all medical management activities of the MCO; and

e. Serving as the director of the Utilization Management (UM) committee and chairperson or co-chair of the Quality Assessment and Performance Improvement (QAPI) committee.

iii. *Chief Financial Officer*

1. The Chief Financial Officer (CFO) must oversee the MCO's budget and accounting systems and operations. The CFO must have access to an actuary and is responsible for ensuring that the MCO meets ODM requirements for financial performance and reporting.

iv. *Behavioral Health Administrative Director*

1. The Behavioral Health Administrative Director must possess an independent, current, and unrestricted Ohio license to provide behavioral health services in the state of Ohio (medical doctor, doctor of osteopathic, registered nurse with advance practice registered nurse [APRN] licensure, psychologist, licensed independent social worker [LISW], professional clinical counselor [PCC], independent marriage and family therapist) with a minimum of five years of experience in the provision and supervision of treatment service for mental illness and substance use disorders. The Behavioral Health Administrative Director must demonstrate knowledge and understanding of Ohio's overall behavioral health system that includes mental health, alcohol and drug addiction, and developmental disabilities services.

2. The responsibilities of the Behavioral Health Administrative Director include but are not limited to:

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

b. Ensuring access to behavioral health services;

c. Ensuring systematic screening for behavioral health related disorders by utilizing standardized and evidence-based approaches;

d. Promoting preventive behavioral health strategies;

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

f. Participating in management and program improvement activities with other key staff (including the Behavioral Health Clinical

Director) for enhanced integration with primary care and coordination of behavioral health services and achievement of outcomes; and

g. Working with the Behavioral Health Clinical Director as needed in the development and maintenance of programs and systems.

v. *Behavioral Health Clinical Director*

1. The Behavioral Health Clinical Director must be full-time, or a combination of part-time dedicated staff to be at least a full-time equivalent, with continuous engagement to perform the functions of the Behavioral Health Clinical Director.

2. The Behavioral Health Clinical Director(s) must be practicing within the scope of their license and hold a current unrestricted Ohio license as a Clinical Psychologist, a specialized advanced practice provider with at least two years of dedicated experience in behavioral health, or a Board-Certified Psychiatrist with a minimum of three years of professional experience in a clinical behavioral health setting. The Behavioral Health Clinical Director must have expertise in behavioral health activities and QI projects.

3. The MCO must have a Behavioral Health Clinical Director with children's behavioral health expertise.

4. The MCO must have at least one Board-Certified Psychiatrist, who must be a prescriber, to perform the following Behavioral Health Clinical Director functions:

    a. Play a lead role in monitoring the overall safety of members with a behavioral health, with a special focus on safe prescribing of psychotropic medications as well as all controlled substances;

    b. Have expertise in the care of individuals with substance use disorders, including the American Society of Addiction Medicine levels of care;

    c. Serve as a key clinical lead in developing and implementing evidence-based clinical policies and practices at both the MCO and the clinical practice levels. This will necessarily require the integration of relevant pharmacy and social data to inform clinical policies and practices;

    d. Participate in regulatory/accreditation reviews; and

    e. Assume key roles in quality improvement initiatives, care management activities, and member safety activities (e.g., incident management).

5. Other duties and responsibilities of the Behavioral Health Clinical Director staff must include:

    a. Overseeing utilization management of behavioral health services to ensure members receiving timely, appropriate, and medically necessary behavioral health care in the most cost-effective setting;

    b. Engaging in oversight and quality improvement activities associated with care management activities;

    c. Providing guidance to behavioral health network development and recruitment in conjunction with provider relations, value-based contracting, support of episodes of care, and full integration of behavioral health services;

    d. Assisting in the review of utilization data to identify variances in patterns, and providing feedback and education to MCO staff and providers as appropriate;

    e. Representing the MCO as the behavioral health clinical liaison to members, providers, and ODM; and

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

vi. *Pharmacy Director*

1. The MCO must have a Pharmacy Director who is a registered pharmacist in the state of Ohio with experience in state and federally funded health care programs, preferably with pharmacy benefit management experience.

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

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

    b. Coordinating with the SPBM;

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

    d. Overseeing the MCO's medication therapy management programs;

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

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

vii. *Dental Director*

1. The MCO must have a Dental Director who is not required to be full time, but must be sufficiently dedicated to meet the roles and responsibilities of the position.

2. The MCO's Dental Director must be a dentist with a current, unencumbered license with the Ohio State Dental Board.

3. The primary roles and responsibilities of the Dental Director include:

   a. Developing and leading the MCO's dental strategy to meet ODM requirements, incorporating oral health prevention and treatment into the MCO's population health efforts and the delivery of holistic, person-centered, integrated care;

   b. Developing and implementing strategies to expand member access to dental services, including recruiting and expanding the service delivery capacity of dental providers;

   c. Overseeing MCO performance on dental performance measures as specified in Appendix I, Quality Measures;

   d. Implementing an ODM-developed, unified dentist manual and prior authorization requirements; and

   e. Overseeing utilization management of dental benefits to ensure members receive timely, appropriate, and medically necessary dental care.

viii. *Population Health Director*

1. The Population Health Director must:

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

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

   c. Report directly to the MCO's Medical Director/CMO or Administrator/CEO/COO.

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

    a. Oversee the MCO's strategic design, implementation, and evaluation of population health initiatives based on a deep understanding of scientific population health principles;

    b. Sponsor and champion MCO and system-wide initiatives, including cultivating the support necessary to achieve the desired operational objectives for each initiative;

    c. Liaison with ODM, the OhioRISE Plan, the SPBM, and other ODM-contracted MCOs on population health activities; and

    d. Develop and implement operational plans that address the market opportunities/challenges and align with the established population health goals.

ix. *Community Initiatives Director*

1. The Community Initiatives Director must:

    a. Hold at least a bachelor's degree from a recognized college or university and a minimum of five years' professional work experience, preferably in public health, social/human services, social work, public policy, health care, education, community development, or justice;

    b. Have demonstrated community and stakeholder engagement experience; and

    c. Have experience in actively applying or overseeing the application of science-based quality improvement methods to reduce differences in health outcomes.

2. The primary roles and responsibilities of the Community Initiatives Director are to:

    a. In close coordination with the Population Health Director, oversee the MCO's strategic design, implementation, and evaluation of population-specific improvement efforts in the context of the MCO's population health initiatives;

    b. Inform decision-making around best payer practices to ensure optimal outcomes for all populations through provision of applicable and relevant population-specific and community-based research and resources, as well as ensuring member perspectives from all subpopulations are incorporated into the codesign of policy and service provision, including the tailoring of population-specific intervention strategies;

c. Collaborate with the MCO's Chief Information Officer to ensure the MCO collects and meaningfully uses race, ethnicity, and language data to identify opportunities for improvement;

d. Coordinate and collaborate with members, providers, local and state government, community-based organizations, ODM, and other ODM-contracted managed care entities to impact differences in health outcomes at a population level; and

e. Ensure that efforts to address poor health outcomes are codesigned with the sub-population and their providers, and are designed collaboratively with other ODM-contracted managed care entities to have a collective impact for the population and that lessons learned are incorporated into future decision-making.

x. *Quality Improvement Director*

1. The QI Director must:

a. Be an Ohio-licensed registered nurse, physician, or physician's assistant, or be certified as a Certified Professional in Health Care Quality by the National Association for Healthcare Quality (NAHQ), Certified QI Associate by the American Society for Quality, and/or Certified in Health Care Quality and Management (CHCQM) by the American Board of Quality Assurance and Utilization Review Providers prior to employment or within six months of the date of hire;

b. Have experience in quality management and quality improvement as specified in 42 CFR 438.206 through 438.370; and

c. Report directly to the Medical Director/CMO.

2. The primary functions of the QI Director are to:

a. Develop and manage the MCO's portfolio of improvement projects, including ensuring impact at a population level and identifying and prioritizing initiatives to align with ODM's Quality Strategy;

b. Oversee MCO improvement teams and coordinate QI training for MCO staff;

c. Reinforce the application of QI tools and methods within MCO improvement projects and initiatives; and

d. Ensure that learning from all improvement projects and initiatives are shared with ODM and ODM's contracted managed care entities.

xi. *Care Coordination Director*

1. The Care Coordination Director must be an Ohio-licensed registered nurse or an Ohio-licensed independent social worker in good standing, preferably with a designation as a Certified Case Manager from the Commission for Case Manager Certification. The Care Coordination Director must have experience in the activities of care management as specified in 42 CFR 438.208. The Care Coordination Director must report through the Medical Director/CMO.

2. The primary functions of the Care Coordination Director position are to:

    a. Oversee the day-to-day operational activities of the Care Coordination Program in accordance with state guidelines. The Care Coordination Director is responsible for ensuring the functioning of care coordination activities across the continuum of care (assessing, planning, implementing, coordinating, monitoring, and evaluating);

    b. Implement mechanisms for identifying, assessing, and developing treatment plans for members with special health care needs;

    c. Ensure access to primary care, behavioral health, and coordination of health care services for all members;

    d. Serve as the MCO's primary point of contact for the OhioRISE Plan on care coordination;

    e. Develop and implement processes and resources for providing support to members who opt out of care coordination;

    f. Coordinate services furnished to the member with the services the member receives from any other health care entity; and

    g. Ensure care coordination and disease management is part of population health and QI activities, when appropriate.

    h. Identify which children are participating in the Medicaid School Program (MSP) and what school-based services they are receiving through the MSP.

    i. Serve as the MCO’s primary point of contact for the MSP.

xii. *Utilization Management Director*

1. The Utilization Management Director must:

    a. Be an Ohio-licensed registered nurse or a physician with a current unencumbered license through the Ohio State Medical Board with experience in the activities of utilization management, in accordance with 42 CFR 438.210;

b. Preferably be certified as a Certified Professional in Health Care Quality by the NAHQ and/or CHCQM by the American Board of Quality Assurance and Utilization Review Providers; and

c. Report through the Medical Director/CMO.

2. The Utilization Management Director's primary responsibilities are to:

a. Oversee the day-to-day operational activities of the Utilization Management Program in accordance with state guidelines;

b. Develop written policies and procedures regarding authorization of services and monitor to ensure that these are followed;

c. Ensure the consistent application of review criteria for authorization decisions;

d. Ensure that decisions to deny or reduce the amount of services are made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease;

e. Ensure MCO Notices of Adverse Action are provided in accordance with 42 CFR 438.404;

f. Ensure that all authorization decisions are made within the specified allowable timeframes; and

g. Evaluate under and over utilization information for impact on member quality of care and outcomes, including access to care.

xiii. *Early and Periodic Screening, Diagnosis, and Treatment/Maternal Child Health Manager*

1. The early and periodic screening, diagnosis, and treatment (EPSDT)/Maternal Child Health Manager must be an Ohio licensed registered nurse, physician, or physician's assistant; or has a master's degree in health services, public health, or health care administration or another related field, and/or is a Certified Professional in Health Care Quality or CHCQM.

2. The primary functions of the EPSDT/Maternal Child Health Manager are to:

a. Ensure member receipt of all EPSDT services;

b. Ensure member receipt of maternal and postpartum care;

c. Promote family planning services;

d. Promote preventive health strategies;

e. Promote the coordination of school-based services;

f. Identify and coordinate assistance for identified member needs specific to maternal/child health and EPSDT;

g. Interface with community partners and pregnancy related services coordinators; and

h. Participate in EPSDT and maternal child quality and performance improvement efforts.

xiv. *Network Development Director*

1. The Network Development Director is responsible for network development, network sufficiency, and network reporting functions. This position ensures network adequacy and appointment access, develops network resources in response to identified unmet needs and oversees network provider workforce development activities.

xv. *Provider Services Director*

1. The Provider Services Director acts as the primary point of accountability to ODM to address escalated provider issues.

2. The primary functions of the Provider Services Director are to:

a. Meet provider services requirements under this Agreement;

b. Supply provider education and develop and deliver provider training;

c. Ensure that network providers impacted by population health initiatives, such as QI projects, are included on project teams to identify provider perceived barriers and provide input on design and intervention test that may impact providers;

d. Ensure that network provider perspectives and feedback are included in evaluations of improvement initiative successes;

e. Collaborate with other ODM-contracted managed care entities to simplify provider requirements and remove administrative barriers; and

f. Develop and implement the MCO's provider claim dispute resolution process as described in this appendix.

xvi. *Claims Administrator*

1. The Claims Administrator is responsible for ensuring prompt and accurate provider claims processing. Sufficient staffing under this position must be in place to ensure the timely and accurate processing of original claims, resubmissions, and overall adjudication of claims.

2. The primary functions of the Claims Administrator are to:

a. Develop and implement claims processing systems capable of paying claims in accordance with state and federal requirements;

b. Develop processes for cost avoidance;

c. Ensure minimization of claims recoupments; and

d. Ensure claims processing timelines are met.

xvii. *Encounter Manager*

1. The Encounter Manager is responsible for ensuring ODM encounter reporting requirements are met. Sufficient staff under this position must be in place to ensure the submission of timely, accurate and complete encounter data to ODM.

xviii. *Chief Information Officer*

1. The Chief Information Officer (CIO) must be fully dedicated to the work under this Agreement and authorized to prioritize change orders and allocate the resources necessary to develop and maintain an information system that meets the performance expectations under this Agreement.

2. The CIO must have the necessary training and experience in information systems, data processing, and data reporting to oversee all information systems functions supporting this Agreement.

3. The primary functions of the CIO are to:

   a. Ensure that multiple MCO data systems are able to connect and coordinate so that fields housed in one system (e.g., updated contact information) can readily inform other systems;

   b. Ensure that information related to data systems, analytical methods, and analysis results is communicated in a way that allows optimal usage by all MCO programmatic areas;

   c. Ensure that program areas are aware of, and understand how to use data resources (e.g., files received from ODM, Health Information Exchanges, Electronic Health Records, and data from MCO contractors) and integrate those resources with programmatic data when necessary;

   d. Ensure that member and provider facing websites and portals are easily navigable by the general public, members, and providers by obtaining and incorporating feedback from these stakeholders;

   e. Ensure that Information Technology projects are implemented timely and correctly, as specified by ODM;

   f. Coordinate with other ODM-contracted managed care entities and ODM to create a seamless view of the Ohio Medicaid interface with

the public, members, and providers, resulting in all members interacting with Ohio Medicaid having a uniform way to access information; and

g. Support program areas to integrate information contained within multiple data systems for use in improvement activities.

xix. *Grievance and Appeal Director*

1. The primary functions of the Grievance and Appeal Director are to:

a. Establish and implement a grievance and appeals system pursuant to OAC rule 5160-26-08.4 and in accordance with 42 CFR Part 438, Subpart F;

b. Ensure the MCO's grievance and appeals system functions in two ways:

i. As an essential process to remediate member access to care and quality concerns; and

ii. As a source of information that serves as indicators of health care system issues and concerns.

c. Share and review grievance and appeal system data with other operational areas, such as population health/quality management, utilization management, network management, member services, and program integrity to collectively develop and monitor interventions to correct system deficiencies.

xx. *Member Services Director*

1. The Member Services Director is responsible for coordinating communications with members, resolving member inquiries and problems, and meeting member service requirements as required in this Agreement. The Member Services Director must also:

a. Ensure that members impacted by population health initiatives, such as QI projects, are included on the project team to identify member perceived barriers and to assist with the design and testing of interventions impacting members;

b. Ensure that member perspectives and feedback are included in evaluations of improvement initiative success; and

c. Ensure that pertinent knowledge obtained through the MCO's population health improvement initiatives is incorporated into member services.

xxi. *Chief Compliance Officer*

1. The Chief Compliance Officer is responsible for developing and implementing a compliance program and policies and procedures designed to ensure compliance with the requirements in this Agreement.

2. The Chief Compliance Officer must report to the Administrator/CEO/COO and the MCO's Board of Directors, and must be solely dedicated to ensuring MCO compliance with this Agreement.

xxii. *Lead Investigator (Special Investigative Unit)*

1. The Lead Investigator must hold either:

    a. A bachelor's degree with a minimum of two years of experience in the healthcare field working in fraud, waste, and abuse investigations and audits; or

    b. An associate's degree, with a minimum of four years of experience working in health care fraud, waste, and abuse investigations and audits.

    c. Experience and training/certifications commensurate with position requirements in lieu of formal educational requirements for the Lead SIU Investigator position may be considered. ODM will determine whether a potential Lead investigator's experience and certifications are acceptable when the stated educational requirements are not met, on a case-by-case basis.

2. The Lead Investigator must be proficient in their ability to understand and analyze health care claims and coding, and must be solely dedicated to Special Investigative Unit (SIU) responsibilities required under this Agreement.

3. The primary responsibilities of the Lead Investigator are to:

    a. Identify risk, and guard against fraud, waste, and abuse throughout the MCO's service delivery system;

    b. Actively monitor for aberrant providers;

    c. In a timely manner, refer potential fraud, waste, and abuse to ODM as required in Appendix G, Program Integrity; and

    d. Actively participate in any meetings identified by ODM, including but not limited to Managed Care Program Integrity Group meetings, the biweekly Home Health Care Fraud Referral meeting, and quarterly Special Investigation Unit lead meetings.

xxiii. *MCO Contract Administrator*

1. The MCO Contract Administrator must serve as the primary point of contact for all MCO operational issues.

2. The primary functions of the MCO Contract Administrator include but are not limited to:

    a. Coordinating the tracking and submission of all contract deliverables;

    b. Fielding and coordinating responses to ODM inquiries; and

    c. Coordinating, preparing for, and facilitating random and periodic audits and site visits.

xxiv. *Transition Coordinator*

1. The Transition Coordinator must serve as the MCO's primary point of contact for planning and managing all MCO transition activities, including member transitions of care as identified in Appendix D, Care Coordination, and transitions resulting from MCO termination and/or non-renewal, as identified in Appendix O, MCO Termination and Non-Renewal.

2. The primary functions of the Transition Coordinator include:

    a. Coordinating the development and submission of the MCO's transition plan;

    b. Coordinating the tracking and submission of all transition-related reports and deliverables;

    c. Coordinating MCO representation and attendance for ODM identified transition meetings;

    d. Coordinating and overseeing all member transition activities to ensure the safe, timely, and orderly transition of members and their care; and

    e. Coordinating the development of submission of MCO transition plan updates and final report to ODM.

d. MCO Organizational Staff

i. *Provider Services Representatives*

1. The MCO must have Provider Services Representative sufficient in number to meet the standards set forth in this Agreement.

a. Provider Services Representatives are responsible for ensuring providers receive prompt resolution to provider issues, including problems with claims payment, prior authorizations, and referrals.

b. Provider Services Representatives must be regionally based and familiar with the communities and providers serving that region.

ii. *Regional Coordinators*

1. The MCO must have Regional Coordinators who develop and execute MCO engagement activities in priority communities.

2. The primary responsibilities of Regional Coordinators are to:

a. Serve as the MCO's primary points of contact for ODM-approved improvement efforts involving community-based organizations and requiring community outreach and active involvement in priority communities (e.g., community-based infant mortality reduction, school-based health services);

b. Attend or oversee MCO attendance at community events in priority communities (e.g., trainings, racism dialogues, infant mortality awareness events, events hosted by the public school district such as parent night, open houses and health fairs);

c. Provide in-person communication with ODM or other state agency funded community-based organizations in order to bolster the presence of the MCO itself as a collaborative and trusted partner of the community-based organization and as a supporter of the ODM initiative;

d. Collaborate with other MCO Regional Coordinators to collectively strategize and address community concerns;

e. As needed, coordinate the tracking and submission of process measures related to MCO improvement efforts in communities (e.g., infant mortality reduction efforts in high priority areas, academic measures for children);

f. Promote the referral of members to community-based organizations when services are provided that will promote better pregnancy outcomes (e.g., Centering Pregnancy);

g. Understand the MSP and coordinate with public school districts as necessary;

h. Respond to ODM inquiries related to MCO community engagement activities.

iii. *Special Investigative Unit Staff*

1. The MCO must maintain adequate staffing and resources for its Special Investigative Unit (SIU) that includes, at a minimum, one SIU staff person per 60,000 members.

2. The MCO's proposed SIU staffing must be included in the MCO's fraud, waste, and abuse plan described in Appendix G, Program Integrity.

3. The MCO must ensure that all SIU staff investigators meet the following qualifications:

    a. A minimum of two years in a health care field working on fraud, waste, and abuse investigations and audits;

    b. A bachelor's degree, or an associate's degree with an additional two years working on health care fraud, waste, and abuse investigations and audits;

    c. The ability to understand and analyze health care claims and coding.

iv. *Population Health Staffing*

1. In addition to senior clinical leadership, the MCO must employ sufficient population health staffing to improve population health outcomes, including the creation of new processes and procedures through iterative testing and evaluation that, at a minimum, incorporates insights from data, research, members, and providers.

2. The MCO's population health staff must understand and execute their role in responding quickly and agilely to the needs of internal (i.e., MCO staff) and external stakeholders (e.g., ODM).

3. The MCO's population health staffing must include community initiative staff, and staff in the fields of analytics, statistics, and informatics.

v. *Member Services Staffing*

1. MCO member services staffing must be sufficient to designate at least one member-relations staff position per population health stream to serve as the contact to address barriers identified by members during QI projects aimed at improving member outcomes.

vi. *Provider Services Staffing*

1. MCO provider services staffing must be sufficient to designate at least one provider-relations staff position per population health stream to serve as the contact to address barriers identified by providers during QI projects aimed at improving member outcomes.

vii. *Utilization Management Staff*

1. The MCO must employ appropriately qualified, licensed staff with subject matter expertise to review prior authorization requests. Appropriately qualified, licensed staff includes but is not limited to dentists, specialist physicians, registered nurses, and licensed behavioral health professionals.

2. The MCO must not use generalists to review and make prior authorization decisions for specialty services (e.g., services for substance use disorders, durable medical equipment).

viii. *Care Coordination Staff*

1. The MCO must employ care coordination staff to support the care coordination and population health needs of its members as specified in Appendix D, Care Coordination.

ix. *Other Organizational Staff*

1. The MCO must employ sufficient organizational staff and appropriately utilize staffing resources to comply with this Agreement. ODM will evaluate staffing adequacy based on the MCO's ability to achieve compliance with this Agreement.

e. MCO Staff Training Requirements

i. The MCO must ensure staff have appropriate education and experience, and provide staff training and orientation to enable staff fulfill the requirements of this Agreement.

ii. The MCO must ensure staff receive training on applicable program requirements commensurate with position responsibilities.

iii. The MCO must use the most appropriate training methods, which may include instructor-lead and web-based trainings.

iv. The MCO must submit an MCO Staff Training Plan, including the topics and frequency of training, to ODM for prior review and approval as specified in Appendix P, Chart of Deliverables. At a minimum, the MCO training must include:

1. Orientation to the Ohio Medicaid managed care program, including roles and responsibilities of the MCO, CCEs, OhioRISE Plan, care management entities (CMEs), SPBM, and MSP;

2. Training on incorporation of member perspectives to codesign policies, services, and supports, as well as remove implicit bias;

3. Training on the identification and report of fraud, waste, and abuse;

4. "Question, persuade, and refer" training for all Care Management staff and 24/7 medical advice line staff; and

5. Any additional training topics as directed by ODM.

v. The MCO must ensure that individuals who develop and deliver training have demonstrable experience and expertise in the topic for which they are providing training.

9. Subcontractual Relationships and Delegation

a. General Requirements

i. The MCO may delegate administrative responsibilities subject to the requirements in this section.

ii. Unless otherwise specified by ODM, administrative services include care management, marketing, utilization management, quality improvement, enrollment, disenrollment, membership functions, claims administration, provider network management, and coordination of benefits.

iii. For any other administrative functions not listed above that could impact a member's health, safety, welfare, or access to covered services, the MCO must contact ODM to request a determination of whether the function may be included as an administrative service that complies with the provisions listed herein.

iv. Delegation requirements do not apply to care management arrangements between the MCO and a Comprehensive Maternal Care Practice, Comprehensive Primary Care Practice or Patient Centered Medical Home as cited in Appendix D, Care Coordination.

v. With the exception of transportation vendors, the MCO must not publish a delegated entity's general call center number.

vi. For purposes of this Agreement, parties to administrative services arrangements and related terms are defined as follows:

1. "First tier entity" means any party that enters into a written arrangement, acceptable to ODM, with the MCO to provide administrative services for Ohio Medicaid-eligible individuals.

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

3. "Related entity" means any related party to the MCO by common ownership or control under an oral or written arrangement to perform some of the administrative services under the MCO's contract with ODM. A related party includes but is not limited to agents, managing employees, individuals with an ownership or controlling interest in the MCO and their immediate families, subcontractors, wholly-owned subsidiaries or

suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or individuals.

4. "FDR" is the collective term for first tier, downstream, and related entities.

5. "FDR agreement" is the written agreement between the MCO and an FDR to delegate administrative responsibilities or service.

b. First Tier, Downstream, and Related Entities Agreements

i. If the MCO delegates administrative responsibilities or services under this Agreement to any first tier, downstream, and related entities (FDR), the MCO must ensure it has an FDR agreement with the FDR to perform administrative services on the MCO's behalf.

ii. The following requirements apply to all FDR agreements.

1. The MCO must evaluate the FDR's ability to perform the administrative services before executing or renewing any FDR agreement.

2. The MCO must notify ODM of a proposed new FDR agreement, amendment or termination at least 45 calendar days prior to the execution or termination of the FDR agreement, the MCO must use the ODM-approved notification process so that ODM can review the information provided. ODM, in its sole discretion, may require the MCO to submit the complete and exact text of the proposed new or amendment of an FDR agreement for ODM review. Unless otherwise specified by ODM, FDR agreements may not be executed, amended, or terminated until ODM has completed its review of the information contained in the notification, and its review of the FDR agreement as applicable.

3. For new, amended, or terminated FDR agreements that directly impact members access to care, claims, provider payments, require system testing, member communication or clinical policy review, or otherwise would require an implementation or transition timeline longer than 45 days, the MCO must ensure there is minimal disruption to members and providers throughout the implementation or transition. The MCO must notify the contract administrator at the earliest opportunity and include:

a. A description of whether the activity will be transitioned to the MCO, delegated to a new or different FDR, or terminated entirely. If the activity will be new or transitioned to different FDR, the MCO must indicate the entity that will be responsible for the activity after termination of the FDR arrangement and submit an FDR agreement notification to ODM as described in this Agreement for the new entity.

b. A transition plan describing how the MCO will ensure minimal disruption to members as a result of the new, amended, or terminated agreement.

4. The MCO must allow ODM to review the terms of any FDR arrangement upon ODM's request.

5. The MCO must completely and accurately respond to ODM's questions and requests for information about the FDR and any provisions in the FDR agreement within the timeframes established by ODM.

6. ODM has the right and authority to designate the FDR agreement, or any portion thereof, incompatible with this Agreement; incompatible with the Ohio Medicaid state plan or other federal authorities; incompatible with federal, state, or local regulations and laws; or unacceptable to ODM for any other reason, without limitation.

7. If ODM determines that the FDR agreement as a whole or any part of the FDR agreement is unacceptable or incompatible as stated above, the MCO must amend the FDR agreement to ODM's satisfaction or seek a new FDR agreement.

8. ODM reserves the ability to review and approve all FDR agreements. Standard form contracts that apply to numerous provider entities, however, are generally excluded from this initial review and prior approval process. If any uncertainty exists regarding whether a potential agreement needs to be disclosed to ODM, the MCO should seek guidance from ODM.

9. The FDR disclosure, review, and approval processes are subject to change at ODM's discretion.

c. Transparency Requirements

i. The MCO must include a term in all FDR agreements that requires the FDR to grant ODM access to documents and other records ODM deems relevant to evaluate the FDR's performance thereunder.

ii. Upon ODM's request, the MCO must disclose to ODM all financial terms and arrangements for payment of any kind that apply between the MCO or the MCO's FDR, and any provider of a Medicaid service, except where federal and state law restricts disclosing the terms and arrangements.

1. If applicable, the MCO and FDR must narrowly designate portions of any FDR agreement as proprietary information. Portions of any FDR agreement designated as proprietary information must be limited to the following:

a. Portions of the FDR agreement that meet the definition of proprietary information in Article VII.B of the Baseline Provider Agreement; and

b. Portions of the FDR agreement that consist of unique business or pricing structures that a competitor may use to gain an unfair market advantage over the FDR.

2. Proprietary designations in every FDR agreement must be limited, consistent with the foregoing.

3. Every portion of an FDR agreement that is not designated as proprietary may be deemed by ODM to be a public record as defined in ORC 149.43.

d. Additional Requirements for FDR Agreements with Related Parties

i. "Related party" means any person or entity related to, or otherwise affiliated with, the MCO by common ownership or control, or aligned financial interests. A related party includes but is not limited to agents, managing employees, individuals with an ownership or controlling interest in the MCO and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons, or otherwise part of the same corporate family, who has the ability or perceived ability to influence the MCO in making financial or operating decisions.

ii. Prior to entering into a new or amended FDR with a related party after July 1, 2025, the MCO must submit to ODM a conflict mitigation plan outlining the protections which will be in place to mitigate any actual, potential, or perceived conflict of interest. The mitigation plan will contain at a minimum a detailed description of the proposed FDR agreement, describe the protections ensuring that the agreement will be negotiated at arms-length and not exploit the relationship for financial gain for either the MCO or the related party, and describe how the MCO will ensure the FDR arrangement does not impede members' access to care or free choice of provider. The MCO may not execute the FDR agreement prior to ODM approving the mitigation plan.

iii. If either prior to its approval of the mitigation plan, or at any point thereafter, ODM determines that the mitigation plan as a whole or any part of the mitigation plan is unacceptable, insufficient, or incompatible as stated above, the MCO must amend the mitigation plan to ODM's satisfaction or else not contract with the related party, or else terminate the agreement with the related party if the agreement has already been executed.

e. FDR Agreement Provisions

i. The MCO must ensure all FDR agreements include the following enforceable provisions:

1. A description of the administrative services to be provided by the FDR and any requirements for the FDR to report information to the MCO;

2. The beginning date and expiration date or automatic renewal clause for the arrangement, as well as applicable methods of extension, renegotiation, and termination;

3. Identification of the service area and Medicaid population, either "non-dual" or "non-dual and dual" the FDR will serve;

4. A provision stating that the FDR must release to the MCO and ODM any information necessary for the MCO to perform any of its obligations under the MCO's provider agreement with ODM, including compliance with reporting and quality assurance requirements;

5. A provision that the FDR's applicable facilities and records will be open to inspection by the MCO, ODM, ODM's designee, or other entities as specified under the MCO's provider agreement with ODM or in OAC rule;

6. A provision that the agreement is governed by and construed in accordance with all applicable state or federal laws, regulations, and contractual obligations of the MCO; and that the agreement is automatically amended to conform to any changes in laws, regulations, and MCO contractual obligations to ODM without the necessity for written amendment;

7. A provision that Medicaid-eligible members and ODM are not liable for any cost, payment, co-payment, cost-sharing, down payment, or similar charge, refundable or otherwise for services performed, including in the event the FDR or the MCO cannot or will not pay for the administrative services. This provision does not prohibit waiver entities from collecting patient liability payments from MCO members as specified in OAC rule 5160:1-6-07.1;

8. The procedures to be employed upon the ending, non-renewal, or termination of the agreement, including, at a minimum, to promptly supply any documentation necessary for the settlement of any outstanding claims or services;

9. A provision that the FDR must abide by the MCO's written policies regarding the False Claims Act and the detection and prevention of fraud, waste, and abuse;

10. A provision that requires the FDR to adhere to all screening and disclosure requirements as described in Appendix G, Program Integrity;

11. A provision that the FDR and all employees of the FDR are subject to the applicable provider qualifications in OAC rule 5160-26-05;

12. For an FDR providing administrative services that result in direct contact with a Medicaid-eligible member, a provision that the FDR must meet the member information requirements as stated in this appendix and identify, and where indicated, arrange pursuant to the mutually agreed upon

policies and procedures between the MCO and FDR for the following at no cost to the member or ODM:

a. Sign language services;

b. Oral interpretation; and

c. Auxiliary aids and services.

13. For an FDR providing administrative services that result in the selection of providers, a provision that the MCO retains the right to approve, suspend, or terminate any such selection;

14. A provision that permits ODM or the MCO to seek revocation of the MCO's contractor with the FDR or other remedies as applicable if ODM or the MCO determines that the FDR has not performed satisfactorily, or the arrangement is not in the best interest of the MCO's members;

15. A provision stating that all provisions in an FDR agreement must conform to and be consistent with all of the provisions of the MCO's provider agreement with ODM;

16. A provision that all of the provisions applicable to the FDR under the MCO's provider agreement with ODM supersede all applicable provisions in the FDR agreement. If a provision in an FDR agreement contradicts or is incompatible with any applicable provision in the MCO's provider agreement with ODM, the applicable provision in the FDR agreement is rendered null and void, unenforceable, and without effect;

17. A provision stating that all FDRs must fully assist and cooperate with the MCO in fulfilling the MCO's obligations under the Ohio Medical Assistance Provider Agreement;

18. A provision that allows the MCO, ODM, and ODM's designee to obtain and gather data, documents, and information from FDRs for purposes of an audit, evaluation, or inspection of its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members; and states that the right to audit will exist through ten years from the final date of the contract period or from the date of completion of any audit, whichever is later, for the purpose of any audit conducted by Ohio Auditor of State, pursuant to ORC Chapter 117;

19. A provision that requires FDRs to provide all data and information to the MCO needed for the MCO to provide complete reporting to ODM for the requirements and standards set forth in Appendix N, Compliance Actions; and

20. A provision stating that FDRs must provide any information that ODM requests for purposes of compliance assessments as described in Appendix N, Compliance Actions.

f. MCO Accountability

i. The MCO is ultimately responsible for meeting all contractual obligations under the MCO's Provider Agreement with ODM, regardless of delegation.

ii. For all MCO delegated responsibilities under this Agreement, the MCO must:

1. Monitor FDR performance on an ongoing basis and conduct a formal review at least annually to identify any deficiencies or areas for improvement;

2. Communicate the results of the performance review to the FDR and impose corrective action on the FDR as necessary;

3. Notify ODM and submit a corrective action plan to ODM if at any time the FDR is found to be in noncompliance with MCO's delegated contractual obligations;

4. Report the results of the annual performance review and any corrective action plan to ODM via the FDR Oversight Report as specified in Appendix P, Chart of Deliverables; and

5. Ensure there is no disruption in meeting the MCO's contractual obligations to ODM, if the FDR or the MCO terminates the arrangement between the FDR and the MCO.

iii. Unless otherwise specified by ODM, all information must be submitted to ODM directly by the MCO.

iv. In accordance with 42 CFR 438.602, the MCO must post on its website the name and title of individuals included in 42 CFR 438.604(a)(6). For the purposes of this requirement, "subcontractor" is defined as any individual or entity that has a contract with the MCO that relates directly or indirectly to the performance of the MCO's obligations under this Agreement, not including a network provider.

10. Comprehensive Disaster/Emergency Response Planning

a. Comprehensive Disaster/Emergency Response Plan

i. As directed by ODM, the MCO must develop and implement a Comprehensive Disaster/Emergency Response Plan for natural, man-made, health care, or technological disasters and other public emergencies (e.g., floods, extreme heat or cold, and public health emergencies).

ii. The MCO, as directed by ODM, must collaborate and share information with ODM-contracted managed care entities to address the disaster and implement the emergency response plan.

iii. The MCO must make the ODM-approved Comprehensive Disaster/Emergency Response Plan available to all staff.

b. Primary Point of Contact

i. As identified in the MCO staffing requirements in this appendix, the MCO must designate both a primary and alternate point of contact who will perform the following functions with respect to the MCO's Comprehensive Disaster/Emergency Response:

1. Be available 24/7 during the time of an emergency;

2. Be responsible for monitoring news, alerts, and warnings about disaster/emergency events;

3. Have decision-making authority on behalf of the MCO;

4. Respond to directives and emergent requests for information issued by ODM; and

5. Cooperate with the local-and state-level Emergency Management Agencies.

c. The MCO must participate in workgroups and processes as required by ODM to establish a state-level emergency response plan that will include a provision for Medicaid recipients, and must comply with the resulting procedures.

d. During the time of an emergency or a natural, technological, or man-made disaster, the MCO must:

i. Generate a current list of members for whom an individual disaster plan, according to the specifications below, has been developed, including the risk and the individual-level plan; and

ii. Distribute the list to local and state emergency management authorities according to the protocol established by ODM.

e. The MCO must identify members who are at risk for harm, loss, or injury during any emergency or potential natural, technological, or man-made disaster. MCO identification of vulnerable members must include populations as identified by ODM.

i. For these members, the MCO must develop an individual-level plan with the member when appropriate.

ii. The MCO must ensure staff, including care coordination staff, are prepared to respond to and implement the plans in the event of an emergency or disaster.

iii. The member-level plan must:

1. Include a provision for the continuation of critical services appropriate for the member's needs in the event of a disaster, including but not limited to access to medication/prescriptions;

2. Identify how and when the plan will be activated;

3. Be documented in the member record maintained by the MCO; and
4. Be provided to the member.

APPENDIX B – COVERAGE AND SERVICES

1. Basic Benefit Package

a. Service Coverage Requirements

i. Pursuant to OAC rule 5160-26-03, the MCO must cover and ensure members have timely access to all medically necessary services described in OAC Chapter 5160 and the services listed below, in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to members under fee-for-service (FFS) Medicaid:

1. Home health and private duty nursing services in accordance with OAC Chapter 5160-12. Ohio Medicaid state plan home health and private duty nursing services must be accessed prior to using the same or similar waiver funded services.

    a. For home health services and private duty nursing, the MCO must not apply a hard limit of 60 calendar days for the authorization period, but rather must prior authorize services in a manner that maximizes the effectiveness of the care provided in accordance with OAC rule 5160-26-03.1. The MCO must take into consideration the member's specific health needs (e.g., whether the member is covered under Healthchek and whether the member's health condition is stable, chronic, and/or debilitating) when determining the length of time for which to authorize services. Person-centered care plans, when appropriate, must reflect needs and interventions, including services authorized and provided;

2. Nursing facility stays as specified in OAC rule 5160-26-03 for Aged, Blind, And Disabled (ABD) and Modified Adjusted Gross Income (MAGI) members. For Group VIII-Expansion members, the MCO must cover nursing facility stays for the length of time medically necessary;

3. Pharmacy services and provider-administered drugs in accordance with OAC rules 5160-4-12 and 5160-26-13;

    a. All other pharmacy services and benefits are covered by ODM's contracted single pharmacy benefit manager (SPBM). The MCO must coordinate and collaborate with the SPBM as necessary to ensure that members receive medically necessary pharmacy services.

4. Services of a pharmacist provider;

    a. The services of a pharmacist rendered within a pharmacist's scope of practice when medically necessary may be rendered for the purpose of managing medication therapy, administering immunizations, or administering medications in accordance with OAC rule 5160-8-52.

5. Blood glucometers and blood glucose test strips as specified by ODM;

6. Immunizations, following the coverage requirements provided by ODM for any newly approved vaccine under the Vaccines for Children (VFC) program. The MCO may, at its discretion, elect to pay non-VFC providers for both the toxoid and the administration of vaccines outside of the VFC program;

7. Preventive services covered by Ohio Medicaid program in accordance with Section 4106 of the Affordable Care Act and 42 CFR 440.130(c);

8. All U.S. Preventive Services Task Force grade A and grade B preventive services and approved vaccines recommended by the Advisory Committee on Immunization Practices and their administration, without cost-sharing, as provided in Section 4106 of the Affordable Care Act. Additionally, the MCO must cover without cost-sharing services specified under Public Health Service Act Section 2713 in alignment with the Alternative Benefit Plan;

9. Screening and counseling for obesity provided during an evaluation and management or preventive medicine visit, as described in OAC rule 5160-1-16;

10. Respite services for Supplemental Security Income members under the age of 21 with long-term care needs in accordance with OAC rule 5160-26-03;

11. Behavioral health services, including those provided by Ohio Department of Mental Health and Addiction Services (OhioMHAS)-certified providers, as described in OAC Chapter 5160-27 for members not enrolled in the OhioRISE Plan. For members under the age of 21 not enrolled in the OhioRISE Plan, MCO covered behavioral health services also include Child and Adolescent Needs and Strengths (CANS) assessments as described in OAC rule 5160-27-02 completed on or before the OhioRISE enrollment date and Mobile Response and Stabilization Services (MRSS) as described in OAC rule 5160-27-13 prior to OhioRISE eligibility and enrollment.

    a. ODM will reimburse the MCO for behavioral health services for members under age 21 who are not enrolled in the OhioRISE Plan using the methodology specified in Appendix M, Rate Methodology.

    b. For members who are enrolled in the OhioRISE Plan, the MCO is required to cover certain behavioral health services per the OhioRISE Mixed Services Protocol developed by ODM.

ii. In accordance with 42 CFR 438.210, the MCO may exclude or place appropriate limits on service coverage, as specified in this appendix, with the exception of emergency and post-stabilization services. The MCO must provide coverage and payment for emergency and post-stabilization services, including behavioral health post stabilization services, in accordance with 42 CFR 438.114 and OAC rule 5160-26-03.

iii. The MCO is not required to pay for services not covered by Ohio Medicaid, except as specified in OAC rule 5160-26-03 and this Agreement. Coverage exceptions can be found in OAC rules 5160-1-61 and 5160-2-03.

b. Ohio Medicaid Services Not Covered by MCO

i. The MCO is not required to cover pharmacy services for members other than the limited pharmacy services as described in this appendix. All other pharmacy benefits are covered by ODM's contracted SPBM. The MCO must coordinate and collaborate with the SPBM as necessary to ensure that members receive medically necessary pharmacy services.

ii. The MCO is not required to cover behavioral health services for members enrolled in the OhioRISE Plan, including those rendered by federally qualified health centers (FQHCs) and rural health clinics (RHCs).

c. Provider-Preventable Conditions

i. The MCO must not use Medicaid funding to pay for a service resulting from a provider-preventable condition (PPC) as defined in 42 CFR 447.26.

1. In accordance with 42 CFR 438.3(g), the MCO must identify and report all PPCs, regardless of the provider's intention to bill for that event, to ODM in the manner specified by ODM.

2. The MCO must ensure that the prohibition on payment for PPCs does not result in a loss of access to care or services for members.

2. Service-Specific Clarifications

a. Healthchek and Pregnancy Related Services

i. The MCO must comply with the requirements outlined in OAC rules 5160:1-2-15, 5160:1-2-16, and 5160-1-14 related to "Healthchek," Ohio's early and periodic screening, diagnosis, and treatment (EPSDT) and Pregnancy Related Services programs.

ii. The MCO must provide Healthchek services include screening, diagnosis, and treatment services to members under the age of 21.

1. A Healthchek screening is an examination and evaluation of the general physical and mental health, growth, development, and nutritional status of a member under the age of 21. It includes the components set forth in 42 USC 1396d(r).

2. Healthchek services include all mandatory and optional medically necessary services (including treatment) and items listed in 42 USC 1396d(a) to correct or ameliorate defects, and physical and mental illness and conditions discovered by a Healthchek screening. Such services and items, if approved through prior authorization, include those services and items listed at 42 USC 1396d(a), including services provided to members

with a primary diagnosis of autism spectrum disorder, in excess of state Medicaid plan limits applicable to adults.

iii. The MCO, for Healthchek services, must:

1. Require the use of ODM-developed, standardized developmental screening tools; and

2. Track Healthchek screenings to:

   a. Ensure screening are completed for members; and

   b. Ensure that members with identified needs through the screening are linked to medically necessary services.

iv. The MCO must develop and implement written policies and procedures describing the MCO's responsibility to inform members and providers about Healthchek and to provide the full range of Healthchek services, including services that are not otherwise included in the basic benefit package.

v. In order to improve access to and delivery of Healthchek services, the MCO must support and encourage providers to deliver services in school-based settings.

vi. With respect to Healthchek services, the MCO must:

1. Inform each new member under the age of 21 about Healthchek services as prescribed by ODM and as specified by 42 CFR 441.56 within five calendar days of receipt of the Health Insurance Portability and Accountability Act (HIPAA) 834C daily enrollment file;

   a. The MCO may meet this requirement by including information with the new member materials as specified in Appendix E, Marketing and Member Materials.

2. Communicate and coordinate with the member's local county Department of Job and Family Services (CDJFS) agency and/or the member’s school district about any requests made by the member for county-coordinated services and supports (e.g., social services, educational supports);

3. Provide members with accurate information in the member handbook regarding Healthchek;

   a. The MCO must provide member handbooks to members within the timeframes specified in Appendix E, Marketing and Member Materials, and must include verbatim the model language developed by ODM.

   b. The model language, at a minimum, includes:

      i. A description of the types of screening and treatment services covered by Healthchek, such as that provided on

the ODM 03528 “Healthchek and Pregnancy Related Services Information Sheet”;

ii. A list of the intervals at which members under the age of 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;

iii. Information that Healthchek services are provided at no additional cost to the member; and

iv. Information that providers may request prior authorization for:

1. Coverage of services that have limitations; and

2. Services not covered for members under the age of 21 if the services are medically necessary.

4. Provide the information included in the member handbook above regarding Healthchek on the MCO's member website as specified in Appendix E, Marketing and Member Materials;

5. Deliver Healthchek information as provided, or as approved, by ODM to its members at the following intervals:

a. When the member is 9 months old;

b. When the member is 18 months old;

c. When the member is 30 months old;

d. January of each calendar year (CY) to all members under the age of 21;

e. In July of each CY for members from age 4 to under 21; and

f. When the member is identified as pregnant, regardless of the member's age.

6. Use the mailing templates provided by ODM not to exceed two 8x11 pages for each mailing with most mailings being one page or less in length. The MCO 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).

vii. The MCO must inform members about Pregnancy Related Services.

1. Upon identifying a member as pregnant, the MCO must deliver a Pregnancy Related Services form as designated by ODM to the member within five calendar days.

2. The MCO may communicate with the member's local CDJFS agency for any requests made by the member for county-coordinated services and supports (e.g., social services).

3. The MCOs must educate members about breastfeeding benefits, and connect members to a lactation consultant. Upon implementation, refer members to a Doula provider upon request, enroll members into group prenatal education and/or group prenatal care as appropriate, and refer members to home visiting.

4. The MCOs must submit a strategic plan to increase access to ODM Maternal and Infant Support Program (MISP) services to improve perinatal outcomes and reduce disparities as specified in Appendix P Chart of Deliverables. The MCOs strategy should include:

    a. A health equity plan to address overcoming barriers to MISP services, especially in populations with the greatest racial disparities in infant and maternal mortality rates;

    b. A description of the MCO's alignment with ODM's population health strategy goals by increasing access to MISP services;

    c. An overview of the MCO's organizational infrastructure including a description of the MCO's Internal Management and Resources, Marketing and Engagement Plan, Operational Timelines, and Data Collection expectations;

    d. A Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis to outline anticipated challenges and known barriers to increasing utilization of MISP services;

    e. A detailed description of how the MCO will apply lessons learned from members, providers and community members and a description of how the MCO will share stakeholder feedback with ODM, other MCOs, providers and members; and

    f. An evaluation plan to determine if the MCO's strategy to increase MISP service utilization was effective.

viii. The MCO must inform and educate providers about Healthchek.

1. The MCO must provide Healthchek education to all network providers on an annual basis that must include, at a minimum:

    a. The required components of a Healthchek exam pursuant to OAC rule 5160-01-14;

b. A list of the intervals at which members under the age of 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;

c. A statement that Healthchek includes a range of medically necessary screening, diagnostic, and treatment services; and

d. A list of common billing codes and procedures related to the Healthchek services (e.g., immunizations, well child exams, laboratory tests, and screenings).

2. The MCO must provide the above information on the MCO's provider website as specified in Appendix A, General Requirements.

ix. The MCO must maintain documentation to verify members and providers were informed of Healthchek and Pregnancy Related Services as specified by ODM.

b. Medication Therapy Management Program

i. The MCO must implement a medication therapy management (MTM) program that includes completion of both Comprehensive Medication Reviews (CMRs) and Targeted Medication Reviews (TMRs). Community pharmacists must have the opportunity to complete CMRs and TMRs.

1. CMRs must be annually offered to all members receiving at least 8 maintenance medications and having at least 3 chronic conditions. The MCO may elect to provide these services to members with a lower number of disease states or medications, but may not increase the above-stated minimums. CMS-recognized key chronic conditions include Alzheimer’s disease, bone disease/arthritis, chronic heart failure, diabetes, dyslipidemia, end-stage renal disease, hypertension, mental health disorders, and respiratory disease. Chronic conditions may be identified via medical and pharmacy ICD codes and should also be implied by pharmacy claims. CMRs must be completed on at least 10% of the MCO’s CMR eligible population. A minimum of 1% of the MCO’s population should be eligible for CMRs. These benchmarks may increase per ODM.

2. The MCO's MTM program must include but not be limited to MTM TMR services focused on polypharmacy, opioids, pediatric services, behavioral health, and any other area identified by ODM to support ODM's population health strategy.

a. The MTM services for opioid services must include but are not limited to initiatives focused on the education and safe use of opioids as well as the proper disposal of opioids.

b. The MTM services for pediatric services must include but are not limited to initiatives focused on improving immunization rates and disease state management for conditions including but not limited to asthma therapy.

c. The MTM services for behavioral health must include but are not limited to initiatives focused on polypharmacy and the use of antipsychotic medications in both adult and pediatric populations.

d. The MTM services for adherence must include but are not limited to initiatives focused on adherence to diabetes medications, renin-angiotension-aldosterone-system (RAAS) medications, statins, antipsychotic medications, and respiratory medications.

3. Clinical and utilization outcomes must be tracked for successfully completed TMRs and submitted to ODM four quarters after TMR completion as specified in Appendix P, Chart of Deliverables,

ii. As requested by ODM, the MCO must work with other MCOs, the OhioRISE Plan, the SPBM, ODM, and other stakeholders to develop MTM services, including the trigger events and MTM activities.

iii. As specified in Appendix P, Chart of Deliverables, the MCO must provide ODM with quarterly MTM Program Updates including but not limited to MTM triggering events, activity that occurs after triggering event, how each MTM interaction is documented and reimbursed, MTM utilization, clinical outcomes, plan to increase successful CMR and TMR rate per enrolled population, and financial metrics for its MTM program.

c. Abortion and Sterilization

i. The MCO is prohibited from providing reimbursements for abortion and sterilization services unless the specific criteria found in federal law and OAC rules 5160-17-01 and 5160-21-02.2 are met.

ii. The MCO 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 paying any such claim.

iii. The MCO must not make payment for associated services such as anesthesia, laboratory tests, or hospital services if the abortion or sterilization itself does not qualify for payment.

iv. The MCO must educate its providers on the requirements and implement internal procedures, including systems edits. The MCO must only pay claims when the MCO has determined that the applicable forms are completed and the required legal criteria are met, as confirmed by the appropriate certification or consent forms. The MCO must maintain documentation to justify any such claim payments.

v. If the MCO has determined that the requirements associated with an abortion, sterilization, or hysterectomy were sufficiently met by the provider, then no

additional information (e.g., unless otherwise required by law, operative notes, history and physical, and ultrasound) is required from ancillary providers.

d. Services for Autism Spectrum Disorder

i. The MCO must provide services to members with a primary diagnosis of Autism Spectrum Disorder as required by the coverage mandates pursuant to ORC section 1751.84 and Healthchek as described above.

e. Moral or Religious Objections

i. In accordance with 42 CFR 438.102, if the MCO 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, the MCO must immediately notify ODM to coordinate the implementation of this change.

1. ODM will provide coverage and reimbursement for these services in accordance with ODM policy.

2. The MCO must notify its members of this change at least 30 calendar days prior to the effective date. The MCO must include any such services that the MCO will not cover in the MCO's member handbook and provider directory, as well as in all marketing materials.

ii. If network hospital elects not to provide specific Medicaid-covered hospital services because of an objection on moral or religious grounds, the MCO must ensure these hospital services are available to its members through another network hospital in the specified county/region.

f. Help Me Grow

i. Pursuant to ORC section 5167.16, upon request and in coordination with the Help Me Grow program, the MCO must arrange for depression screening and cognitive behavioral health therapies for members enrolled in the Help Me Grow program who are either pregnant or the birth mother of an infant or toddler under three years of age.

ii. The MCO must provide screening and therapy services in the home when requested by the member.

g. Medicaid school Program (MSP)

i. The MCO must collaborate with school districts on the coordination of school-based services for members through the Medicaid School Program (MSP) and other school-based services.

h. Boards of Alcohol, Drug Addiction, and Mental Health Services

i. The MCO must collaborate and coordinate with local Alcohol, Drug Addiction, and Mental Health (ADAMH) Boards to identify and address behavioral health service

gaps and needs (e.g., mental health services, addiction services, and recovery supports).

i. Institutions for Mental Disease for Mental Health Stays

i. Federal regulation, 42 CFR 438.6(e), allows for a short term Institutions for Mental Disease (IMD) stays of 15 calendar days or less for members ages 21 through 64. The MCO may provide mental health services to members ages 21 through 64 for up to 15 calendar days per calendar month while receiving inpatient treatment in an IMD as defined in Section 1905(i) of the Social Security Act.

ii. The MCO is not prohibited from contracting with an IMD to provide mental health services to members aged 21 through 64, but ODM will not compensate the MCO for the provision of such services beyond 15 calendar days per calendar month, either through direct payment or considering any associated costs in Medicaid rate setting.

iii. The MCO must report IMD stays that exceed 15 calendar days per calendar month (IMD for Extended Stay) on a quarterly basis to ODM as specified in Appendix P, Chart of Deliverables.

iv. For IMD stays that exceed 15 calendar days per calendar month, ODM will recover a percentage of the MCO's monthly capitation payment as described in Appendix L, Payment and Financial Performance.

j. Emergency Room Services

i. The MCO must cover emergency room services for all members, including those enrolled in the OhioRISE Plan.

1. For member enrolled in the OhioRISE Plan presenting to an emergency room precipitated by a behavioral health problem, the MCO must notify the OhioRISE Plan and assigned care management entity (CME) to initiate care coordination for the member.

2. For members under the age of 21 not enrolled in the OhioRISE Plan presenting to an emergency room precipitated by a behavioral health problem, the MCO must arrange for the member to receive a CANS assessment/eligibility determination.

3. The MCO must track the volume and spend for emergency room services, as specified by ODM, for members enrolled in the OhioRISE Plan and report this information to ODM upon ODM's request.

k. Behavioral Health Crisis Services

i. The MCO must ensure that member-serving MCO staff know the continuum of community resources for behavioral health crisis services, including the 988 Suicide & Crisis Lifeline (988) and the statewide Mobile Response Stabilization Service (MRSS).

ii. The MCO must train MCO staff who interface with the public or have direct member contact on how to connect (through warm handoffs) members in need of behavioral

health crisis services to 988. Staff making warm transfers to 988 must use the National Suicide Prevention Lifeline 10-digit terminal numbers when geolocation based on the member's location cannot be used, such as when the call is being transferred from the MCO's member call center.

iii. The MCO must track and document behavioral health crisis contacts from members and ensure that this information is shared as soon as possible and no later than the next business day with the member's MCO's care coordination staff, OhioRISE Plan, and/or care coordination entity (CCE) for appropriate follow-up.

iv. The MCO must work with ODM, the Ohio Department of Mental Health and Addiction Services (OMHAS), and other entities as identified by ODM to develop a robust continuum of behavioral health crisis services.

l. Substance Use Disorder Treatment

i. The MCO must utilize the American Society of Addiction Medicine (ASAM) level of care criteria, and the MCO must not add additional criteria when reviewing level of care for substance use disorder (SUD) treatment provided in a community behavioral health center. When making medical necessity determinations for inpatient or outpatient hospital services for co-occurring behavioral health and physical health conditions or for co-occurring substance use and mental health disorders, the MCO must use evidenced-informed medical necessity criteria for determining hospital level of care(i.e, MCG or InterQual) that take into consideration of all symptoms and clinical issues (SUD, psychiatric, and other medical conditions). For individuals with SUD conditions, MCOs must consider ASAM criteria prior to denying inpatient or outpatient hospital services. Inpatient or outpatient services for individuals with SUD must be authorized if either of the following apply:

1. The request meets level of care criteria using the MCO's clinical guidelines for hospital services (i.e. MCG or InterQual); or

2. The request meets ASAM criteria.

ii. The MCO must use the adolescent ASAM level of care criteria for members under the age of 21.

iii. The MCO must continue to work with ODM in implementing the 1115 SUD demonstration waiver to provide services to members with a SUD diagnosis. Additional work will include developing utilization management strategies, increasing care coordination efforts, and monitoring network adequacy. Upon implementation of a standardized SUD treatment form, when properly submitted by a provider, the MCO must accept the identified form to prior authorize SUD services and determine level of care.

m. Emergency Hospitalizations

i. In accordance with ORC section 5122.10 regarding emergency hospitalizations, also referred to as "pink slips," the MCO must cover initial evaluation for up to 24 hours and stabilization services for up to three court days thereafter.

n. Organ Transplants

i. *Organ Transplant Coverage*

1. Pursuant to OAC rule 5160-2-65, the MCO must ensure coverage for organ transplants and related services.

2. The MCO's coverage for all organ transplant services, except kidney transplants, is contingent upon review and recommendation by the "Ohio Solid Organ Transplant Consortium." The review and recommendation for coverage is based on criteria established by Ohio organ transplant surgeons and authorization from the ODM prior authorization unit.

3. 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." The review and recommendation for coverage is based on criteria established by Ohio experts in the field of bone marrow transplant and authorization from the ODM prior authorization unit.

4. While the MCO may require prior authorization for these transplant services, the approval criteria must be limited to confirming the member has been referred to, and approved for a transplant by the applicable consortium and authorized by ODM.

5. Pursuant to OAC rule 5160-2-03, the MCO must cover all services for the organ donor related to covered organ donations to an organ recipient member.

ii. *Prior Authorizations for Transplant Evaluations (Pre-Transplants)*

1. The MCO is prohibited from requiring prior authorization that may create a barrier to accessing the "Ohio Solid Organ Transplant Consortium" or "Ohio Hematopoietic Stem Cell Transplant Consortium" for review and recommendation (e.g., a member must be able to access pre-transplant services required for consortium review).

2. The MCO may require providers to submit information for the purposes of assisting members with identifying available providers, initiating care coordination services, and addressing any compensation issues.

3. When identifying available providers that could ultimately impact where the transplant is performed, the MCO must not solely consider whether the provider is a network provider, but also consider the proximity to a member's residence, the member's support system, and the providers who coordinate the member's care.

o. Gender Transition

i. The MCO is not precluded from determining whether a particular health service is medically necessary or otherwise meets applicable coverage requirements in individual cases.

ii. When an individual who has transitioned needs medically necessary services related to their gender at birth, the MCO must review for medical necessity and cannot categorically deny a service due to gender.

iii. The MCO must comply with all applicable state and federal laws and regulations, related to any gender transition services.

p. Hospice Services

i. In accordance with Sections 1902(a)(13)(B) and 1905(o)(3)(C) of the Social Security Act, the MCO must pay room and board payments to the hospice provider instead of the nursing facility if the member resides in a nursing facility and is receiving hospice services.

q. Inpatient Hospital Services

i. The MCO must enforce the three calendar day roll-in requirements pursuant to OAC rule 5160-2-02.

ii. The MCO must follow the readmission policies as outlined in OAC Chapter 5160-2 for inpatient hospital stays as follows:

1. For readmissions within 30 calendar days due to complications or other circumstances that arose because of an early discharge and/or other treatment errors, the two inpatient hospital stays must be combined into one claim, and the MCO must not deny the second admission due to being a readmission.

    a. The MCO must maintain a list of the types of conditions or admissions that are exempt from review to combine claims, including any behavioral health conditions or admissions.

    b. The MCO must exempt behavioral health admissions from readmission considerations unless otherwise approved by ODM.

2. Upon receipt of claims for two admissions, the MCO must conduct a clinical review to determine whether two admissions must be combined as one claim.

3. The MCO must not deny a prior authorization request solely based on a readmission request. Prior to making an authorization decision regarding a readmission, the MCO must conduct a clinical review to determine if the readmission is related to the original admission.

r. Coordinated Services Program

i. The MCO must develop a Coordinated Services Program (CSP), in accordance with OAC rule 5160-20-01, to address the overuse or misuse of services. The MCO must obtain ODM approval prior to implementation of its CSP.

ii. The MCO must complete and submit the ODM 01039 “Ohio Medicaid Coordinated Services Program (CSP) Managed Care Organization (MCO) Program Description” to CSP@medicaid.ohio.gov. The deliverable is required once initially and subsequently if an MCO adopts a change to its CSP.

iii. The MCO must, at a minimum, follow all applicable provisions for initial and continued enrollment in the CSP pursuant to OAC rule 5160-20-01.

iv. The MCO must offer to provide care coordination to any member who is enrolled in the CSP.

v. The MCO must use data files provided by ODM to determine whether a member meets a CSP eligibility criterion, including the Abuse Potential Medications and Addiction Codes file.

vi. The MCO must use the cover sheet provided by ODM to assist in the state hearing process for the CSP. The MCO may customize the cover sheet with its logo and branding but may not change the verbiage.

vii. The MCO must submit its enrollment of members in the CSP program via the "Inbound from MCO" file no later than the last calendar day of each month prior to enrollment or reenrollment to ensure CSP enrollment is recorded in the HIPAA 834 files. The MCO must monitor the "Outbound to MCO" file to review file submission errors and correct submissions via the "Inbound from MCO" file, including changes in CSP enrollment, new CSP enrollments, and CSP disenrollments.

viii. Changes to provider assignments must be recorded via the “inbound from MCO” file on the date the member requests a change, if it is approved by the MCO.

s. Non-Emergency Medical Transportation Services

i. The MCO must have ODM's prior approval of policies and procedures, and subsequent changes thereto, associated with arranging and providing transportation for members.

ii. The MCO must arrange and provide transportation to any member requesting transportation when the member must travel 30 miles or more each way from the member's home to receive a medically necessary Medicaid-covered service provided by the MCO and pharmacy services provided by the SPBM. The MCO must provide information and assistance to members to ensure members receive medically necessary transportation.

iii. The MCO's member services call center must have a selection for transportation for members. Member services representatives must be trained to respond to

transportation requests in accordance with MCO policies and procedures for arranging and providing transportation services.

iv. The MCO must arrange and provide transportation for members who are enrolled with the OhioRISE Plan in a manner that ensures that children, youth, and their families served by the OhioRISE Plan do not face transportation barriers to receive services regardless of Medicaid payer.

1. The MCO Care Guide Plus is responsible for arranging for transportation, regardless of whether the transportation is covered by the county or MCO. Members and their families must be able to contact the MCO's Care Guide Plus within reasonable timeframes to arrange for transportation, including same day appointments. The MCO Care Guide Plus must work with the OhioRISE Plan care management resources, including CMEs to ensure transportation services are well-coordinated with the services the OhioRISE Plan member or family is receiving.

2. The MCO is responsible for arranging transportation in cases where transportation of families, caregivers, and sibling (other minor residents of the home) when needed to facilitate the treatment needs of the member and their family.

3. The MCO must provide additional transportation benefits for members under the age of 21. This medically necessary service cannot be a value-added service or have annual limitations.

4. The MCO must ensure specialized transportation for members who have cognitive or behavioral challenges that require different transportation providers or supports than available from counties or standard Medicaid provider network.

v. The MCO must not require more than 48 hours of advance notice for transportation needs and must provide exceptions for advance notice requirements for urgent member needs (e.g., for same or next day urgent appointments) and hospital discharges.

vi. The MCO must ensure the member is transported to their appointment on time and that transportation pick-up is no more than 15 minutes before nor 15 minutes after the pre-scheduled pick-up time.

vii. The MCO must ensure that transportation pick-up is completed no more than 30 minutes after the requested time for pick-up.

viii. The MCO must ensure the transportation vendor attempts to contact the member if the member is not present at the time of pick-up.

ix. The MCO must ensure the transportation vendor does not leave the pick-up location prior to the pre-scheduled pick-up time.

x. When providing transportation for more than one member to more than one location, the MCO must ensure that the total transit time for any single member on

the trip does not exceed 60 minutes beyond the member's point-to-point transit time.

xi. The MCO may not restrict the number of transports in a single day.

xii. The MCO must identify and accommodate any special transportation assistance needs of its members (e.g., door-to-door assistance, attendant support, member-specific timeliness requirements).

1. The MCO must communicate member-specific needs to the transportation vendor and update the vendor as frequently as is needed to support the member's transportation needs.

2. The MCO must document any member-specific transportation needs in the member's person-centered care plan, when applicable.

xiii. The MCO must submit a plan to ODM that addresses the provision of transportation services during winter snow and other weather emergencies. The MCO's plan must describe how the MCO will identify, triage, and transport members requiring critical services, and notify members of canceled transportation and rescheduling.

1. The MCO's plan must specify the snow emergency level and any other weather-related criteria that require a change to scheduled transportation.

2. The MCO must notify the ODM Contract Administrator immediately when the MCO cancels transportation due to a weather emergency in accordance with the plan.

xiv. The MCO must collaborate with ODM, other ODM-contracted MCOs, and the counties within the MCO's service area to improve member experience and access to transportation services, including standardizing the way for members to access transportation services.

xv. The MCO must submit a quarterly Transportation Performance Report to ODM as specified in Appendix P, Chart of Deliverables.

t. Nursing Facility Services Level of Care Determination

i. For Medicaid covered nursing facility stays, the MCO must evaluate the member's need for the level of services provided by a nursing facility.

ii. To make this decision, the MCO 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.

iii. The MCO must evaluate both intermediate and skilled levels of care concurrently when making a level of care determination.

iv. Pursuant to OAC rule 5160-3-14, the preadmission screening and resident review (PASRR) process must be completed before the MCO issues a level of care determination. The MCO must have processes in place to ensure that the PASRR

requirements are met pursuant to OAC chapter 5160-3 prior to issuing a level of care determination.

v. The MCO must provide documentation of the member's level of care determination to the nursing facility. If properly submitted by a provider, the MCO must accept the Ohio Medicaid Managed Care/MyCare Ohio Nursing Facility Request Form to prior authorize nursing facility services and determine level of care. The MCO must maintain a written record documenting that the criteria were met. If the criteria were not met, the MCO must issue a Notice of Action and maintain documentation that a Notice of Action was issued pursuant to OAC rule 5160-26-08.4.

vi. The Notice of Action must include the specific level of care criteria that were not met (i.e., no determined need for assistance with two or more areas of assistance with daily living, no need for medication administration, no cognitive impairment resulting in a need for 24 hour support to prevent harm, or no need for a skilled nursing service or therapy).

vii. The MCO must provide ODM a PASRR Report as specified in Appendix P, Chart of Deliverables.

u. COVID-19 Testing and Treatment

i. The MCO must cover all Medicaid covered COVID-19 testing codes, treatment, and vaccinations without restrictions or cost sharing. The MCO must cover each COVID-19 vaccine effective on the date the vaccine is approved by the Centers for Disease Control (CDC).

v. Coverage of Doula Services

i. The MCO must cover doula services in accordance with OAC 5160-8-43. The MCO must reimburse for doula services no less than Fee-For-Service rate found in Appendix DD to OAC 5160-1-60 for a period of two years.

w. Coverage of lactation consulting services

i. The MCO must cover lactation consulting services in accordance with OAC 5160-8-42 upon implementation. The MCO must reimburse for lactation consulting services no less than Fee-For-Service rate found in Appendix DD to OAC 5160-1-60 for a period of two years.

x. Coverage of Nurse Home Visiting (NHV) services

i. The MCO must cover Nurse Home Visiting (NHV) services in accordance with OAC 5160-21-05. The MCO must reimburse for NHV services no less than Fee-For-Service rate found in Appendix DD to OAC 5160-1-60 for a period of two years.

y. Consolidated Appropriations Act Section (2023) Section 5121 Requirements

i. The MCO will work with ODM and partners (e.g., state agencies, carceral facilities) to develop required processes needed to implement Section 5121 of the Consolidated Appropriations Act (2023). MCO responsibilities related to Section 5121 will be

specified in *ODM's Expectations for Managed Care Organizations to Support Justice-Involved Individuals.*

z. Coverage of Pediatric Recovery Center (PRC) Services

i. The MCO must cover pediatric recovery center (PRC) services in accordance with OAC 5160-18-02 upon implementation. The MCO must reimburse for PRC services no less than the Fee-For-Service rate found in Appendix DD to OAC 5160-1-60 for a period of two years starting 7/1/2025.

aa. Coverage of Family Connects Services

i. The MCO must cover Family Connects services in accordance with OAC 5160-21-06. The MCO must reimburse for Family Connects services no less than Fee-For-Service rate found in Appendix DD to OAC 5160-1-60 for a period of two years.

3. Additional Benefits

a. Value-Added Services

i. In accordance with 42 CFR 438.3(e)(1)(i), the MCO may elect to provide services in addition to those covered under the Ohio Medicaid fee-for-service (FFS) program. Before the MCO notifies potential or current members of the availability of those services, the MCO must first notify ODM of its plans to make such services available.

ii. While the MCO is not responsible for outpatient pharmacy services, the MCO may provide members debit cards to purchase over-the-counter medications not covered by the Ohio Medicaid program.

iii. The MCO must demonstrate to ODM's satisfaction that the value-added services are readily available and accessible to members who are eligible to receive them for at least six calendar months, unless otherwise approved by ODM.

iv. When determining the types of value-added services the MCO elects to provide, the MCO should consider the population health needs within the region or regions served by the MCO.

v. The MCO may not vary the availability of value-added services by county within a region, except out of necessity for transportation services (e.g., bus versus cab). However, if the MCO serves multiple regions, the MCO may vary the availability of value-added services by region.

vi. If the MCO offers transportation to its members as a value-added service and the added transportation benefit only covers a limited number of trips, the MCO must not count the required transportation benefit listed above in this appendix against the trip limit under the added transportation benefit.

vii. If the MCO offers transportation to members as a value-added service and has a limit on this benefit (e.g., specified number of trips), transportation provided for members to access out-of-network providers for services the MCO is unable to provide in-network must not be counted toward the transportation benefit limit.

viii. If the MCO offers transportation to its members as a value-added service, the MCO must meet the same transportation performance standards and reporting requirements identified above in this appendix for the value-added transportation benefit.

ix. The MCO must obtain ODM approval of any MCO-initiated change to value-added services that would take effect 90 calendar days prior to open enrollment as well as within 90 calendar days after the completion of open enrollment. Unless approved by ODM, changes will not be accepted from May 2 through November 30.

x. The MCO must give advance notice of at least 90 calendar days to ODM and members when decreasing or ceasing any additional benefits. When the MCO finds that it is impossible to provide 90 calendar days prior notice for reasons beyond its control, as demonstrated to ODM's satisfaction, the MCO must notify ODM within at least one business day of discovery.

b. Pilot and Trial Incentive Programs

i. The MCO must submit a description of a proposed pilot, health care quality improvement activity, or trial incentive program to ODM for review and approval prior to implementation. A pilot incentive program is a short-term program in a specified region(s) or with a defined member population that is measured to determine if it meets the specified program goal. A health care quality improvement activity is a structured quality improvement activity meeting the requirements specified in 45 CFR 158.150. A trial incentive program is a time limited monetary or non-monetary reward offered to a member who complies with the intended goals of the program as outlined by the MCO (e.g., recommended health screenings) in the submission.

ii. The MCO's proposed pilot or trial incentive program:

1. Must aim to improve health outcomes by engaging members in their own care;

2. May consist of short-term incentives (e.g., one-time flu shot incentive) and time-limited incentive programs (e.g., pregnancy pilot), but should also offer long-term projects (e.g., women's health screenings);

3. Must demonstrate that the MCO used data to select incentive program goals and priorities; and

4. Must not discriminate against members based on race, national origin, limited English proficiency, gender, disability, chronic disease, whether a person resides or receives services in an institutional setting, frailty, health status, or other prohibited basis. The MCO must implement incentive programs to ensure equal access for members eligible for the MCO’s proposed incentive program.

iii. The MCO must not use a medically necessary Medicaid-covered service or an additional benefit as offered in the MCO's member handbook as an incentive.

iv. Pilot and trial incentive program requirements described in this section do not apply to quality withhold programs specified in Appendix J, Quality Withhold, of this Agreement or any federally required quality improvement projects.

v. The MCO must refer to and submit the ODM form 10267 Managed Care & MyCare Ohio Organization Pilot Program Request Template for additional clarification including information on the cadence for process and outcomes measure reporting.

vi. The MCO must ensure that any incentive program or combination of incentive programs complies with state and federal requirements. ODM's approval of a pilot or trial incentive program should not be construed as an assurance that the program meets such requirements.

c. In Lieu of Services

i. In accordance with 42 CFR 438.3(e)(2), the MCO may propose coverage for services that are in lieu of services covered under the Ohio Medicaid state plan (in lieu of services).

1. The MCO's proposal must demonstrate that any in lieu of service is a medically appropriate and cost-effective substitute for a service covered under the Ohio Medicaid state plan.

2. The MCO proposal must include a cost-benefit analysis for any in lieu of service it proposes to provide, including how the proposed service would be a medically appropriate and cost-effective substitute for a service covered under the Ohio Medicaid state plan.

ii. In lieu of services must be prior approved by ODM in writing.

iii. The MCO must not require a member to use an in lieu of service as an alternative to a service covered under the Ohio Medicaid state plan.

4. Member Cost-Sharing

a. Pursuant to OAC rules 5160-26-05 and 5160-26-12 and 42 CFR 438.108, the MCO may impose the applicable member co-payment amount for dental services, vision services, and/or non-emergency emergency department services.

b. If the MCO intends to impose a co-payment, the MCO must notify ODM of the timing of the implementation of imposing the co-payment and obtain ODM's written approval of the MCO's proposed notice to members.

c. If the MCO intends to impose a co-payment for a mental health or SUD benefit, the co-payment must comply with parity requirements in 42 CFR 438.910(c). The MCO must submit documentation to ODM demonstrating that the co-payment complies with parity and receive ODM’s approval prior to implementing the co-payment.

d. If ODM determines the MCO's decision to impose a particular co-payment on its members would constitute a significant change for those members, ODM may require the effective date of the co-payment to coincide with the open enrollment month.

e. Notwithstanding the preceding paragraph, the MCO must provide an ODM-approved, written notice to all its members 90 calendar days in advance of the date that the MCO proposes to impose the co-payment.

f. With the exception of member co-payments the MCO has elected to implement in accordance with OAC rules 5160-26-05 and 5160-26-12, the MCO's payment for any covered services constitutes payment-in-full, and the MCO must ensure its providers do not charge members or ODM any additional co-payment, cost sharing, down payment, or similar charge, refundable or otherwise.

g. In accordance with 42 CFR 438.106(b), the MCO 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 MCO.

h. Pursuant to OAC rule 5160-26-05, the MCO must ensure that MCO subcontractors and providers do not bill members any amount greater than would be owed if the entity provided the services directly (i.e., no balance billing).

5. Utilization Management Program

a. General Requirements

i. The MCO must develop, implement, and maintain a Utilization Management (UM) program that is National Committee for Quality Assurance (NCQA) accredited and that facilitates the delivery of high quality, cost efficient, and effective care. The MCO's UM program must be used to inform the MCO's population health and quality improvement (QI) strategies as outlined in Appendix C, Population Health and Quality.

ii. The MCO must monitor its UM program on an ongoing basis, and evaluate and update UM program requirements at least annually as a component of the MCO's QI plan and assessment. Based upon the evaluation and assessment, the MCO must update the UM program policies, structures, and processes as necessary. The MCO's monitoring and evaluation of its UM program must include:

1. Monitoring the timeliness of service authorization;

2. Monitoring the consistency of the MCO's application of service authorization criteria;

3. Assessing to determine whether the MCO's prior authorization procedures unreasonably limit member access to covered services;

4. Reviewing the MCO's list of services that are subject to prior authorization to determine whether there is an ongoing need for prior authorization to ensure appropriate utilization of services;

5. Using provider feedback to identify opportunities to standardize and streamline service authorization processes to reduce administrative burden for providers; and

6. Monitoring for updates to ODM clinical coverage criteria, evidence-based nationally recognized medical necessity guidelines, and other professional literature to inform and update the MCO's clinical coverage policies and criteria.

iii. While the MCO must have mechanisms in place to ensure that its UM program interfaces with and informs the MCO's program integrity responsibilities under Appendix G, Program Integrity, the MCO must demonstrate that the primary function of its UM program is to meet the clinical needs of its members, to meet all state and federal requirements, including EPSDT, and to deliver efficient and appropriate services.

iv. In accordance with 42 CFR 438.210(e), the MCO must ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member.

v. In accordance with 42 CFR 438.210, the MCO must ensure that required services are not arbitrarily denied or reduced in amount, duration, or scope solely because of diagnosis, type of illness, or condition of the member.

vi. The MCO must use UM data (including data from the SPBM) and other quality information to identify and appropriately address providers who appear to be operating outside peer norms with respect to service utilization, prescribing patterns, and quality of care concerns. The MCO must report providers who are operating outside of such peer norms, including practices that impact member safety, to ODM.

vii. The MCO must use information available through the Ohio Board of Pharmacy's prescription drug monitoring program, in addition to other available resources (e.g., claims data), to monitor member utilization and provider prescribing patterns of controlled substances and other drugs.

viii. The MCO must have the capabilities to receive service authorization requests by EDI or a flat file.

b. Policies and Procedures

i. The MCO must develop and implement clearly defined UM policies, structures, and processes pursuant to OAC rule 5160-26-03.1 to maximize the effectiveness of care provided to members.

ii. The MCO must implement UM requirements for SUD services as necessary to support Ohio's SUD 1115 demonstration waiver implementation plan.

iii. The MCO must submit clinical coverage policies and any subsequent proposed changes to ODM for review and approval prior to implementation. The MCO's submission must include a proposed list of the services and items subject to UM clinical coverage reviews.

1. As part of the MCO's submission of clinical coverage policies or changes thereto, the MCO must include a summary of the MCO's analysis, in the

format specified by ODM, that demonstrates that the policy and/or changes thereto comport with the parity requirements in 42 CFR 438.910(d).

2. The MCO's analysis must demonstrate that the non-quantitative treatment limits resulting from the MCO's clinical coverage policies for mental health/SUD benefits in all classifications are comparable to and are applied no more stringently than the non-quantitative treatment limits for medical/surgical benefits in the classification.

iv. The MCO must notify network and out-of-network providers of clinical coverage policies. The communication must include an outline or a summary specifying the changes and their impact on specific providers receiving the policy changes. Changes to policies require 30 days advance notice. Provider notifications must meet the requirements in Appendix A, General Requirements.

c. Utilization Management Program Structure

i. The MCO must structure its Utilization Management (UM) program to meet requirements in OAC rule 5160-26-03.1.

ii. The MCO must ensure that the administrative and organizational structure of the MCO's UM program reports to the MCO's Chief Medical Officer.

iii. The MCO's UM structure must include a UM Committee, chaired by the MCO's Chief Medical Officer or designee, to review and approve the MCO's UM program, plan, and annual evaluations, as well as UM policies and procedures. The MCO must include the Behavioral Health Clinical Director as a member of the UM Committee.

iv. The MCO must have appropriately qualified UM review staff who are available by telephone from 8:00 am to 5:00 pm Eastern Time, Monday through Friday, (except for the major holidays and two optional closure days as required in Appendix A, General Requirements) to render UM decisions for providers. UM review staff must be available by telephone 24/7 to respond to authorization requests for inpatient admissions, or the MCO must have policies and procedures that allow for emergency inpatient admissions with authorization the next business day.

v. In addition to having appropriately licensed clinical staff with subject matter expertise to review and make prior authorization decisions as specified in Appendix A, General Requirements, the MCO must have appropriately licensed clinical professionals to supervise staff making medical necessity decisions.

vi. The MCO must ensure that MCO staff performing peer-to-peer consultations as described below in this appendix are health care professionals who have appropriate clinical expertise in treating the member's condition.

d. Authorization Data and Reporting

i. Pursuant to OAC rule 5160-26-03.1, the MCO must submit information on prior authorization requests as directed by ODM.

ii. The MCO must submit detailed prior authorization data to ODM for the Utilization Management Tracking Database (UMTD) as specified in Appendix P, Chart of Deliverables.

iii. The MCO must conduct root cause analysis of authorization denials and appeals and develop a targeted plan to decrease inappropriate denials and ensure ease of appeal of medical necessity denials.

iv. The MCO must provide ODM an Unstaffed Home Care Report as specified in Appendix P, Chart of Deliverables. The Unstaffed Home Care Report must include details for any member with a need for aide or nursing service without a provider, as described in the required reporting template. This includes services without a provider at the planned service start date or when a member experiences the loss of a provider after the services were authorized.

6. Coverage Requirements

a. Medical Necessity Criteria

i. Pursuant to OAC rule 5160-26-03, the MCO's coverage requirements and decisions must be based on the coverage and medical necessity criteria published in OAC Chapter 5160 and practice guidelines as specified in OAC rule 5160-26-05.1.

ii. The MCO must have objective, written criteria based on sound clinical evidence to make medical necessity and utilization decisions. The MCO must involve appropriate providers in the development, adoption, and review of medical necessity criteria. The MCO's written criteria must meet NCQA standards and must specify procedures for appropriately applying the criteria.

iii. The MCO must use ODM-developed medical necessity criteria where it exists. In the absence of ODM-developed medical necessity criteria, the MCO must use clinically-accepted, evidence-informed medical necessity criteria (e.g., InterQual®, MCG®, and ASAM) as approved by ODM.

iv. In the absence of ODM-developed medical necessity criteria or ODM-approved, clinically-accepted, evidence-informed medical necessity criteria, the MCO's adaptation or development of medical necessity criteria must be based upon evaluated, peer reviewed medical literature published in the United States.

1. Peer reviewed medical literature must include investigations that have been reproduced by non-affiliated authoritative sources.

2. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale that is based upon well-designed research and endorsements by national medical bodies or panels regarding scientific efficacy and rationale.

v. When applying coverage policies and medical necessity criteria, the MCO must consider individual member needs and an assessment of the local delivery system.

b. Inter-Rater Reliability

i. The MCO must perform inter-rater reliability testing to ensure consistent application of MCO medical necessity criteria when making coverage decisions.

ii. At least annually, the MCO must ensure that all staff performing initial and continuing authorizations and denial reviews participate in inter-rater reliability testing to assess consistency in the application of medical necessity criteria.

iii. The MCO must establish specific inter-rater reliability thresholds by service or category of service.

iv. The MCO must not permit staff performing below acceptable thresholds for inter-rater reliability to make independent authorization decisions until such time that staff member can be retrained and monitored and demonstrate performance that exceeds the acceptable threshold.

v. The MCO must continually monitor performance and implement corrective measures if the MCO does not meet internal inter-rater reliability benchmarks.

7. Service Authorization

a. General Requirements

i. The MCO must cooperate with ODM to develop processes and systems necessary to allow providers to submit requests for product or service authorization, and for the MCO to accept and respond to authorization requests from providers through secure electronic transmission and exchanges with ODM's OMES. Authorization requests include prior authorizations, concurrent reviews, and retrospective reviews. The MCO must require its providers to comply with service authorization submission requirements through ODM's OMES as determined by ODM.

ii. The MCO must comply with requirements in OAC rule 5160-26-03.1 for responding to provider requests for initial and continuing authorization of services.

iii. For any service or prior authorization request or decision, ODM may require an additional clinical review or a different clinical review process. The MCO must cooperate with and assist, as needed, with this additional or different review. ODM retains authority to ultimately decide whether a service should be approved.

iv. The MCO must comply with service authorization requirements to meet the member transition of care requirements in Appendix C, Population Health and Quality, and within this Agreement.

v. The MCO must permit and facilitate ODM real time, read-only access to the MCO's service authorization systems, including all approval and denial documentation.

vi. The MCO must implement ODM expectations to standardize and streamline requirements to reduce administrative burden for providers, including:

1. Defining what constitutes an "episode of care" (i.e., one stay versus more than one stay when the member moves between levels of care);

2. Standardizing some aspects of approved lengths of stay for certain services requiring prior authorization (e.g., one year for assertive community treatment, 30 days for SUD residential services);

3. Developing a single method to order home monitoring devices (e.g., home blood pressure cuffs for member with high-risk hypertension and durable medical equipment);

4. Standardizing prior authorization requirements for SUD residential services;

5. Standardizing MCO notification of providers for submission of authorization requests to continue services that require prior authorization;

6. Standardizing and specifying the type of clinical documentation required for prior authorization decision-making;

7. Waiving prior authorization requirements for providers who consistently demonstrate excellence in prior authorization performance and meeting coverage criteria.

b. Behavioral Health Service Authorization

i. *Prohibition of Prior Authorization and Concurrent Review*

1. The MCO is prohibited from requiring prior authorization for the following behavioral health services:

a. An Ohio Children's Initiative Child and Adolescent Needs and Strengths (CANS) assessment; and

b. Up to 72 hours of MRSS, except in accordance with OAC rule 5160-27-13.

ii. *Substance Use Disorder Services*

1. The MCO must make medical necessity determinations for inpatient and outpatient substance use disorder (SUD) treatment authorizations in accordance with the ASAM criteria and guidelines for placements and level of care. When making medical necessity determinations for inpatient services, the MCO must also use other clinical criteria (i.e., MCG® or InterQual®) in addition to ASAM criteria and must authorize services when either ASAM or MCG®/InterQual® indicates the need for inpatient services.

2. The MCO must ensure that all MCO reviewers, medical directors, peer advisors, clinical directors, and clinicians involved in conducting

reconsiderations of SUD treatment service authorization denials are trained annually in use of ASAM criteria and complete competency and inter-rater reliability testing to ensure consistent application of criteria.

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

4. Upon medical necessity review and in accordance with ASAM criteria, if a needed level of care for SUD treatment is not available, the MCO must authorize at the next highest available level of care for SUD treatment. For example, if an authorization request for ASAM 4.0 does not meet clinical criteria for inpatient hospitalization, but the member needs medically monitored withdrawal management at ASAM level 3.7, the MCO must authorize level 4.0 until access to level 3.7 withdrawal management can be assured.

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

c. Home Health Assessment Service Authorization

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

d. Retroactive Coverage Requirements

i. Pursuant to ORC section 5160.34(C), the MCO is prohibited from retroactively denying a prior authorization request as a UM strategy. When performing a pre-payment review of a claim, the MCO may not deny the claim due to medical necessity when the service was prior authorized. In addition, the MCO must conduct the retrospective review of a claim submitted for a service where prior authorization was required but not obtained in accordance with the criteria in ORC section 5160.34(B)(9).

e. Notification of Authorization Decisions

i. The MCO must meet Notice of Action requirements pursuant to OAC rule 5160-26-08.4.

1. The MCO must submit all new and revised Notice of Action templates to ODM for approval prior to distribution, and all information included by the MCO must meet the member information requirements as described in Appendix A, General Requirements.

f. Peer-to-Peer Consultation and Provider Appeals

i. When the MCO denies a service authorization request from a provider, the MCO must include and offer the following information to providers in the initial denial notice, via a separate notice, the option to request a peer-to-peer consultation, provider appeal, and external medical review. The provider appeal process must satisfy the requirements and timeframes in ORC 5160.34(B)(12).

ii. The MCO must use accepted clinical guidelines under this Agreement when conducting peer-to-peer consultations and provider appeals.

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

iv. The MCO must ensure that MCO staff conducting peer-to-peer consultations and provider appeals are health care professionals who have clinical expertise in treating the member's condition, with the equivalent or higher credentials as the requesting/ordering provider.

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

vi. The MCO must offer a peer-to-peer consultation within a mutually agreed upon time within 24 hours of a provider's request for a peer-to-peer consultation.

8. Mental Health Parity and Addiction Equity Act (MHPAEA) Requirements

a. The MCO must comply with Mental Health Parity and Addiction Equity Act requirements outlined in 42 CFR Part 438 Subpart K, with regard to services provided to managed care members. The requirements apply to the provision of all covered benefits and additional services (i.e., value-added and in lieu of services) to all populations included under the terms of this Agreement.

i. The MCO must participate in ODM-requested meetings, respond to ODM information requests, work with ODM to resolve compliance risks, and notify ODM of any changes to benefits or limitations that may impact compliance with MHPAEA.

ii. The MCO must conduct ongoing monitoring to determine compliance with MHPAEA and report compliance analysis and determinations using the MHPAEA Compliance Assessment Tool (MHPAEA Tool) provided and required by ODM.

iii. The MCO must submit an updated MHPAEA Tool and written attestation of MHPAEA compliance to ODM:

1. At least 30 calendar days prior to the proposed effective date for implementing any new clinical coverage policy or changes to previously approved clinical coverage policies;
2. At least 30 calendar days prior to the proposed effective date to apply a financial requirement (co-payment);
3. At least 30 calendar days prior to the effective date of a change to benefits or limitations that may impact MHPAEA compliance;
4. Annually, as specified in Appendix P, Chart of Deliverables; and
5. Upon ODM's request.

iv. The MCO's annual updated MHPAEA Tool must include an annual summary of self-monitoring activities that describes:

1. The MCO's processes for reviewing and analyzing changes to benefit packages, service delivery structures, operational requirements, and policies to ensure ongoing parity compliance; and
2. The MCO's processes for monitoring parity compliance in operation on a regular basis, including:
    a. The data/information monitored by the MCO to identify potential parity compliance concerns, the frequency of the MCO's review of the data/information;
    b. How the MCO determines when further analysis is necessary; and
    c. The process used by the MCO to conduct further analysis when the data/information suggests the possibility of a parity compliance concern.

v. The MCO will work with ODM to ensure all members are provided access to a set of benefits that meets the MHPAEA requirements regardless of which behavioral health services are provided by the MCO.

APPENDIX C – POPULATION HEALTH AND QUALITY

1. Population Health Management

a. General

i. ODM defines "population health management" as an approach to maintain and improve physical and psychosocial well-being and address differences in health outcomes through cost-effective, person-centered health solutions that address members' health needs in multiple settings at all points along the continuum of care.

ii. ODM will lead Ohio's Medicaid population health management framework and will identify the respective roles and responsibilities of ODM, the MCOs, the OhioRISE Plan, and single pharmacy benefit manager (SPBM) for population health. The MCO must participate in ODM-led meetings and activities and meet ODM-established population health roles and responsibilities as directed by ODM.

iii. Consistent with the construct of ODM's population health management framework, the MCO must develop and implement its MCO-specific Population Health Management Strategy (PHMS), to include the MCOs role in leading population health efforts across the MCO, OhioRISE Plan, and SPBM for its members. The MCO must submit its PHMS to ODM every three years for review and approval as specified in Appendix P, Chart of Deliverables. The 2025 submission will cover years CY 2026 – CY 2028. The MCO must submit annual updates to the *PHMS* based on the QAPI evaluation/learnings or significant program or policy changes on an annual basis in the interim years.

iv. The MCO must continuously evaluate the effectiveness of its PHMS by monitoring performance on key (or ODM-required) outcome and process measures throughout the year, as well as by obtaining input from members, families, providers, and other stakeholders such as the OhioRISE plan. Subsequent submissions of the MCO's PHMS must include updates to reflect the evaluation of its PHMS as described in Paragraph 5 of this appendix.

b. MCO Population Health Management Strategy (PHMS)

i. The MCO’s Population Health Management Strategy (PHMS) must be structured by ODM-specified population streams, include data analysis to indicate an understanding of each population stream’s health and opportunities for improvements, as well as demonstrate how the MCO is contributing to population health using the stairstep framework components below:

1. The development of an optimal person-centered health system;

2. Improving access to that system (e.g., member assignment and connection to a PCP);

3. Ensuring that higher risk (sub)populations are identified using an integration of all available data sources;

4. Ensuring that all members are provided with best evidenced care and enhanced services to meet their needs; and

5. Maintaining and supporting continuity of care throughout the life course through establishing a local presence in communities in which members live, elevating the expertise of community members, and demonstrating trustworthiness by reliably responding to member, family, community, and health system needs.

ii. The MCO must submit the above stairstep approach for each population stream along with their PHMS template submission as described in Appendix P.

iii. The MCO's PHMS must also describe the following core elements, described in more detail below in this appendix:

1. Population health infrastructure, including the leadership, resources, and information systems needed to support the MCO's PHMS;

2. Population identification and segmentation to inform its PHMS, including assignment of members in alignment with ODM-identified population streams and the MCO's risk stratification framework, criteria, and thresholds;

3. Population health approaches, including care coordination, quality improvement, optimal care delivery, value-based purchasing, and other innovative approaches. The MCO must describe:

   a. The approaches in place to improve the population health within each of ODM-identified population streams, with particular attention to subpopulations with poorer outcomes;

   b. Specific initiatives within each of these strategic approaches;

   c. The timelines and milestones for all the initiatives undertaken as part of the MCO's Population Health Management Strategy; and

   d. Cross-system coordination – how the MCO will collaborate and coordinate with other entities that impact population health as a result of their involvement in the support, care, and treatment of members, including the OhioRISE Plan and SPBM.

4. Evaluation – how the MCO will monitor, evaluate, and refine its PHMS, including using information obtained through system data, activities related to the MCO's Quality Assessment and Performance Improvement Program, input from OhioRISE, and External Quality Reviews to inform and improve its Population Health Management Strategy.

2. Population Health Infrastructure

a. General

i. The MCO must provide the infrastructure necessary to support its population health management approach that must include:

1. The support of senior leadership;

2. A robust information system and the related analytics; and

3. Adequate staffing and resources to support each MCO's strategic initiatives to improve population health and to evaluate and integrate the results of population health's improvement strategies into MCO practices.

b. Senior Leadership Support

i. The MCO's senior leadership must foster and create an ongoing dynamic culture of innovation and health care excellence through its population health management approach. The lead member of the senior quality improvement (QI) leadership team must report directly to the MCO's CEO.

ii. The MCO must ensure that the Medical Director/Chief Medical Officer (CMO) is involved with and provides oversight for all clinically-related population health initiatives.

iii. The MCO, through its senior leadership, must:

1. Provide direction and oversight of all population health improvement efforts;

2. Promote an MCO culture that is focused on supporting an optimal health care delivery system through collaborative, cross-system population health management strategies;

3. Ensure a focus on both individual -and system-wide levels of improving the quality of care and optimizing health outcomes for all subpopulations;

4. Ensure that gaps in care are remedied at both the individual and systemic levels;

5. Consistently and frequently use data and analytics strategically to identify improvement opportunities, evaluate the effectiveness of improvement initiatives, and incorporate results and lessons learned into MCO business processes;

6. Ensure that all MCO population health initiatives support optimization of health outcomes for all subpopulations;

7. Ensure the MCO shares results of improvement activities with other ODM contracted managed care entities, care coordination entities (CCEs), and ODM to work collaboratively to develop and implement strategies to have

a collective impact in improving population health outcomes, including addressing population-specific differences and social determinants of health (SDOH);

8. Ensure relevant staff (e.g., member services, provider relations, UM staff) are engaged in population health improvement efforts (e.g., care coordination and quality improvement efforts) to inform and address barriers to optimal care and health outcomes;

9. Ensure transparent communication and coordination among the leadership team, the Chief Executive Officer (CEO) and relevant functional areas of the organization;

10. Promote on-going, rapid-cycle improvement of the quality of care and services provided by the MCO and its subcontractors and providers; and

11. Engage in high-impact leadership activities as described in High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs[1].

c. Staffing Resource Allocation

i. *General*

1. The MCO must allocate sufficient staffing to its population health activities to support each strategic initiative, and respond to the needs of internal and external stakeholders.

ii. *Analytical Support*

1. The MCO must have dedicated staff who conduct data analytic activities that include but are not limited to:

a. Data cleaning and quality assurance;

b. Data integration and data aggregation;

c. Population identification and risk stratification;

d. Descriptive and predictive analyses necessary to support population health strategies (e.g., care coordination, quality improvement efforts, and school-based health services alternative payment models);

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

e. Collaboration with other ODM-contracted managed care entities and health care system and community stakeholders, including school districts and school-based health partners, to ensure that data integration and analysis is optimized for population health improvement.

iii. *Community Initiative Staffing*

1. The MCO must have sufficient community initiative staffing resources to:

   a. Actively contribute to QI projects within each of the ODM-identified population streams;

   b. Attend ODM-led meetings and make connections with community initiative staff from ODM and other ODM-contracted managed care entities; and

   c. Establish relationships with communities and community-based entities, including school districts and school-based health partners to inform and address local health and population-based opportunity issues.

iv. *Quality Improvement Staffing*

1. The MCO must use QI activities and initiatives to improve population health outcomes, including the creation of new processes and procedures through iterative testing and evaluation that, at a minimum, incorporate insights from data, research, members, and providers.

2. The MCO must dedicate sufficient staff to fulfill the MCO's set of clearly defined QI functions and responsibilities, so that staffing is proportionate to, and adequate for, the planned number and types of QI initiatives.

3. The MCO must have QI teams composed of MCO staff fully dedicated to the Ohio Medicaid program that represent the following areas of expertise:

   a. Continuous quality improvement;

   b. Analytics;

   c. Subject matter expertise in clinical and nonclinical improvement topics being addressed through improvement efforts;

   d. Intervention co-design with members and providers;

   e. MCO policies and processes related to the improvement topic; and

   f. Member and provider perspectives (may be staff or liaisons with the MCOs member and provider services).

4. The MCO must designate at least one member of each QI team as having decision-making authority for testing and evaluating QI team changes to improve MCO operations, demonstrating that the MCO's QI teams are empowered to identify and make needed changes.

v. *Care Management Staffing*

1. The MCO must provide the required care management staffing resource allocation necessary to support the MCO's approach to population health management as specified in Appendix D, Care Coordination.

d. Population Health Information System

i. *General*

1. The MCO must have information systems necessary to integrate and analyze data from multiple data sources to identify population streams, risk levels, individual-and population-level needs, and calculate quality performance metrics, including but not limited to HEDIS. Information technology must also allow for monitoring the effectiveness of the MCO's response to identified needs and its impact on improving outcomes.

ii. *System Capabilities*

1. The MCO's information system must fully support all components of its Population Health Management Strategy, and comply with the requirements in Appendix K, Information Systems, Claims, and Data. At a minimum, the MCO's data information system must have the capabilities necessary to support the MCO in performing the following essential activities:

a. Integration of multiple data and information sources (e.g., enrollment data, care management data, claims, member services, 24/7 medical advice line, and prior authorization data) to facilitate internal MCO communication and coordination related to a specific member (e.g., the Utilization Management reviewer is able to see the care coordination risk level and care coordinator assigned to a particular member) or population;

b. Inform population identification, risk assignment, stratification, and assignment of care coordination status;

c. Identification of providers and community-based organization involvement; and

d. House data to support the MCO's population health management strategies, including:

i. MCO type of care coordination (i.e., Care Manager, Care Manager Plus, Care Guide, and Care Guide Plus);

ii. Identification of the primary entity providing care management and/or coordination;

iii. Person-centered care plan content, including goals, interventions, outcomes, and completion dates;

iv. Identification of population health improvement opportunities and choice of an appropriate population health management approach; and

v. Data needed to monitor the effectiveness and impact of the MCO's population health strategies.

2. The MCO must search for and proactively incorporate useful data sources to improve its ability to serve its members, network providers, families, and communities.

3. The MCO's information system must support the MCO to perform timely information system improvements, testing, and execution necessary to operationalize MCO-and ODM-coordinated population health efforts.

4. The MCO's information system must support the use of health information exchanges (HIEs) and electronic health records (EHRs) necessary for near real-time understanding of member needs and reporting metrics, such as electronic clinical quality measures (eCQMs).

5. The MCO's data systems must integrate key member information to facilitate internal MCO communication and care coordination related to a specific member, as well as to inform the MCO population stream initiatives. Key information includes but is not limited to:

   a. Clinical data (including EHR and HIE data);

   b. Data provided by CCEs;

   c. Health risk assessments and other assessments (e.g., Child and Adolescent Needs and Strengths [CANS]) whether conducted by the MCO, providers, or community-based organizations;

   d. Enrollment data;

   e. Financial data;

   f. Utilization data (e.g., professional, hospital, pharmacy, services provided by the OhioRISE Plan);

   g. Labs;

   h. Data from member and provider portals;

   i. Programmatic data (e.g., care management, disease management);

j. Member participation in Medicaid School Program and school-based services provided to member through the MSP;

k. Improvement project outcome, process, and balancing measures;

l. Survey data (e.g., Consumer Assessment of Healthcare Providers [CAHPs], Behavioral Risk Factor Surveillance System [BRFSS], Ohio Pregnancy Assessment Survey [OPAS], American Community Survey [ACS]);

m. Registry data (e.g., immunization data);

n. Complaints, grievances, and appeals;

o. Resource information from community-based organizations serving members;

p. Local governmental data (e.g., local health department data, Alcohol, Drug Addiction, and Mental Health [ADAMH] Board data, County Department of Job and Family Services [CDJFS] data, family first councils);

q. Data from MCO subcontractors and providers (e.g., transportation, home health agencies, HUBS);

r. Data from the OhioRISE Plan and SPBM; and

s. Administrative data from ODM (e.g., ODM's Enhanced Maternal and Reproductive Care File Specifications, 834 file).

t. Identification of members receiving services through the Medicaid School Program (MSP) and the services provided to each member through the MSP.

u. Member participation in MSP and school-based services provided to member through the MSP.

6. The MCO's data system must support population-specific efforts by:

   a. Allowing for the identification of differences in areas such as service access, utilization, health outcomes, intervention effectiveness, social risk factors, and survey (e.g., CAHPS) results by member characteristics; and

   b. Supporting the monitoring and comparison of process and outcome measures over time to inform disparity reduction efforts.

7. The MCO's data system must efficiently and securely share data with ODM, CCEs, the OhioRISE Plan, the SPBM, and community-based organizations, subject to state and federal privacy requirements, including:

a. Data to identify gaps in services for members;

b. Attribution file;

c. Risk factors related to SDOH and other relevant information; and

d. Tracking and confirming MCO referrals to social services.

8. The MCO's data system must efficiently and securely exchange care coordination data with providers (e.g., primary care providers [PCPs] and behavioral health providers) to facilitate integrated care planning, subject to state and federal privacy requirements. Data sharing must use industry standard formats (Consolidated Clinical Document Architecture and Fast Health Interoperability Resources).

3. Population Identification and Segmentation

a. Population Stream Assignment

i. The MCO must utilize the population stream assignment file provided by ODM to drive the population health management approach, prioritization of initiatives, and resource allocation and to optimize health outcomes. The MCO's assigned population stream must align with ODM-identified population streams, which are currently: healthy children and adults, women and infants, behavioral health children and adults, children and adults with chronic physical and developmental conditions, and older adults.

ii. The MCO must incorporate ODM-provided, structured guidance for identifying the population streams as described in ODM's Quality Strategy, located on ODM's website, into the MCO's Population Health Strategy as required by ODM.

iii. The MCO must, in its Population Health Management Strategy, describe each population stream and include the incidence and prevalence of medical and behavioral health conditions, and considerations that may impact health status, such as:

1. Age, gender, race, ethnicity, geography, language, and other socio-economic barriers;

2. Current and previous trauma experiences that might impact the effective provision of health care services; and

3. Living or caregiver arrangements that might pose challenges for certain members.

iv. The MCO must integrate information from a variety of data sources, including those referenced in this appendix, to assign members to one of the ODM-identified population streams.

v. The MCO must assign each member to a population stream based upon the member's age, health care conditions, and needs.

vi. The MCO must have systems and processes in place to identify and track the population stream assigned to each member.

b. Risk Stratification

i. Within each population stream, the MCO must establish and assess member risk levels.

ii. The MCO must develop a risk stratification framework, criteria and thresholds that must be approved by ODM prior to application as part of its Population Health Management Strategy. The MCO's risk stratification must be comprised of three tiers (i.e., from lowest to highest: low risk [Tier 1], moderate risk [Tier 2], and high risk [Tier 3]). The MCO must develop ODM-approved criteria and thresholds for each tier to determine member assignments.

1. The MCO's criteria and thresholds must identify the factors considered when determining a member's risk stratification level.

    a. At a minimum, the criteria and thresholds must include the following current and historical factors: acuity of chronic conditions, substance use and mental health disorders, maternal risk (e.g., prior preterm birth), inpatient and emergency department utilization, SDOH, and safety risk factors.

    b. To determine the needs of the member, the MCO must consider information from the member's health risk assessment, CANS assessment, and other available information.

2. The MCO must assign an initial risk stratification tier within the first month of a member's enrollment for members newly enrolled with the MCO.

3. The MCO must evaluate a member's stratification tier whenever there is a significant change in the member's needs or circumstances. If the MCO changes the member's stratification tier as a result of this evaluation, the MCO must document the change in member's need or circumstances that led to the change in stratification.

4. In coordination with other data sources, the MCO must use risk stratification to assist in targeting interventions aimed at improving population health, as well as identifying and providing for member needs (e.g., transportation, housing instability, food insecurity).

5. The MCO, in collaboration with ODM and other ODM-contracted managed care entities, must develop a process to collectively monitor Ohio's high-risk groups (e.g., women at risk of preterm birth, youth with multisystem involvement) across the life course to prevent current and future adverse events.

6. The MCO must submit a file to ODM that contains a risk stratification level for all members (MCO Risk Stratification Data Submission File), in a file

format as required in the Medi*caid Managed Care: Risk Stratification Data Submission Specifications* and as specified in Appendix P, Chart of Deliverables.

4. Population Health Approaches

a. General

i. The MCO's population health improvement approaches include:

1. Care coordination consistent with the requirements in Appendix D, Care Coordination;

2. Optimizing the delivery system through quality and performance improvement activities, population-specific community initiatives, and the identification and promotion of clinical and payer best practices; and

3. Supportive payment structures to promote a system-wide population health management approach.

b. Optimal Delivery System

i. The MCO must continuously improve all aspects of the care delivery system to optimize the health of members through inclusion of input from members, providers, and other partners across the care continuum into the design, execution, evaluation, and refinement of MCO service delivery policy and practice.

ii. The MCO must develop and apply clinical and payer best practice guidelines for service delivery decisions pertaining to: utilization management (UM), member grievance and appeals, provider dispute resolution, member education, coverage of services, QI projects, creating population-specific approaches to addressing less than optimal health outcomes, and other areas to which these guidelines apply.

1. *Clinical Best Practice Guidelines*

a. The MCO must develop and implement clinical practice guidelines that:

i. Are based on valid and reliable clinical evidence or consensus of health care professionals in a particular field;

ii. Consider the needs of members;

iii. Are adopted in consultation with the MCO's network providers, which may be done through a provider advisory group;

iv. Are reviewed and updated quarterly, or more frequently if needed;

v. Are provided in an efficient and effective format to all affected providers, members, and potential members;

vi. Incorporate the results of QI projects when applicable; and

vii. Are reported annually within ODM's Population Health Management Strategy Evaluation template.

b. The MCO must ensure the Chief Medical Officer, Population Health Director, Community Initiatives Director, QI leadership, and subject matter experts are engaged with and are removing administrative barriers to best-clinical care in the Regional Quality Improvement (QI) Hub initiative by:

i. Actively partnering with Ohio's Colleges of Medicine by listening to and incorporating their input and feedback into MCO interventions and strategies;

ii. Honing and applying knowledge of best-evidenced care, including:

1. Using data (e.g., care coordination data, HRAs, grievances and appeals, critical incidents) and QI principles to understand the current system, including the provider and patient experience journey and barriers to best-evidenced care experienced by both patients and providers, and

2. Continuously synthesizing current research on best-evidence care;

3. Actively applying lessons learned in previous projects (e.g., DSME) and what is learned from individual cases;

iii. Identifying individuals needing care and services, sequence of needs, and duration and intensity of services, including:

iv. Listening to and collaboratively addressing the issues raised by health systems and clinical partners (e.g., transportation, DSME, care coordination to connect to community resources);

v. Actively participating in discussions on how to support best evidenced care, removing administrative and other processes that do not add value;

vi. Assisting in addressing underlying social drivers of health needs (e.g., transportation) through fast access to care

coordination (e.g., care guide and care guide +) and community engagement.

vii. Undertaking additive actions for addressing differences in access and health outcomes (e.g., data bringing difficult to reach individuals to care, mobile units, etc.);

viii. Launching pilots to learn how to better address member needs and preferences, as well as learn more about potential plan impact (i.e., on site home blood pressure cuffs) and potential cost, and then applying lessons learned;

ix. Identifying potential areas of collective impact (making it easier to access value added services);

x. Actively testing and/or evaluating improvement activities;

xi. Sharing lessons learned via QI tools and data with ODM and other MCOs regarding best payer practice (i.e., removal of administrative burden) for supporting clinicians and patients within the Regional QI Hubs and how lessons learned have been applied to MCO operations;

xii. Meeting with ODM, CoMs, and other MCOs, on an ODM determined schedule, to share lessons learned and data, and strategies timelines for addressing identified member and provider needs;

xiii. Ensuring all referrals result in services being provided (i.e., closed loops); and

xiv. This initiative, led by the colleges of medicine and health system partners, adds value to Ohio's health system as it is focused on driving more effective care and intentionally addressing differences in health outcomes through structured quality improvement interventions.

2. *Payer Best Practices*

a. As a strategy for optimizing the care delivery system, the MCO must identify and demonstrate best payer practices that optimize member and provider experiences and support best clinical practice. The MCO must provide evidence of best practices (e.g., results of intervention testing, pilot, or program evaluations) to ODM upon request. Activities in support of payer best practices must include:

i. Incorporating the perspective of members, families, communities and providers;

ii. Obtaining input from network providers on burdens generated by MCO policies and procedures and efforts to minimize these burdens;

iii. Incorporating feedback from provider and member advisory groups on their needs and barriers to obtaining services to address the needs;

iv. Researching industry standards;

v. Reviewing trade journals and other literature;

vi. Conversing with other lines of business within the MCO's parent company; and

vii. Co-designing and testing strategies with members and providers through science-based QI methods and incorporating successful strategies into MCO operations and policy.

b. Provider Engagement Council

i. The MCO must establish a provider engagement council.

ii. The MCO must hold provider engagement council meetings at least three times a year. The MCO must offer meeting attendance in person, by phone, or by webinar.

iii. The MCO must ensure that the provider engagement council represents participating providers from diverse specialties and practice settings, including dental and behavioral health providers.

iv. The provider engagement council should serve as a sounding board for the MCO when considering various administrative, operational, or strategic initiatives.

v. The MCO must ensure that participating provider diversity aligns with Appendix F of the provider agreement (West, Northeast, and Central/Southeast).

vi. The MCO must ensure that participating providers reflect and understand cultural nuances of the communities they serve.

vii. The MCO must ensure that participating providers have an active participation agreement, are in good standing, and fall under ODM’s required provider type and geographical context (refer to Table 1 and Table 2).

viii. The primary purpose of the provider engagement council is collaboratively identifying issues and work on co-designed solutions. The meeting agenda must include:

1. Engaging providers in discussions about co-designing healthcare solutions, including setting priorities for future co-design initiatives;
2. Exploring challenges, opportunities, and strategies for improving collaboration between providers and stakeholders;
3. Identifying, tracking, and resolving issues causing provider burden;
4. Planning strategies to improve member and provider satisfaction;
5. Asking providers for input and feedback on new and ongoing initiatives, policies, and procedures, and must demonstrate how providers were involved in the co-design of solutions;
6. Discussing critical incidents, patient safety, and clinical best practices; and
7. Updates on the MCO's population health management strategy.

ix. The MCO's provider engagement council must be chaired by the Chief Medical Officer (CMO).

x. The MCO must invite ODM to attend provider engagement council meetings and provide an agenda to ODM in advance of meetings.

xi. Twice a year, the MCO must submit the ODM Provider Engagement Council Activity Report, as specified in Appendix P, Chart of Deliverables. The MCO must use ODM's template, which includes meeting dates, provider engagement council attendees, provider types represented, geographic region represented, a list of input, feedback, challenges, opportunities and improvement ideas that providers have shared, and a description of the actions the MCO has taken in response to the provider feedback.

xii. At a collective meeting once a year with all MCOs and ODM, each MCO provider engagement council Chair must share their MCO's learnings from the past year in the form of a summary slide presentation. The Chairs must describe the challenges and opportunities that were identified from their

provider engagement council meetings and the actions they took in response.

xiii. Provider engagement council success will be assessed within the following domains:

1. **Governance and Structure:**
    i. Clear roles, responsibilities, and leadership;
    ii. Regularity and effectiveness of meetings; and
    iii. Inclusiveness of representation (diverse provider types, specialties, and demographics).
2. **Engagement and Participation:**
    i. Level of active participation by members;
    ii. Representation of provider perspectives in discussions; and
    iii. Use of members' feedback in decision-making processes.
3. **Alignment with ODM Population Health and Quality Goals:**
    i. Integration of PEC initiatives with specific population health priorities (e.g., addressing community needs, population specific efforts).
4. **Quality Improvement Integration:**
    i. Engagement in measurable quality improvement (QI) initiatives; and
    ii. Alignment with ODMs QI strategy and stairstep framework.
5. **Outcomes and Impact:**
    i. Tangible contributions of the PEC to MCO's Population Health Management Strategy (PHMS); and
    ii. Impact of recommendations or projects on healthcare outcomes and provider experience; and
    iii. Sustainability of co-designed relationships and maintenance of initiatives.

Table C.1 Categories for Geographic Diversity

Central/Southeast Region
Northeast Region
West Region

Table C.2 Categories for Provider Type Diversity

Independent Medical Provider
Medical Provider Group
FQHC or FQHC look-alike
Hospital
Dental Provider
Behavioral Health Provider
DMEPOS
CMC & CPC

c. Care Coordination

i. The MCO must provide care coordination consistent with the requirements and principles in Appendix D, Care Coordination.

d. Community Initiatives

i. The MCO must participate in and support ODM's efforts to reduce demographic differences in health outcomes, address social risk factors, and achieve optimal health for all of its members. The MCO's community initiatives efforts must include the following:

1. Identifying demographic differences in health care access, service provision, satisfaction, and outcomes. This includes:

a. Obtaining data on member demographics and social determinants; and

b. Stratifying MCO data (e.g., claims, Healthcare Effectiveness Data and Information Set [HEDIS], CAHPS, health risk assessment, member-identified race, ethnicity, geography, language, and SDOH) to determine populations with the highest needs.

2. Ensuring the delivery of services in a culturally appropriate and effective manner to all members by promoting cultural humility at all levels of the MCO and with network providers, including promoting awareness of implicit biases and how they impact policy and processes;

3. Engaging members and families when designing services and interventions that integrate care and address childhood adversity and trauma;

4. Obtaining ongoing input from members within population streams who have less than optimal outcomes to:

    a. Create strategies for optimizing outcomes that incorporate the perspective of the member;

    b. Define metrics, timelines, and milestones that indicate success; and

    c. Establish credibility and accountability through active member involvement and feedback.

5. Ensuring that each functional area with outward facing communications tests potential publications with members for understanding and conveyance of the intended message, as well as cultural appropriateness;

6. Collaboratively partnering with members, other ODM-contracted managed care entities, network providers, and internal staff to test, refine, and share successful strategies for improving outcomes for all members;

7. Connecting and engaging with individuals and organizations within the communities the MCO serves to understand community needs and resources;

8. Partnering with community-based organizations and contributing to solutions addressing SDOH-related needs, such as:

    a. Lack of access to nutritious food (food insecurity, food deserts, and food swamps);

    b. Employment;

    c. Homelessness and housing instability;

    d. Education;

    e. Transportation;

    f. Interpersonal safety; and

    g. Toxic stress.

9. Ensuring the active referral to and follow-up on identified needs related to SDOH such as those outlined above by:

    a. Providing validated up-to-date community resource lists for member and provider use;

b. Sharing health risk assessments and other sources identifying SDOH needs, subject to state and federal privacy requirements, with network providers, HUBS, and community health workers;

c. Allowing provider choice regarding method of referral and follow-up/confirmation;

d. Reimbursing providers for notification of SDOH needs (e.g., use of ICD z codes); and

e. Reimbursing network providers for follow-up after referral to confirm that the member received the service (e.g., HIEs).

10. Identifying members who have not seen a PCP in a year or more, assessing their needs and risk stratifying appropriately, making referrals to needed services, and following up to confirm that the member received the services;

11. Staying informed of innovations and research findings that impact the health of populations experiencing less than optimal health outcomes; and

12. Tracking data over time and increasing performance targets when milestones are met.

13. Submission of the Report of Pregnancy (ROP) for all MCO identified pregnant women without a Report of Pregnancy or Pregnancy Risk Assessment Form (PRAF) already in NurtureOhio.

ii. Within ODM's QAPI evaluation template, the MCO must describe how the MCO meets the requirements for optimizing health outcomes for all segments of its population

e. MCO Specialized Services and Resources

i. The MCO must provide services and resources tailored by population, community, and risk tier along the care continuum from low to high risk.

1. When a need for services or resources is identified through a risk assessment, such as the Pregnancy Risk Assessment Form (PRAF), the MCO must provide a monthly report as specified in Appendix P.

ii. As part of its Population Health Management Strategy, the MCO must include a description of specialized services and other resources (e.g., health and wellness programs, 24/7 medical advice line, care coordination) for each population stream tailored to risk level and communities.

iii. The MCO must identify community services and resources that can be offered to members and build working relationships with community organizations to refer to and support provision of those services.

1. *Specialized Services for High Risk Populations*

    a. The MCO must provide or arrange for specialized (or non-traditional) services to be delivered via different models in the community (e.g., home visiting, group prenatal care, community hub, community workers, school-based setting) as appropriate for high risk populations identified by the MCO, or as required by ODM. High risk populations include but are not limited to women who are at risk of a preterm birth, members undergoing treatment for addiction, members involved with the justice system, members receiving services through the Medicaid School Program, members enrolled in the OhioRISE Plan, and multi-system youth and children.

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

    c. The MCO must ensure that all services provided to high risk or special populations align with the associated ODM guidance documents for those populations. ODM guidance documents can be found on ODM's website.

    d. The MCO is responsible for ensuring that the community services meet member expectations and needs, while honoring member preference, and not duplicating other services paid for by the MCO or ODM.

    e. Members who are pregnant or capable of becoming pregnant who reside in a community served by a qualified community hub, as defined in ORC section 5167.173(A)(5), may be recommended to receive HUB pathway services (by a physician, advance practice registered nurse, physician assistant, public health nurse, or another licensed health professional specified by the MCO or ODM). For those members, the MCO at a minimum must provide for the delivery of the following services provided by a certified community health worker or public health nurse, who is employed by, or works under contract with, a qualified community hub:

        i. Community health worker services or services provided by a public health nurse to promote the member's healthy pregnancy; and

        ii. Care coordination performed for the purpose of ensuring that the member is linked to employment and educational/training services, housing, educational services, social services, group pregnancy education, group prenatal care, lactation/breastfeeding consulting, evidence home based visiting, or medically necessary physical and behavioral health services.

iv. The MCO must support and implement ODM's programs and initiatives for justice-involved individuals as specified in *ODM's Expectations for Managed Care Organizations to Support Justice-Involved Individuals*.

f. Utilization Management

i. The MCO must monitor health care service under- and over-utilization as outlined in Appendix B, Coverage and Services, and OAC rule 5160-26-03.1 to inform its Population Health Management Strategy. This includes:

1. Analyzing utilization by subpopulation demographics to ensure optimal care for all populations;

2. Analyzing utilization by service areas (service types and geographies) prioritized by the MCO for utilization management;

3. Establishing a process for setting thresholds for selected types of utilization (e.g., clinical criteria);

4. Establishing standards for timeliness of UM decisions and MCO performance against standards;

5. Immediately investigating any identified under-utilization of services in order to determine root cause, corrective action to identified problem areas, and monitoring of data over time to ensure sustained correction of the problem that led to the service under-utilization;

6. Establishing methods to ensure that the MCO UM decision-making process is as efficient and uncomplicated as possible for the member, the provider, and the provider's staff;

7. Evaluating the consistency of the application of UM criteria through inter-rater reliability testing, as specified in Appendix B, Coverage and Services; and

8. Communicating identified trends to MCO staff, ODM, and providers, as appropriate.

ii. In accordance with 42 CFR 438.330, the MCO must describe its mechanisms to detect both under-utilization and over-utilization of services as part of the QAPI evaluation. The MCO must link the utilization analysis to population health outcomes, and incorporate the information obtained through this analysis into the MCO's Population Health Strategy.

g. Community Reinvestment

i. The MCO must demonstrate a commitment to improving health outcomes in local communities in which it operates through community reinvestment activities. The MCO's community reinvestment must be used to support population health strategies within the region or regions the MCO serves.

1. The MCO must not use community reinvestment funding to pay for Medicaid covered services or MCO administrative expenses.

2. The MCO must contribute a specified percentage of its estimated annual after-tax underwriting margin to fund community reinvestment. The original calculation for the 2023 community reinvestment amount was an estimate provided by ODM based on the projected member months for each calendar year. For 2023, ODM calculated 3% of the MCO's assumed 1.5% risk margin with the expectation that the MCO would begin implementation of community reinvestment activities during CY 2023, following approval of its Community Reinvestment Plan. The actual underwriting margin will be calculated for 2023 based on the MCO's annual cost report with adjustments applied in recognition of taxes, as applicable. If the MCO's underwriting margin results are negative or otherwise less than actual community reinvestment spending in 2023, ODM will apply a credit to the MCO for the next community reinvestment year... If the MCO's underwriting margin results are positive or otherwise more than actual community reinvestment spending for 2023, the MCO must add the balance to the next year's community reinvestment required amount.

   Beginning in 2024, the actual underwriting margin will be calculated annually based on the same year's annual cost report with adjustments applied in recognition of taxes, as applicable. In 2024, the MCO must contribute 4% of the annually calculated after-tax underwriting margin amount to fund community reinvestment by December 31, 2025. For 2025 and beyond, the MCO must contribute 5% of the annually calculated after-tax underwriting margin amount to fund community reinvestment by the end of the following year, e.g., the 2025 amount must be contributed by December 31, 2026.

   All funds must be kept in an interest-bearing account and the interest must be returned to the fund.

   Expenditures on community reinvestment activities for 2024-2026 will be at a set amount of $7 million annually. ODM will review this amount annually to confirm the amount for the following years. Any unspent community reinvestment dollars required in any year must be carried over and added to the required amount for the next year.

3. The MCO must work collaboratively with the other ODM-contracted MCOs in a region and the OhioRISE plan to maximize the collective impact of community reinvestment funding.

4. The MCO must use available population health data, e.g., opportunity index data, and consider existing local community health assessments (e.g., local health districts and hospital assessments) to develop its community reinvestment plan.

5. The MCO must prioritize community reinvestment opportunities generated from community partners.

6. The MCO must submit the collaborative Community Reinvestment Plan and Evaluation to ODM for ODM approval as specified in Appendix P, Chart of Deliverables. The MCO's and the OhioRISE Plan's collaborative Community Reinvestment Plan must detail the MCO's and OhioRISE Plan's anticipated community reinvestment activities and describe how those activities support the MCO's population health strategies.

7. After the first submission, the MCO must include a collaborative evaluation of the Community Reinvestment Plan to ODM as part of its annual Community Reinvestment Plan submission to ODM. The evaluation must describe and quantify the impact of community reinvestment funding on population health improvement.

h. Quality Improvement

i. *General Requirements*

1. The MCO must establish and implement an ongoing, comprehensive Quality Assessment and Performance Improvement (QAPI) program in accordance with the requirements in 42 CFR 438.330.

2. The MCOs QAPI program must employ a deliberate and defined, science-informed approach that is responsive to member and provider needs and incorporates systematic methods for discovering reliable approaches to improving population health for all segments of the population.

3. The MCO's QAPI program must encompass all levels of the organization, clearly linking the MCOs QI strategy to the MCOs and ODM's mission and vision.

4. The MCO must provide the MCO's stairstep PHMS framework, QI strategy, and QI structure as part of its Population Health Management Strategy. The MCO must report on the execution of its QAPI program to ODM as part of its annual QAPI Evaluation described below in this appendix.

5. The MCO must work collaboratively with other MCOs, OhioRISE, and SPBM on quality improvement efforts.

ii. *Quality Improvement Strategy*

1. As described in this appendix, the MCO must annually submit a clearly delineated, outcomes-driven QI strategy within the Population Health Management Strategy submission.

iii. *Quality Assessment and Performance Improvement Program Structure and Accountability*

1. *Organizational and Cross-Organizational Quality Improvement Efforts*

    a. The MCO must integrate QI efforts throughout the organization.

    b. The MCO must ensure that staff at all levels of the organization are fully equipped and committed to optimizing health outcomes for all segments of their populations.

    c. The MCO must openly communicate the results of successful and unsuccessful QI efforts, internally and externally, to foster a culture of innovation.

    d. The MCO must engage and empower staff across all levels of the organization to seek out the root cause of problems, collaboratively test improvement strategies, and rapidly learn what works to maintain and spread successes.

    e. The MCO must collaborate with ODM, the OhioRISE Plan, the SPBM, and other contracted entities, on QI activities as required by ODM.

2. *Administrative Oversight by Senior Leadership*

    a. As part of its population health infrastructure described above in this appendix, the MCO must establish administrative oversight and accountability for its QI program.

    b. The MCO's oversight must include the assignment of an ODM-approved, senior QI leadership team responsible for the QI program (e.g., QI Director, Medical Director).

    c. The MCO must ensure that the Medical Director/Chief Medical Officer (CMO) is involved and provides oversight for all clinically-related improvement projects.

    d. The lead member of the senior QI leadership team must report directly to the MCO's CEO.

3. *Quality Improvement Tools, Methods, and Principles*

    a. General

        i. The MCO must provide opportunities for staff training and hands-on application of ODM-approved, QI science tools, methods, and principles in daily work and strategic initiatives in order to build internal MCO staff QI skills and capacity throughout the organization.

b. Quality Improvement Training Requirements

i. To create an organizational foundation with the necessary QI skills and proficiencies, the MCO must:

1. Ensure the MCO's Medical Director, Behavioral Health Clinical Director, Population Health Director, Community Initiatives Director, QI Director, Dental Director, Pharmacy Director, analytic support staff, and at least one MCO staff person assigned to each improvement team have completed training that covers the QI training content described below from an ODM-approved entity. The MCO's QI training is not a substitute for the certification required in Appendix A, General Requirements; and

2. Document the MCO's ongoing efforts to build QI expertise and capacity in its annual Population Health Management Strategy Evaluation.

c. Quality Improvement Training Content

i. The MCO's QI training content must include opportunities to use and understand the following:

1. The Deming System of Profound Knowledge® (SoPK);

2. Use quantitative and qualitative data to understand opportunities for improvement, including understanding of how improvement opportunities differ by subpopulations, geographies, and provider types, as well as where differences exist in access to care, optimal service utilization, experience, and health outcomes;

3. The Model for Improvement developed by the Associates in Process Improvement and popularized by the Institute for Healthcare Improvement (IHI);[2]

4. Defining a Quality Improvement Project goal as a Specific, Measurable, Achievable, Relevant, and Time-bound (SMART) Aim;

5. Continuously obtaining, listening to, and incorporating information and feedback from members, providers, and other stakeholders (e.g., voice of the customer and

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

stakeholder, Gemba walks) to inform MCO understanding of:

a. The member/patient journey demonstrated through the use of process mapping;

b. Barriers at each step of the process resulting in failure to achieve the SMART Aim as shown by the use of simplified Failure Mode and Effects Analysis (sFMEA);

c. Identification of root cause(s) of the most prevalent and/or important failures using the 5 Whys or similar tool;

d. Development of the theory for improvement as displayed in a Key Driver Diagram[3] with key drivers specific to what will lead to an improvement in the SMART Aim and testable interventions that reflect the hypothesized way in which improvement in the key drivers will occur; and

e. Codesigning interventions through iterative testing with those impacted using Plan Do Study Act cycles.

6. Selection and use of process, outcome, and balancing measures to allow assessment of whether interventions are having the desired impact on the theorized key drivers of the SMART Aim;

7. Codesigning and active intervention testing through rapid (i.e., less than monthly) Plan-Do-Study-Act (PDSA) cycles with clearly defined predictions of success, metrics and data to determine whether results match predictions, documentation of resulting learning, and consequent planned actions, as well as updates to the theory for improvement (i.e., KDD) to reflect learning;

8. The use of time series and trend charts to understand and act upon special cause variation, including the use of annotated run charts and the Shewhart control charts;

[3] http://www.ihi.org/resources/Pages/Tools/Driver-Diagram.aspx

9. Considerations and techniques for successful implementation (i.e., permanence), spread, and sustainability of interventions with data-based evidence of success under multiple circumstances, including subpopulations, geographies, and provider types; and

10. The sequencing and iterative use of the above tools and methods to achieve sustainable improvements to member and provider experience, access to services and supports, and health outcomes.

d. *Quality Improvement Training Completion*

i. The MCO must submit training curricula to ODM for approval prior to start of MCO operations under this Agreement, and prior to substantive changes to the training curricula.

ii. The MCO must submit Evidence of QI Training Completion as specified in Appendix P, Chart of Deliverables.

iii. Medical Directors with a substantial role in improvement projects or who are accountable for the QAPI program, as well as QI Directors, must complete the course work within six months. Medical and QI Directors are exempt to this requirement if they have evidence of course completion covering the content above within.

e. *Applying Quality Improvement Training Concepts*

i. The MCO must ensure that during and subsequent to quality improvement training, MCO staff are actively involved as QI team members in at least one improvement project in order to continue to build the QI capacity of the MCO.

ii. For purposes of this Agreement, "active involvement" means applying QI tools, methods, and concepts to a clinical or non-clinical problem, including the analysis of data to determine opportunities for improvement, root cause determinations, barrier assessment, intervention design, and testing using PDSA cycles, longitudinal measurement, and assessment of intervention impact on outcome measures using statistical process control methods.

iv. *MCO Clinical and Non-Clinical Improvement Projects*

1. The MCO must design and conduct improvement projects in clinical and non-clinical topic areas that use the tools, methods, and principles defined above to improve population health (focused on areas with greater improvement needs) across the care continuum.

2. The MCO must self-initiate improvement projects, as well as conduct improvement projects that ODM requires. ODM-required improvement projects may include projects in coordination with other ODM-contracted managed care entities (e.g., improvement of medication reconciliation by clinics and hospitals, medication adherence, safety, and quality) and/or other stakeholders (e.g., providers, health systems, colleges of medicine, quality collaboratives).

3. MCO improvement projects must aim to achieve significant and sustained improvement over time in population health outcomes, quality of life, and provider/member satisfaction.

4. In conducting improvement projects, the MCO must:

    a. Designate a member of the Senior QI Leadership team as project sponsor to ensure that resource needs are met, issues are identified and elevated on a timely basis, and learning is effectively shared throughout the organization;

    b. Appropriately staff projects as described in this appendix;

    c. Use ODM-specified QI methods and tools such as PDSA cycles, along with frequent and ongoing analysis to quickly determine the effectiveness of interventions;

    d. Use ODM developed templates (e.g., QI template, key driver diagram [KDD] template, PDSA template) to document the MCO's manual, rapid cycle, iterative work required, as well as the lessons learned from this process;

    e. Use data to identify improvement opportunities and longitudinally monitor project progress. This includes using data analysis methods such as statistical process control to differentiate common and special cause variation in order to identify improvement, sustained successes, and additional opportunities for improvement;

    f. Analyze data to identify differences in services and/or care and tailor interventions to specific populations when needed in order to ensure optimal health outcomes; and

    g. Actively incorporate member and provider perspectives into improvement activities.

5. The MCO must use ongoing analysis, data feedback, and the associated learning to determine improvement subjects and interventions.

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

7. Performance Improvement Projects

   a. Performance improvement projects (PIPs) are a subset of all MCO improvement projects that must also comply with 42 CFR 438.330. Each year, ODM designates at least one improvement project to serve as the MCO PIP. As with all other improvement projects, ODM requires that PIPs are conducted using rapid cycle QI science techniques.

      i. The MCO must initiate and complete PIPs in topics selected by ODM.

      ii. The MCO must work with ODM and ODM's external quality review organization (EQRO) to develop and implement at least one PIP designated by ODM.

      iii. As part of this process, the MCO must participate in PIP planning, including assisting in the recruitment of participating practices, determining initial key drivers and interventions.

      iv. The MCO must ensure that all PIPs designed and/or implemented demonstrate improvement and the MCO must clearly articulate lessons learned during the course of the initiative.

      v. The MCO must adhere to ODM-specified reporting, submission, and frequency guidelines during the life of the PIP; establish and implement mechanisms for rapid testing of interventions; and, establish mechanisms for spreading and sustaining successful interventions in order to optimize improvement gains.

      vi. Upon request, the MCO must provide longitudinal data demonstrating sustained improvement over the course of the project and during the sustainability phase following final validation of the PIP by ODM's EQRO.

      vii. The MCO must fully cooperate with ODM's EQRO in its PIP validation activities, performed in accordance with 42 CFR Subpart E.

   b. The MCO is required to work collaboratively on Antipsychotic Metabolic Monitoring (APMM).

   c. Collaborative PIPs require that the participating managed care entities (MCEs) select a lead analyst who is charged with ensuring the use of common data definitions across MCEs and compiling individual MCE data to meet the needs of the PIP.

v. Collection and submission of performance measurement data as specified in Appendix I, Quality Measures

vi. *Quality Improvement Communication Strategy*

1. The MCO must develop and use a clearly defined communication strategy for QI activities. The MCO's communication strategy must include:

a. Mechanisms for data receipt and exchange, analyzing and interpreting data, and transparently and proactively involving stakeholders and partners in applying data to inform improvement efforts;

b. A description, including lines and methods of communication, of the internal mechanisms used to frequently, transparently, and proactively communicate improvement status updates across the organization, to executive leadership, and to ODM. Status updates must include lessons learned from intervention testing, advances to the theory of knowledge, and progress on process and outcome measures; and

c. Mechanisms for proactive, regular communication with ODM and EQRO staff regarding improvement opportunities and priorities, intervention successes, lessons learned, and future activities.

i. Mechanisms and standards for responding promptly and transparently to data and information requests by ODM or the EQRO Cross-System Collaboration.

i. The MCO must facilitate cross-system collaboration and coordination with other entities that impact population health as a result of their involvement in the support, care, and treatment of members. All collaboration and coordination is subject to state and federal privacy requirements. Such entities include but are not limited to:

1. Care coordination entities, including ODM-funded entities associated with alternative payment models (Comprehensive Maternal Care [CMC], Comprehensive Primary Care [CPC], Behavioral Health Care Coordination [BHCC]) and conflict-free case management agencies (PASSPORT Administrative Agencies, County Boards of Developmental Disabilities, Ohio Home Care Case Management Agencies);

2. OhioRISE Plan, OhioRISE Plan care management entities (CMEs), and the SPBM;

3. Other entities within the health care delivery system; and

4. Other ODM-contracted MCOs and involved entities (e.g., local health departments, ADAMH Boards, schools, child welfare, County Job and Family Services, justice system).

ii. Cross-system collaboration and coordination includes:

1. Identification of service gaps and assistance in closing gaps in care (e.g., scheduling appointments, arranging transportation, and facilitating referrals and linkages to MCO health and wellness programs) in order to optimize health outcomes;
2. Data sharing, subject to state and federal privacy requirements;
3. Coordination between involved entities, care coordinators, and primary care providers;
4. Coordination and collaboration with public school districts;
5. Ensuring seamless care transitions and follow-up as outlined in Appendix D, Care Coordination;
6. Early identification of care needs (e.g., pregnancy, lack of preventive care, behavioral health) and connection to services;
7. Promotion of services that facilitate care delivery (e.g., telehealth);
8. Integrating behavioral and physical health; and
9. Addressing SDOH, such as food insecurity, housing instability, and transportation needs.

iii. The MCO is required to participate in and support Cross-System Collaboration initiatives including the School-MCE Partnerships and other initiatives developed in accordance with the Shared Agreement between ODM, Managed Care Entities, Pediatric ACOs, and interested Children's hospitals, such as the Accelerate Children's Outcomes Improvement initiative.

j. Value-Based Payment as described in Appendix H.

5. Evaluation

a. <u>QAPI Evaluation</u>

i. The MCO's annual evaluation of its PHMS and QAPI must be used to inform the MCO's PHMS updates for the upcoming year.

ii. The MCO's evaluation of its PHMS and QAPI must be submitted using the QAPI Evaluation template as described in Appendix P.

iii. For each population stream, the MCO's Evaluation must assess the effectiveness of the MCO's PHMS in contributing to:

1. Development of an optimal person-centric health system;
2. Improved access to the health system;
3. Improved identification of higher-risk subpopulations;
4. The provision of best-evidenced care and enhanced services; and

5. The maintenance and support of continuity of care over the life course.

iv. For each population stream, the MCO must assess the MCO's progress towards meeting the objectives and goals associated with the population health stream-specific strategic aims.

v. For the Behavioral Health Children population health stream, the MCO must obtain input from the OhioRISE plan regarding its success in actively supporting the integration of physical and behavioral health needs for this population and use that feedback to inform its future population health management efforts.

vi. The MCO's QAPI Evaluation must assess data from multiple areas of the system (e.g., claims, health risk assessments, member grievances and appeals, care coordination) in order to identify patterns (e.g., service utilization patterns) and anticipate problem areas (e.g., unmet SDOH needs) to refine the MCO's Population Health Strategy for the upcoming year.

vii. The MCO's QAPI Evaluation must assess the extent to which the input from members, providers, and other partners was included in the design, execution, and refinement of MCO service delivery policy and practice.

viii. The MCO's QAPI Evaluation must describe how the MCO has institutionalized effective policies and practices it has found to be effective so that they are a permanent and sustained part of its operations.

ix. The MCO must assess the effectiveness of the MCO's collaboration with the OhioRISE Plan and SPBM.

x. The MCO must utilize its monitoring of process and outcome measures to inform risk stratification algorithms, as well as its ongoing design or adaptation of strategies and initiatives to better serve the needs of the population.

xi. The MCO's report of the implementation of the Quality Assessment and Performance Improvement program, required by 42 CFR 438.330, is reported as part of the PHMS Evaluation and must include:

1. A description of ODM- and MCO-initiated improvement projects, including the annual Performance Improvement Project(s). The description must include:

    a. How the performance improvement project was designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction;

    b. The trended measurement of performance (e.g., outcome measures, measures of success) using objective quality indicators;

    c. Interventions that were undertaken to achieve improvement in the access to and quality of care;

d. Evaluation of the effectiveness of the interventions based on metrics; and

e. Planning and initiation of activities for increasing or sustaining improvement.

xii. Collection and submission of performance measurement data;

xiii. A description of mechanisms the MCO uses to detect both underutilization and overutilization;

xiv. A description of mechanisms the MCO uses to assess the quality and appropriateness of care furnished to members with special health care needs and members receiving long-term services and supports;

xv. A description of mechanisms the MCO uses 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 person-centered care plan, if applicable; and

xvi. A description of the MCO efforts to prevent, detect, and remediate critical incidents that are based, at a minimum, on state requirements for home and community-based waiver programs.

b. Quality Improvement Meeting Requirements

i. The MCO must document project learning using the ODM QI meeting template and submit the template at least two business days prior to each meeting, as specified in Appendix P, Chart of Deliverables.

1. During the planning phase of an improvement project, the MCO must support ODM in its efforts to coordinate and lead the QI meetings. The MCO must provide its QI template that includes, as appropriate to the topic, the following:

a. Detailed and high-level process maps of the MCO's processes related to the outcome of interest;

b. Results of obtaining member and provider perspectives on the MCO's processes (e.g., identified barriers and ideas for improvement); and

c. Strategies, timelines, and milestones for next steps (including what must be accomplished before the next meeting).

2. During the active testing stage of an improvement project, the MCO must ensure its QI template and accompanying meeting reflects the results of the MCO's weekly or more frequent PDSA cycles as demonstrated by documentation of testing and annotated run or control charts.

3. Once changes have resulted in improvement, the MCO must begin actively testing in new circumstances for purposes of effectively spreading the improvement.

c. External Quality Review

i. ODM will select an EQRO to provide for an annual external and independent review of the quality, outcomes, timeliness of, and access to services provided by the MCO.

ii. The MCO must submit data and information, including member medical records, at no cost to, and as directed by, ODM or its designee for the annual external quality review activities.

iii. The MCO must participate in an annual external quality review that must include but is not limited to the following activities:

1. A comprehensive administrative compliance review as directed by ODM in accordance with 42 CFR 438.358;

a. In accordance with 42 CFR 438.360 and 438.362, the MCO, if it is accredited by a national organization approved by the Centers for Medicare and Medicaid services may request to be exempted (deemed) from certain portions of the administrative compliance review. ODM will inform the MCO if the MCO may request a non-duplication exemption.

b. The EQRO may conduct focused reviews of MCO performance as directed by ODM in the following domains that include but are not limited to the following:

i. Availability of services;

ii. Assurances of adequate capacity and services;

iii. Coordination and continuity of care;

iv. Coverage and authorization of services;

v. Provider selection;

vi. Confidentiality;

vii. Grievance and appeal systems;

viii. Sub contractual relationships and delegation;

ix. Practice guidelines; and

x. Health information systems.

2. Encounter data studies;

3. Validation of performance measurement data;
4. Review of information systems;
5. Validation of performance improvement projects;
6. Provider surveys and member satisfaction and/or quality of life surveys; and
7. Network access validation and oversight activities (e.g. appointment availability surveys, provider directory audits).

APPENDIX D – CARE COORDINATION

1. MCO Care Coordination

a. General Requirements

i. The MCO must develop and implement a high-performing care coordination program that meets the care coordination requirements in this appendix, and reflects the guiding principles to optimize the health of the individual members and populations it serves.

ii. Care coordination, for purposes of the requirements in this Agreement, is used in the broadest sense to encompass the full spectrum of care coordination activities, ranging from short-term assistance to meet care gaps to longer-term, intensive, and holistic care management for members with the most intense needs. Other terminology used in this appendix is as defined in the Definitions section of this Agreement.

iii. The MCO's care coordination program must serve as the foundation to ensure that all members have access to quality care coordination, whether the member is receiving care coordination from a care coordination entity (CCE), the OhioRISE Plan, an OhioRISE

iv. Plan-contracted care management entity (CME), the MCO, or a combination thereof.

v. The MCO may delegate any requirement specified in this appendix to a CCE in accordance with the requirements in the subcontractual relationships and delegation section in Appendix A, General Requirements. If the MCO does not enter into a delegated arrangement with the CCE, while the MCO is not required to monitor and oversee the CCE, the MCO is expected to maintain a collaborative relationship and coordinate care with the CCE to meet members' needs. The collaborative and coordinated relationships between the MCO and CCEs do not invoke the delegation requirements in Appendix A, General Requirements.

vi. The MCO's care coordination program must safeguard confidential information in accordance with the privacy compliance requirements specified in Appendix A, General Requirements.

b. Guiding Principles

i. The MCO's care coordination program must reflect the following guiding principles:

1. Care coordination identifies and addresses physical, behavioral, and psychosocial needs of members.

2. Care coordination supports member goals and choices through a person-centered, trauma-informed, and culturally attuned approach.

3. Care coordination provides care continuity while honoring member experience and choice.

4. The MCO preserves existing care relationships between members and local CCEs.

5. The MCO leverages the strengths of CCEs, the OhioRISE Plan, and CMEs by supporting and developing partnerships with CCEs, the OhioRISE Plan, and CMEs.

6. The MCO establishes clear communication and delineation of roles and responsibilities of various entities throughout the care coordination process to minimize the duplication of services and streamline service delivery.

7. The MCO implements systems capable of efficiently receiving, providing, and exchanging the data and information necessary to effectively coordinate the care of members who are served by multiple entities.

c. MCO Care Coordination Program Description

i. The MCO must submit its care coordination program description in writing for ODM approval prior to implementation. Following initial approval, the MCO must submit any changes to its care coordination program to ODM for approval prior to implementing the change. The MCO must submit the Care Coordination Program Submission as specified in Appendix P, Chart of Deliverables.

ii. The MCO's care coordination program submission must describe the following components, described in more detail within this appendix:

1. The MCO's care coordination staffing, including the number of staff by role, qualifications, and physical location;

2. The training topics and frequency of training provided to MCO care coordination staff;

3. The MCO's risk stratification framework, including the criteria and threshold for each tier;

4. The assignment of MCO care coordination staff, including proposed caseload sizes and assignment methodology;

5. The MCO's requirements related to contact schedules;

6. The MCO's roles and responsibilities to support CCEs and the OhioRISE Plan/CMEs (for OhioRISE Plan enrolled members) in providing care coordination to the MCO's members and ensuring the members' needs are met;

7. The MCO's roles and responsibilities for performing care coordination activities when the MCO is exclusively providing care coordination to members;

8. How the MCO will notify members of care coordination assignment;

9. The MCO's data and information systems and how they will be used to support MCO's responsibilities for care coordination regardless of which entities are providing care coordination; and

10. How the MCO will monitor the care coordination program for individual and systemic improvements.

2. Care Coordination Requirements

a. Staffing and Training

i. The MCO's care coordination staffing must include a range of disciplines with complementary skills and knowledge to deliver a comprehensive, integrated care coordination program fully capable of addressing members' physical, behavioral, and psychosocial needs.

ii. The MCO must ensure staff who are performing care coordination functions are operating within their professional scope of practice, are appropriate for the member's health care needs, and comply with the state's licensure and credentialing requirements.

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

iv. The MCO's proposed care coordination program may employ an integrated team approach of clinical and non-clinical staff, whose skills and professional experience complement and support one another, performing required care coordination activities. However, the MCO must ensure a primary point of contact for care coordination and that licensed care coordination staff perform care coordination activities that require licensed staff to perform those activities as required by this Agreement and state law.

v. The MCO's care coordination staffing must reflect four distinct roles and levels of support from the MCO: Care Manager, Care Manager Plus, Care Guide, and Care Guide Plus.

1. *Care Manager*

a. The MCO must perform the full scope of care coordination activities and responsibilities for members who need care coordination and are not assigned to a CCE, the OhioRISE Plan, and/or CME, or who choose to receive their care management from the MCO. The MCO Care Manager serves as the single point of contact for care coordination.

b. The MCO must offer/assign a Care Manager to a member when long-term care coordination needs are identified, the level of clinical expertise to

coordinate care exceeds the capabilities of the Care Guide, and when indicated by risk stratification.

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

d. Care Managers must be licensed within the state of Ohio. The following licenses are acceptable for MCO Care Managers: registered nurse, licensed social worker (LSW, LISW), and licensed professional counselor (LPC, LPCC, LPCC-S).

2. *Care Manager Plus*

a. If the member is assigned to a CCE, the OhioRISE Plan, and/or CME, but the MCO, CCE, OhioRISE Plan, and/or CME collectively determine the needs of the member are greater than the capability of the CCE, OhioRISE Plan, and/or CME, the MCO must assign an MCO Care Manager Plus. An MCO Care Manager Plus serves as the single point of contact at the MCO to support CCE-, OhioRISE Plan-, and/or CME-delivered care coordination.

b. The MCO must assign a Care Manager Plus to a member when long-term care coordination needs are identified, the level of clinical expertise to coordinate care exceeds the capabilities of the Care Guide Plus, and when indicated by risk stratification.

c. The Care Manager Plus is responsible for ensuring the member receives the full scope of care coordination services, including comprehensive assessment completion (inclusive of the health risk assessment), person-centered care plan completion (ensuring no duplication with the CCE, OhioRISE Plan, and/or CME), and identifying and addressing ongoing needs.

d. The Care Manager Plus is responsible for providing actionable data, information, and support to assist the CCE, OhioRISE Plan, and/or CME in meeting the member's care needs. The Care Manager Plus must integrate information collected by the CCE into its Care Coordination Portal to minimize duplication.

e. Care Manager Plus must be licensed within the state of Ohio. The following licenses are acceptable for MCO Care Manager Plus: registered nurse; licensed social worker (LSW, LISW); and licensed professional counselor (LPC, LPCC, LPCC-S).

3. *Care Guide*

a. The MCO Care Guide serves as a single point of contact for care coordination when there is no CCE, OhioRISE Plan, and/or CME involvement and short-term care coordination needs are identified. Care Guides must be

representative and reflect the community of the populations being served. The staff member's level of clinical expertise and member's risk stratification must also be evaluated when offering/assigning an MCO Care Guide. Members needing Care Guide assistance for longer than 60 calendar days should be considered for referral to a Care Manager. The MCO Care Guide serves as the single point of contact for care coordination.

b. Care Guide qualifications include experience in care coordination for a minimum of one year and knowledge of internal MCO processes and procedures related to Care Guide responsibilities.

c. Care Guide responsibilities include:

i. Assuring completion of a health risk assessment;

ii. Assisting members to remediate immediate and acute gaps in care and access;

iii. Assisting members with filing grievances and appeals;

iv. Connecting members to CCEs, the OhioRISE Plan, or MCO Care Management if the member's needs indicate a higher level of coordination;

v. Providing information to members related to MCO requirements, services, and benefits; and

vi. Providing members with information and/or referrals to community resources.

4. *Care Guide Plus*

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

b. Care Guide Plus qualifications include experience in care coordination for a minimum of one year and knowledge of internal MCO processes and procedures related to Care Guide Plus responsibilities.

c. Care Guide Plus responsibilities include:

i. Assuring completion of a health risk assessment;

ii. Assisting members to remediate immediate and acute gaps in care and access;

iii. Assisting members with filing grievances and appeals;

iv. Connecting members to designated CCEs, the OhioRISE Plan, or MCO Care Management if the member's needs indicate a higher level of coordination;

v. Providing information to members related to MCO requirements, services, and benefits; and

vi. Providing members with information and/or referrals to community resources.

5. The MCO must submit Care Coordination Contact Lists as specified in Appendix P, Chart of Deliverables.

b. Risk Stratification

i. In addition to conducting risk stratification for the purposes of population health activities on a population level as described in Appendix C, Population Health and Quality, the MCO must use individual-level risk stratification as one factor when determining the level of care coordination that is appropriate for each member.

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

iii. The MCO's criteria and thresholds must identify the factors the MCO considers when determining a member's risk stratification level.

1. At a minimum, the criteria and thresholds must include the following current and historical factors:

a. Acuity of chronic conditions, substance use and/or mental health disorders, maternal risk (e.g., prior preterm birth), inpatient or emergency department utilization, SDOH, and safety risk factors; and

b. Information from the member's health risk assessment.

iv. The MCO must assign an initial risk stratification tier within the first month of a member's enrollment for members newly enrolled with the MCO. The MCO must review and update the risk stratification tier following the completion of the member's health risk assessment.

v. The MCO must evaluate a member's risk stratification tier whenever there is a significant change in the member's needs or circumstances. If the MCO changes the

member's stratification tier as a result of this evaluation, the MCO must document the change in member's need or circumstances that led to the change in stratification.

vi. The MCO must communicate risk stratification to ODM, CCEs, the OhioRISE Plan, and the single pharmacy benefit manager (SPBM) as required by ODM in Appendix C, Population Health and Quality.

c. Care Coordination Assignment

i. *General*

1. The MCO must respect, promote, and support care coordination provided by CCEs within the community, while honoring member choice. CCEs may include:

    a. Entities associated with value-based payment models (e.g., Comprehensive Maternal Care [CMC], Comprehensive Primary Care [CPC], and Behavioral Health Care Coordination Entity [BHCCE]);

    b. Conflict-free case management agencies (PASSPORT Administrative Agencies, County Boards of Developmental Disabilities, Ohio Home Care Case Management Agencies); and

    c. Other community-based care coordination models (e.g., CMEs).

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

3. For CCEs that the MCO is not contracted with (i.e., CCEs that are not in a delegated arrangement with the MCO, the OhioRISE Plan, and OhioRISE Plan-contracted CMEs), the MCO retains responsibility ensure the member needs are met and supplement care coordination as necessary.

4. The MCO must ensure that its care coordination staff are not related by blood or marriage to the member or any paid caregiver, financially responsible for the member, or empowered to make financial or health related decisions on behalf of a member.

ii. *Care Coordination Assignment for OhioRISE Plan Enrolled Members*

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

must assign MCO care coordination necessary to meet the needs of the member.

2. The MCO must provide the OhioRISE Plan with up-to-date contact information for the MCO care coordination staff assigned to the member.

iii. *Care Coordination Assignment for Members Not Enrolled in the OhioRISE Plan*

1. For members not enrolled in the OhioRISE Plan, the MCO must make a Care Manager, Care Manager Plus, Care Guide, or Care Guide Plus available as needed or upon request, as described below. Member access to MCO care coordination is not solely dependent upon risk stratification. MCO assignment of care coordination staff must consider:

    a. The assessment of the member's short and long-term care coordination needs;

    b. The member's level of needs based upon risk stratification;

    c. Whether the member is receiving care coordination from a CCE;

    d. The capability of the CCE to effectively manage the member's needs; and

    e. Member choice.

2. If a member is assigned to a CCE, the MCO must preserve and support the care coordination relationship between the CCE and the member.

    a. The MCO must ensure that the member's care coordination needs are met by the CCE and must assign an MCO Care Manager Plus or MCO Care Guide Plus as determined necessary by the MCO.

    b. The MCO must also assign an MCO Care Manager Plus or MCO Care Guide Plus if requested by the CCE.

3. For those members not assigned to a CCE or who choose to receive care coordination from the MCO, the MCO must determine assignment to an MCO Care Manager and MCO Care Guide based upon need.

iv. *MCO Care Coordination Caseload Assignments*

1. The MCO must implement maximum caseload sizes and a caseload assignment methodology that results in the consistent and appropriate assignment of caseloads that ensures health, safety, and welfare of members.

2. The MCO's caseload assignment methodology must consider the following factors: population; acuity status mix; MCO staff qualifications, years of experience, and level of responsibilities; availability of support staff; location of MCO staff (e.g., MCO administrative office, MCO field office,

provider office); geographic proximity to members; and access to and capabilities of technology and information systems.

3. The MCO must not exceed maximum caseload sizes prior approved by ODM as part of the MCO's care coordination program submission. Maximum caseload sizes apply to staff whether they are directly providing care coordination or supplementing care coordination activities provided by the CCE.

v. *Care Coordination Status*

1. The MCO must assign and report a care coordination status for each member who is assigned to a Care Manager, Care Manager Plus, Care Guide, or Care Guide Plus. Care coordination status consists of the following indicators:

   a. Assigned: Care Manager;

   b. Assigned: Care Manager Plus;

   c. Assigned: Care Guide;

   d. Assigned: Care Guide Plus; and

   e. Not Assigned: not assigned to a Care Manager, Care Manager Plus, Care Guide, or Care Guide Plus.

2. The MCO must report care coordination status (Care Coordination Status Submission File) as specified in Appendix P, Chart of Deliverables, in a file submission as required in *ODM's Medicaid Managed Care: Care Coordination Status Submission Specifications.*

d. Care Coordination Activities

i. *MCO Activities in Support of CCE- and OhioRISE Plan-Led Care Coordination*

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

2. The MCO's Care Manager Plus or Care Guide Plus is responsible for assisting CCEs and the OhioRISE Plan/CME (for OhioRISE Plan enrolled members) in a timely manner with the following care coordination activities upon CCE or OhioRISE Plan request:

   a. Supporting member outreach efforts;

   b. Facilitating a timely initial Child and Adolescent Needs and Strengths (CANS) assessment or other assessments when indicated or requested;

c. Participating in transdisciplinary care team meetings for members for whom the CCE or OhioRISE Plan/CME is the leading care coordinator.

d. Participating in CCE-led care teams and/or Child and Family Teams (for OhioRISE Plan members) to support the assessment and person-centered care planning process in the role as identified by the CCE or OhioRISE Plan/CME;

e. Assisting the CCE and OhioRISE Plan/CME to identify and link members to network providers as needed (e.g., specialists, dentists, behavioral health providers);

f. Assisting in the coordination of MCO covered services as needed (e.g., scheduling appointments, arranging transportation, facilitating referrals, and linking members to MCO health and wellness programs);

g. Educating CCEs and OhioRISE Plan/CME about resources/services (e.g., value-added benefits) that are available to members;

h. Arranging for MCO staff to provide clinical consultation upon CCE or OhioRISE Plan/CME request;

i. Assisting with bi-directional communication between the CCE, OhioRISE Plan/CME, and SPBM; and specialists, pharmacies, labs, and imaging facilities as needed in order to facilitate timely exchange of information;

j. Sharing care coordination data and information with ODM, CCEs, the SPBM, and the OhioRISE Plan/CMEs as applicable to prevent gaps in care and duplication of efforts;

k. Identifying gaps in care and taking action as necessary to close gaps in care;

l. Participating in discharge planning activities with the inpatient facility and the CCE and/or OhioRISE Plan/CME to support a safe discharge placement and to prevent unplanned or unnecessary readmissions, ED visits, and adverse outcomes;

m. Ensuring member access to post discharge services covered by the MCO as specified in the discharge and transition plan;

n. Facilitating clinical hand offs between the discharging facility and other MCO network providers involved in the care and treatment of the member;

o. Actively securing the necessary authorizations for the services that are the responsibility of the MCO, coordinating with the CCE, SPBM, OhioRISE Plan/CME, and providers to ensure the member's timely

access to the services identified in the person-centered care plan; and

p. Monitor to ensure that the services are delivered as recommended in the person-centered care plan.

ii. *MCO Activities for MCO-Led Care Coordination*

1. For members who are assigned to an MCO Care Manager or Care Guide, the Care Manager or Care Guide is responsible for performing the following care coordination activities for members:

a. Outreaching members to engage in care coordination;

b. Conducting or arranging for member assessments as described in more detail below;

c. Leading the development and ongoing updates to the person-centered care plan as described in more detail below;

d. Leading transdisciplinary care team meetings for members for whom the Care Manager or Care Guide is the leading care coordinator;

e. Offering and linking members, as appropriate, to health education, disease management, and wellness/prevention coaching;

f. Identifying and linking members to network providers as needed;

g. Coordinating member access to covered services as needed (e.g., scheduling appointments, arranging transportation, making referrals, and linking the member to MCO health and wellness programs);

h. Educating the member about available resources and services (e.g., value -added benefits) and assisting the member in accessing those resources and services;

i. Communicating and exchanging information with providers (e.g., PCP, specialists, labs, imaging facilities), ODM, and the SPBM to coordinate the care of the member;

j. Sharing care coordination data and information with ODM and the SPBM as applicable to prevent gaps in care and duplication of efforts;

k. Identifying gaps in care and taking action as necessary to close gaps in care;

l. Participating in discharge planning activities with the inpatient facility to support a safe discharge placement and to prevent

unplanned or unnecessary readmissions, ED visits, and adverse outcomes;

m. Ensuring member access to post discharge as specified in the discharge and transition plan;

n. Facilitating clinical hand offs between the discharging facility and other network providers involved in the care and treatment of the member;

o. Actively securing the necessary authorizations for the services to ensure the member's timely access to the services identified in the person-centered care plan; and

p. Monitor to ensure that the services are delivered as recommended in the person-centered care plan.

iii. *Health Risk Assessment*

1. The MCO must complete or ensure CCE completion of an ODM-approved health risk assessment (HRA) for all members. The HRA must be completed within 90 calendar days of a member's effective enrollment date into the MCO. Thereafter, the MCO must complete or ensure an HRA is completed, at a minimum, annually (every 365 days) thereafter.

2. The MCO must report health risk assessment results (Health Risk Assessment Submission File) as specified in Appendix P, Chart of Deliverables.

3. The MCO must include the following components as part of its Care Coordination Program for ODM approval:

    a. The methods and timelines utilized to complete the HRA, including any variances by risk tier;

    b. How the MCO will use the HRA to develop and confirm the risk stratification level for each member, and determine the appropriate care coordination assignment;

    c. The MCO's outreach and engagement approaches for members who cannot be reached or who refuse to complete HRAs;

    d. How the MCO will store HRA data and make it available to members of the multi-disciplinary care team to coordinate care;

    e. How the MCO will share HRA data with ODM, the CCEs, the SPBM, and the OhioRISE Plan/CMEs as applicable to prevent duplication of efforts.

iv. *Other Assessments*

1. The MCO must conduct or arrange for assessments (e.g., comprehensive assessment, disease specific assessment, CANS assessment) for those members not assigned to a CCE or OhioRISE Plan/CME.

    a. The MCO must share results of any identification and assessment of the member's needs through the MCO's Care Coordination Portal to prevent duplication of those activities.

    b. The MCO must complete a CANS assessment for any member that the MCO is connected and engaged with who may benefit from OhioRISE when the MCO does not expect the member or family to follow through with a CANS assessment from a community-based CANS assessor.

2. The MCO must have a process for conducting or arranging for assessments appropriate to each member's unique circumstances and needs (e.g., physical, behavioral, social, and safety) that includes the following:

    a. Methods and timelines used by the MCO to complete assessments, including any variances by risk tier;

    b. Identification of the triggers for completion of reassessments or certain types of assessments, including:

        i. Comprehensive assessments; and

        ii. Disease-specific assessments or a re-assessments when there is a change in the member's health status or needs, a change in diagnosis, or as requested by the member, provider, or CCE.

    c. How the assessment will be used to develop and update the person--centered care plan and confirm the risk stratification level for each member;

    d. How data from the member's PCP or other providers will be used to prevent duplication of assessment efforts and to assist with identification of priorities for the member; and

    e. How members who cannot be reached or who refuse assessments will be handled by the MCO, including multiple contacts if initial contacts are unsuccessful.

v. *Person-Centered Care Plans*

1. For members assigned to an MCO Care Manager, and for members for whom an MCO Care Manager Plus is the leading care coordinator, the MCO must lead the development of a single person-centered care plan

that is shared with providers, CCEs, the SPBM, and the OhioRISE Plan/CMEs as applicable. Person-centered care plans are not required for members assigned to a Care Guide or a Care Guide Plus.

2. The MCO must have a person-centered care planning process that includes the following:

    a. Developing the person-centered care plan based on the most recent assessment;

    b. Updating the person-centered care plan at least every 12 months or when the member's needs change significantly;

    c. Tracking and complying with the timeframes for developing the initial person-centered care plan and making subsequent updates to the care plan;

    d. Developing measurable goals, interventions, and outcomes with the member and obtaining the member's agreement;

    e. Aligning person-centered care plan goals with the priority issues identified by the member and provider (e.g., PCP) so the MCO can support the provider-member relationship;

    f. Validating that the member received the services in the person-centered care plan and has a backup plan developed in the event if services cannot be received. If services were not received, taking necessary action to address and close gaps in care; including activating the backup plan and updating services if needed;

    g. The MCO must review back up plans for higher risk members. If a backup plan is not feasible, the MCO must assist with the development and adjustment of the backup plan as needed; and

    h. Retaining the person-centered care plan and sharing it with members of the multi-disciplinary team.

vi. *Contacts*

1. The MCO must establish an ODM-approved minimum contact schedule for members assigned to an MCO Care Manager, Care Manager Plus, Care Guide, and Care Guide Plus to facilitate ongoing communication with the member. The ODM-approved contact schedule must include number of subsequent attempts to reach the member if the member does not respond to the initial attempt. The ODM-approved contact schedule must reflect telephonic and in-person, face-to-face visits, depending on the member’s needs and preferences.

2. If a member, CCE, OhioRISE Plan/CME, or SPBM outreaches to the MCO, unless a standard is established elsewhere in this Agreement (e.g.,

transportation), the MCO must respond in a timeframe to meet the presenting need of the member, but no later than one business day.

vii. *Incident Reporting*

1. The MCO or their delegated entity must report the following incident types upon discovery/identification/notification for all members: Abuse, Neglect, Exploitation, Misappropriation of greater than $500, unnatural/accidental death, and self-harm or suicide attempts requiring medical intervention within one business day into Ohio's Incident Management System (IMS). For members also enrolled in the OhioRISE Program or OhioRISE Waiver, the MCO or their delegated entity must also report all natural death incidents to the OhioRISE Plan immediately upon discovery of the incident, but no later than one business day after discovering the incident.

    a. The MCO must collaborate, communicate, and coordinate as needed with the CCE and/or the OhioRISE Plan/CME to support a prevention plan and/or intervention (e.g., re-evaluating risk stratification, doing a home visit, offering services and resources, creating a prevention plan).

    b. For members assigned to a CCE, incidents must be submitted in accordance with the 1915c and 1915i waivers by the CCE. The MCO must work with the CCE to support the prevention plan and/or intervention. The MCO must collaborate with the CCE to ensure the incident is submitted in the appropriate incident system.

    c. For each incident entered by the MCO, the MCO must support ODM in conducting a review of the incident and identifying contributing factors by providing any information and/or documentation related to the case that is requested by ODM and doing so in accordance with the requested timeframe. For incidents that are entered by the OhioRISE Plan/CME, the MCO will support the incident management process by collaborating with and providing any necessary information to the OhioRISE Plan/CME in accordance with the requested timeframe.

    d. When an incident is substantiated, except in the case of death, the MCO must enter a prevention plan into the IMS and close the case no later than seven business days after the conclusion of the review. The MCO must enter prevention plans in ODM’s IMS for all members, regardless of tier assignment.

viii. Member Safeguards

1. The MCO must comply with the member safeguard requirements below when the MCO identifies or becomes aware of risks to a member’s health, safety, or welfare.

2. The MCO must develop and implement safeguards, systems, and processes that detect, prevent, and mitigate harm and/or risk factors that could impact a member's health, safety, or welfare.

3. When the MCO 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.

4. When a member poses or continues to pose a risk to the member's health, safety, or welfare, the MCO may develop and implement a health and safety action plan between the MCO and the member, identifying the risks and setting forth interventions recommended by the MCO to remedy risks to the member's health, safety, and/or welfare.

    a. The MCO's process for development and implementation of a health and safety action plan must be in accordance with ODM's specifications.

    b. The MCO must document in the clinical record the member's health and safety action plan, any refusal of the member to sign the health and safety action plan, and/or lack of adherence by the member to the agreed upon actions or interventions.

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

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

e. Care Coordination Information Systems/Data

i. *Care Coordination Portal*

1. The MCO must provide a Care Coordination Portal that collects, stores, integrates, shares, and pushes out pertinent member information with/to the entities involved in coordinating the member's care (ODM, CCEs, OhioRISE Plan/CMEs, MCO Care Coordination Delegates and SPBM as applicable). The MCO's Care Coordination Portal must have the capability of sending electronic notifications of sentinel events to entities involved in the member's care coordination. The MCO must exchange member-level data as required under the Model Agreement.

2. The MCO must provide timely electronic notification of sentinel events to all entities involved in the member's care coordination to support appropriate care coordination, including the OhioRISE Plan for OhioRISE Plan enrolled members. Sentinel events, with expectations of required reporting timeframes, must be entered as follows:

a. All cause (physical health and behavioral health) inpatient hospitalizations/re-hospitalizations must be entered on the same day as admission.

b. ED visits must be entered upon notification to the MCO.

c. Identified gaps in care must be entered within 72 hours of identification, unless immediate action is necessary to ensure health or safety of the member.

d. Residential treatment admissions must be entered within 72 hours of admission.

e. Residential treatment discharges must be entered at least 72 hours prior to the planned discharge.

f. Members with Mobile Response and Stabilization Services (MRSS) contact must be entered within 24 hours.

3. The MCO's Care Coordination Portal must be available to members, ODM, the SPBM, CCEs, and/or OhioRISE Plan/CMEs, subject to access controls and requirements necessary to comply with state and federal privacy requirements.

4. The MCO must provide ODM full access to the Care Coordination Portal for Medicaid members, subject to the privacy requirements as specified in Appendix A, General Requirements.

5. The MCO must create a "single sign on" as specified in Appendix K, Information System, Claims, and Data, for the Care Coordination Portal for state staff, as well as the CCEs, OhioRISE Plan, and/or CMEs providing care coordination services.

ii. *MCO Responsibilities for Portal Data*

1. The MCO must maintain the following data in the MCO's Care Coordination Portal:

a. MCO name;

b. Member name, all membership numbers assigned to the member (e.g., MCO identifier, Medicaid number), and eligibility span;

c. Member demographics and contact information;

d. Care coordination assignment (Care Manager, Care Manager Plus, Care Guide, Care Guide Plus);

e. MCO care coordinator name/contact information;

f. Risk tier;

g. MCO care coordination status (assigned, not assigned);

h. MCO conducted assessments, including HRA;

i. Verification of CANS assessment completion, if applicable;;

j. MCO-developed person-centered care plan, if applicable;

k. Early and periodic screening, diagnosis, and treatment (EPSDT) screening;

l. Utilization data (claims, prior authorizations, emergency department visits and hospitalizations, value-added benefits) within 24 hours;

m. Grievances, appeals, and/or state hearings;

n. 24/7 medical advice line information;

o. Member service information;

p. MCO-identified sentinel events;

q. Member school district, if applicable;

r. MCO-identified critical incidents; and

s. Care team contacts, including all care coordinators and providers of services currently received by the member.

2. All Care Coordination Notes created in the MCO Clinical platform:

i. The MCO;

ii. Delegates;

iii. Utilization management;

iv. Peer to Peer;

v. Other care coordination adjacent activities related to care of the member.

vi. 24/7 medical advice line; and

vii. Member services.

iii. *Member Access to the Portal*

1. The MCO must ensure that members have access to the following data and functions in the MCO's Care Coordination Portal:

a. Member assignment to the MCO;

b. Member ability to request care coordination from the MCO;

c. Care coordination assignment and contact information;

d. Care team contacts; and

e. Ability to complete an HRA.

iv. *Public Children's Service Agency and IV-E Court (Title IV-E Agency) Access to the Portal*

1. The MCO's secure Care Coordination Portal (CCP) must be accessible by Public Children's Service Agencies and IV-E Courts (collectively referred to as Title IV-E Agencies) and the child protection oversight agency for children and youth in their custody who are enrolled in the MCO. The CCP must allow each Title IV-E Agency to access information about all children and youth in their custody through a single login.

   a. The MCO must follow ODM specifications for creating user role designation types and processing daily user transfer files, including MCO processing service level expectations for new users, updated users, and inactive users including provisioning new users within two business days and revoking user access within the next business day.

   b. The MCO must provide a daily report via email to the email addresses specified in the PCSA *User File Specifications and Architecture Document* (latest version) to indicate the status of the daily file.

   c. The MCO must create and provide comprehensive CCP user guide for Title IV-E Agency users per ODM specifications.

      i. The comprehensive user guide must contain step by step instructions of how to navigate and utilize the breadth of functions of the CCP that includes screen shots or pictures.

      ii. The user guide must be updated to reflect CCP changes and reviewed by ODM.

   d. The MCO must create a quick reference guide for Title IV-E Agency users per ODM specifications.

      i. The MCO must provide a 'Title IV-E Agency User CCP Quick Reference Document' specific to the features and functions per ODM specifications.

      ii. Screen shots or pictures must be included to help this user group quickly navigate to important content.

      iii. The quick reference document must be updated to reflect portal changes and reviewed by ODM.

2. At a minimum, the portal must contain the following features and functions for each child or youth in custody per ODM specifications:

    a. All information listed in this Provider Agreement for what members have access to on a Care Coordination Portal.

    b. All information about requests for prior authorizations or services and request status.

    c. The MCO must provide a 'roster' view feature in the portal.

        i. The 'roster' view provides the Title IV-E Agency user with to a complete listing of only youth in their custody.

        ii. The 'roster' view provides the child protection oversight agency user with a complete listing of 'child/youth in custody' members in custody.

    d. The MCO must provide a Medicaid ID search feature in the portal. This feature allows users the ability to search for a specific 'child/youth in custody' member using solely the member's Medicaid ID.

    e. The MCO must provide a name search feature in the portal. The name search feature must allow a user to search for a 'child/youth in custody's member using the member's first and last name and any additional argument(s) to the first and last name in order to return a more narrowed search result.

    f. The MCO's care coordination portal must display all non-prescription claims with the following information:

        i. This feature will return a complete beginning-to-date list of non-prescription claims and claim status associated with a 'child/youth in custody' member.

        ii. At minimum the information included for each claim must be the date of service, provider, and diagnosis code.

        iii. The claim information and diagnosis code should be displayed so that a non-medical person can understand what procedures or services were received on what date and provided by what provider per claim.

    g. The MCO's care coordination portal must display claims data received from the Single Pharmacy Benefit Manager (SPBM).

        i. This feature will return a complete beginning-to-date list of SPBM claims and claim status associated with a 'child/youth in custody' member. At minimum the information displayed

on the care coordination portal for each SPBM claim must be the date of fill, prescriber, pharmacy location, and name of medication. If provided in the claim data, the dosage must also be included.

ii. In lieu of displaying all prescription claims data received from the SPBM, the MCO may provide the targeted medication review report referenced in Appendix R on the portal. The MCO must report to ODM that they will provide the targeted medication review report in the portal in lieu of displaying all SPBM claims data.

f. Care Coordination Monitoring

i. The MCO must monitor to ensure the care coordination needs of members are met.

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

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

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

iii. The MCO must monitor the quality and effectiveness of care coordination provided by the MCO and CCEs that are in a delegated arrangement through the review of member and provider surveys and case reviews. Case reviews must include whether established quality, clinical best practice, and care coordination standards have been met.

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

3. Care Coordination Support for Specific Populations

a. The MCO must adhere to care coordination requirements and protocols for specific populations as described in ODM’s collaborative communication and coordination protocols.

4. Transitions of Care Requirements

a. Transitions of Care for New Members

i. *General*

1. The MCO must follow the transition of care requirements as outlined below for new members transitioning to the MCO from fee-for-service (FFS) or another MCO. The Care Coordination Portal must be used to facilitate the exchange of member-specific data.

ii. *Provision of Member Information*

1. For new members enrolled with the MCO and transitioning from FFS or another MCO, the MCO will receive member information as specified by ODM from FFS or the disenrolling MCO.

2. Upon notification from ODM that an enrolled member will be disenrolling from the MCO and transitioning to another MCO or MyCare Ohio plan, the MCO must provide member information to the enrolling MCO's new member as specified by ODM.

iii. *Pre-Enrollment Planning*

1. The MCO must coordinate with and utilize data provided by ODM, another MCO, the OhioRISE Plan (when applicable) and/or collected by the MCO (e.g., through assessments, new member outreach in advance of the member's enrollment effective date) to identify existing sources of care and to ensure each new member is able to continue to receive existing services without disruption in accordance with this appendix.

2. For OhioRISE Plan enrolled members, the MCO must reach out to the OhioRISE Plan and primary care coordination staff to engage the OhioRISE Plan in pre-enrollment planning.

iv. *Continuation of Services for Members*

1. The MCO must allow a new member to receive services from network and out-of-network providers in the following circumstances:

    a. If the MCO confirms that the Group VIII-Expansion member is currently receiving care in a nursing facility on the effective date of enrollment with the MCO;

        i. In that event, the MCO must cover the nursing facility care at the same facility until a medical necessity review is completed and, if applicable, a transition to an alternative location has been documented in the member's person-centered care plan.

b. If the MCO is aware of a pregnant member's enrollment, the MCO must identify the member's maternal risk and facilitate connection to services and supports in accordance with ODM's guidance; and

i. The MCO must allow the pregnant member to continue with an out-of-network provider if the member is in her third trimester of pregnancy and/or has an established relationship with an obstetrician and/or delivery hospital.

c. If the member has a prior authorization approved prior to the member's transition.

i. The MCO must honor the prior authorization through the expiration of the authorization, regardless of whether the authorized or treating provider is in or out-of-network with the MCO.

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

iii. The MCO may assist the member to access services through a network provider when any of the following occur:

1. The member's condition stabilizes and the MCO can ensure no interruption to services;

2. The member chooses to change the member's current provider to a network provider; or

3. If there are quality concerns identified with the previously authorized provider.

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

v. The MCO must cover organ, bone marrow, or hematopoietic stem cell transplant pursuant to OAC rule 5160-2-65 and as described in Appendix B, Coverage and Services, of this Agreement.

2. The MCO must provide the following services to the member regardless of whether services were prior authorized/pre-certified or the treating provider is in or out-of-network with the MCO:

a. Ongoing chemotherapy or radiation treatment;

b. Hospital treatment (if member was released from hospital 30 calendar days prior to enrollment); and

c. Private duty nursing, home health services, and durable medical equipment (DME) must be covered at the same level with the same provider as previously covered until the MCO conducts a medical necessity review and renders an authorization decision pursuant to OAC rule 5160-26-03.1.

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

v. *Documentation of Transition of Services*

1. The MCO must document the provision of transition of services as follows:

a. The MCO must seek confirmation from an out-of-network provider that the provider agrees to provide the service and accepts the Medicaid FFS rate as payment or a negotiated rate.

i. If the provider agrees, the MCO must distribute materials to the out-of-network provider as specified in Appendix E, Marketing and Member Materials, of this Agreement.

ii. If the provider does not agree, the MCO must notify the member of the MCO's availability to assist with locating another provider as expeditiously as the member's health condition warrants.

b. If the service will be provided by a network provider, the MCO must notify the network provider and the member to confirm the MCO's responsibility to cover the service.

c. The MCO must use the ODM-specified model language for the provider and member notices and maintain documentation of all member and/or provider contacts relating to such services.

b. Transitions of Care Between Health Care Settings

i. The MCO, in coordination with CCEs, the OhioRISE Plan, and/or CMEs as assigned, must effectively and comprehensively manage transitions of care settings in order to prevent unplanned or unnecessary readmissions, emergency department visits, and/or adverse outcomes. The Care Coordination Portal must be used to facilitate the exchange of member-specific data. The MCO must:

1. Identify members who require assistance transitioning between settings and notify the member's CCE, the OhioRISE Plan, and/or CME as assigned;

2. Develop a method for evaluating risk of readmission or deterioration (e.g., evaluating risk tier) in order to determine the intensity of follow up required for the member after the date of discharge, and share this information with the CCE, OhioRISE Plan, and/or CME, as assigned;

3. Ensure the member's care coordinator, or other designated care coordination staff if the member does not have a Care Manager or Care Guide, communicates with the discharging facility and informs the facility of the designated contacts of the member's care team, including all care coordinators and providers of services currently received by the member;

4. Ensure timely notification and receipt of admission dates, discharge dates, and clinical information is communicated between MCO departments and with the CCE, OhioRISE Plan/CME, care settings, and the member's PCP, as appropriate;

5. Participate in discharge planning activity with the facility, including making arrangements for safe discharge placement and facilitating clinical hand-offs between the discharging facility and the MCO, CCE, the OhioRISE Plan, and/or CME, as assigned;

6. Obtain a copy of the discharge/transition plan and share the plan with the member's care team;

7. Arrange and confirm services are authorized and delivered in accordance with the discharge/transition plan;

8. Ensure that providers are able to obtain copies of the member's medical records as appropriate and consistent with federal and state requirements; and

9. Conduct timely follow up with the member and the member's primary provider to ensure post discharge services have been provided.

ii. When the MCO and/or CCE is contacted by an inpatient facility with a request to participate in discharge planning, the MCO and/or CCE must cooperate as outlined above to ensure a safe discharge placement and services are arranged for the member.

c. Transitions of Care Between the MCO and the OhioRISE Plan

i. *General*

1. The MCO must follow the transition of care requirements as outlined below for a member whose coverage and coordination of behavioral health services is transitioning from the MCO to the OhioRISE Plan, or from the OhioRISE Plan to the MCO. The Care Coordination Portal must be used to facilitate the exchange of member-specific data.

ii. *Coordination of Inpatient Hospital Prior Authorization*

1. Upon receipt of a prior authorization request for an inpatient hospital psychiatric or substance use disorder (SUD) admission for individuals under the age of 21 not yet enrolled in the OhioRISE Plan, the MCO must:

    a. Notify and inform the hospital within one business day of receipt:

        i. That the prior authorization will be denied by the MCO because the service is the responsibility of the OhioRISE Plan and provide guidance to the hospital how to submit the prior authorization to the OhioRISE Plan;

        ii. The importance of entering the psychiatric or SUD admission into the CANS IT system to ensure claims can be submitted to the OhioRISE Plan; and

        iii. That the OhioRISE Plan will perform outreach to coordinate the transition of care through the inpatient stay.

    b. Once the hospital has been notified that the prior authorization is the responsibility of the OhioRISE Plan, the MCO must deny the prior authorization request and issue a Notice of Action (NOA). The NOA must indicate the service is being denied due to it being the responsibility of the OhioRISE Plan to pay for the service.

    c. The MCO must contact the OhioRISE Plan's Transition of Care Coordinator and notify the Transition Coordinator of the prior authorization request, provide contact information for the hospital, ensure entry of the psychiatric or SUD admission is in the CANS IT system, and share any documentation related to the request by the hospital as agreed upon in the Model Agreement.

2. If the primary diagnosis on the prior authorization request initially indicated the OhioRISE Plan authorized the service and would be responsible for the claim, and later changes in care delivery result in the APR-DRG becoming the responsibility of the MCO per the OhioRISE Mixed Services Protocol, the MCO must accept the prior authorization approval issued by the OhioRISE Plan and may not require any additional prior authorization request from the provider.

iii. *Care Coordination Assignment*

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

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

iv. *Provision of Member Information*

1. Upon notification from ODM that a member will be enrolled with the OhioRISE Plan for behavioral health services, the MCO must provide member information to the OhioRISE Plan as specified by ODM.

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

v. *Continuation of Services for Members*

1. Upon notification from the OhioRISE Plan, the MCO must participate in developing a transition of care plan for services the member was receiving from the OhioRISE Plan that will be transitioning to the MCO.

    a. The MCO must honor any prior authorizations approved prior to the member's transition through the expiration of the authorization, regardless of whether the authorized or treating provider is in or out-of-network with the MCO.

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

        ii. The MCO may assist the member to access services through a network provider when any of the following occur:

            1. The member's condition stabilizes and the MCO can ensure no interruption to services.

            2. The member chooses to change to a network provider.

            3. If there are quality concerns identified with the previously authorized provider.

    b. The MCO must honor any inpatient hospital prior authorization approved by the OhioRISE Plan when the primary diagnosis on the prior authorization request initially indicated the OhioRISE Plan would be responsible for the claim and changes in care delivery result in the APR-DRG becoming the responsibility of the MCO per the OhioRISE Mixed Services Protocol and may not require an

additional prior authorization request from the provider, regardless of whether the authorized or treating provider is in or out-of-network with the MCO.

2. The MCO must provide the following services to the member regardless of whether services were prior authorized/pre-certified or the treating provider is in or out-of-network with the MCO:

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

    b. The MCO must allow a member who was receiving behavioral health services from the OhioRISE Plan to continue to receive those behavioral health services with out-of-network providers if the provider is an ODM-enrolled provider, even if the services were prior authorized by the OhioRISE Plan. The MCO must allow the member to receive behavioral health services from out-of-network providers for at least 45 calendar days from the date of the member's transition out of the OhioRISE Plan or until the MCO is able to transition services to a network provider. For continuity of care purposes, the MCO must:

        i. Work with the provider to add the provider to its network;

        ii. Implement a single case agreement with the provider; or

        iii. Assist the member in finding and transitioning service delivery to another provider without a disruption in services.

vi. *Documentation of Transition of Services*

1. The MCO must document the provision of transition of behavioral health services as noted above in this appendix.

APPENDIX E – MARKETING AND MEMBER MATERIALS

1. Marketing

a. Marketing Activities

i. When marketing, the MCO:

1. Must ensure MCO representatives, as well as materials and plans, represent the MCO in an honest and forthright manner, and do not make statements that are inaccurate, misleading, confusing, or otherwise misrepresentative, or that defraud eligible individuals or ODM;

2. Must ensure no marketing activity directed specifically toward the Medicaid population begins prior to ODM's approval;

3. Must not engage directly or indirectly with cold-call marketing activities, defined as any unsolicited personal contact by the MCO with an eligible individual for the purpose of marketing, including door-to-door or telephone contact;

4. Must request and receive prior approval from ODM for any event or location where the MCO plans to provide information to eligible individuals;

5. Must not offer material or financial gain, including but not limited to the offering of any other insurance, to an eligible individual as an inducement to select MCO membership;

6. Must not offer inducements to any county Department of Job and Family Services or Ohio Medicaid Consumer Hotline staff or to others who may influence an eligible individual's decision to select MCO membership;

7. Is permitted to offer gifts, promotional products, prizes, or similar-type items worth no more than $15 prior approved by ODM to an eligible individual as long as these items are offered whether or not the eligible individual selects membership in the MCO;

8. Is permitted as prior approved by ODM to host a free raffle or giveaway as part of a marketing event, as long as the prize is worth no more than $15. Additionally, the entry for the raffle or giveaway shall not require an eligible individual to provide contact information or select membership in the MCO;

9. Is permitted as prior approved by ODM to reference member incentive/appreciation items that are available solely to its Ohio Medicaid members in marketing presentations and materials;

10. Must not make marketing presentations, defined as a direct interaction between an MCO marketing representative and an eligible individual, in any setting unless initiated and requested by the eligible individual;

11. Must offer the ODM-approved solicitation brochure to the eligible individual at the time of the marketing presentation and must provide:

    a. An explanation of the importance of reviewing the information in the ODM-approved solicitation brochure that describes how the eligible individual can receive additional information about the MCO prior to making an MCO membership selection, how the eligible individual can receive additional information about OhioRISE eligibility, and the process for contacting ODM or its designee to select an MCO;

    b. Information that membership in the particular MCO is voluntary and that a decision to select or not select the MCO will not affect eligibility for Medicaid or other public assistance benefits;

    c. Information that each member must choose a primary care provider (PCP) and must access providers and services as directed in the MCO's member handbook and provider directory:

        i. The MCO must also provide information that the member may access a comprehensive provider directory on ODM's website. Upon request, the MCO must provide eligible individuals with a printed copy of the provider directory.

    d. Information that all medically necessary Medicaid covered services, as well as any additional services provided by the MCO, will be available to all members; and

    e. Must never offer 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 MCOs. All enrollment activities must exclusively be completed by the Ohio Medicaid Consumer Hotline.

b. Marketing Representatives and Training

    i. If the MCO utilizes marketing representatives for marketing presentations requested by eligible individuals, the MCO must ensure compliance with all of the following:

        1. All marketing representatives must be employees of the MCO. The MCO must submit a copy of the representative's job description to ODM prior to engaging in marketing activities.

        2. No more than 50% of each marketing representative's total annual compensation, including salary, benefits, and bonuses may be paid on a commission basis. For the purpose of this requirement, any performance-based compensation is considered a form of commission. Upon ODM's request, the MCO must make available for inspection the compensation packages of its marketing representatives.

3. Marketing representatives subject to ORC section 3905.02 must be trained and duly licensed by the Ohio Department of Insurance (ODI) to perform such activities.

4. The MCO must develop and submit to ODM for prior approval (at initial development and at the time of revision) a marketing representative training program that must include:

    a. A training curriculum that includes:

        i. A full review of the MCO's solicitation brochure, provider directory, and all other marketing materials, including all video, electronic, and print;

        ii. An overview of the applicable public assistance benefits designed to familiarize and impart a working knowledge of these programs;

        iii. The MCO's process for meeting the member information requirements under Appendix A, General Requirements, for oral and written marketing materials for eligible individuals to whom marketing presentations are being given;

        iv. Instruction on acceptable marketing tactics, including a requirement that the marketing representatives may not discriminate on the basis of age, gender, gender identity, sexual orientation, disability, race, color, religion, national origin, military status, genetic information, ancestry, health status, or the need for health services;

        v. An overview of the ramifications to the MCO and the marketing representatives if ODM rules are violated; and

        vi. Review of the MCO's code of conduct or ethics.

    b. Methods that the MCO will use to determine initial and ongoing marketing representative competencies that reflect the training curriculum.

5. Any MCO staff person providing MCO information or making marketing presentations to an eligible individual must:

    a. Wear a visible identification tag, offer a business card when speaking to an eligible individual, and provide identifying information that ensures the MCO staff person is not mistaken for an Ohio Medicaid Consumer Hotline, federal, state, or county employee;

    b. Inform eligible individuals that the following MCO information or services are available and how to access the information or services:

i. Sign language, oral interpretation, oral translation, and auxiliary aids and services for persons with disabilities at no cost to the member;

ii. Written information in the prevalent non-English languages of eligible individuals or members residing in the MCO's service area; and

iii. Written information in alternative formats.

c. Not discriminate on the basis of age, gender, gender identity, sexual orientation, race, color, religion, national origin, military status, veteran status, ancestry, disability, genetic information, health status, or the need for health services; and

d. Not ask eligible individuals questions related to their health status or need for health services.

6. Only ODM-approved MCO marketing representatives may make a marketing presentation upon request by the eligible individual or in any way advise or recommend to an eligible individual that they select membership in a particular MCO. Pursuant to ORC Chapter 1751 and ORC section 3905.01, all non-licensed agents, including providers, are prohibited from advising or recommending to an eligible individual that they select MCO membership in a particular MCO, as this would constitute the unlicensed practice of marketing; and

7. MCO informational displays do not require the presence of a marketing representative if no marketing presentation will be made.

c. Marketing Materials

i. The MCO must ensure that marketing materials comply with the following requirements:

1. MCO marketing materials must be available in a manner and format that is easily understood.

2. Written materials developed to promote membership selection in the MCO must meet the member information requirements under Appendix A, General Requirements.

3. Sign language, oral interpretation, oral translation, and auxiliary aids and services must be available for the review of marketing materials at no cost to eligible individuals.

4. MCO marketing materials are distributed to the MCO’s entire service area.

5. The mailing and distribution of all MCO marketing materials must be prior approved by ODM and must not contain information or text on the

outside of the mailing that identifies the addressee as a Medicaid recipient.

6. MCO marketing materials must not contain any implied or actual assertion or statement, whether written or oral, that the MCO is endorsed by the Centers for Medicare and Medicaid Services (CMS), the federal, state, or local government or similar entity.

ii. The MCO may request ODM or its designee to mail MCO marketing materials to eligible individuals. The MCO must pay ODM or its designee for the postage and handling for each mailing. The MCO must not use the MCO's address as the return address in mailings to eligible individuals processed by ODM or its designee.

d. Solicitation Brochure

i. The MCO must have a solicitation brochure available to eligible individuals that contains, at a minimum:

1. The identification of the Medicaid members eligible for the MCO's coverage;

2. Information that the member will receive an MCO identification (ID) card from the MCO that will replace the member's monthly Medicaid card;

3. A statement that all medically necessary Medicaid-covered services will be available to all members, including Healthchek services for members under age 21;

4. A description of any additional services available to all members;

5. Information that membership selection in a particular MCO is voluntary, that a decision to select MCO membership or to not select MCO membership in the MCO will not affect eligibility for Medicaid or other public assistance benefits, and that eligible individuals may change MCOs under certain circumstances;

6. Information on how the eligible individual can request or access additional MCO information or services, including clarification on how this information can be requested or accessed through:

a. Sign language, oral interpretation, oral translation, and auxiliary aids and services for persons with disabilities at no cost to the eligible individual;

b. Written information in the prevalent non-English languages of eligible individuals or members in the MCO's service area; and

c. Written information in alternative formats.

7. Clear identification of corporate or parent company identity when a trade name or Doing Business As (DBA) is used for the Medicaid line of business;

8. A statement that the brochure contains only a summary of the relevant information and more details, including a list of providers and any physician incentive plans the MCO operates, will be provided upon request;

9. Information that the individual must choose a PCP from the MCO's network of providers and that the PCP will assist with the coordination of the member's health care;

10. Information that a member may change PCPs at least monthly;

11. A statement that all medically necessary health care services must be obtained from or through the MCO's providers except emergency care, behavioral health services provided through facilities, and any other services or provider types designated by ODM;

12. A description of how to access emergency services, including information that access to emergency services is available within and outside the service area;

13. A description of the MCO's policies regarding access to providers outside the service area;

14. Information on member-initiated termination options in accordance with OAC rule 5160-26-02.1;

15. Information on the procedures an eligible individual must follow to select membership in an MCO, including any ODM selection requirements; and

16. If applicable, information on any member co-payments the MCO has elected to implement in accordance with OAC rule 5160-26-12.

e. Annual Marketing Plan

i. The MCO must maintain record of all planned activities for promoting membership in, or increasing awareness of, the MCO.

f. ODM Marketing and Member Material Approval

i. The MCO must submit all new and revised marketing communications (including materials used for marketing presentations) and member communications (including scripted verbal communications and mailing and distribution of written materials) to ODM for approval prior to distribution to eligible individuals or members. The MCO must submit the materials to ODM's designated SharePoint site for marketing and member materials, to request review and approval.

ii. The MCO must comply with ODM's Marketing Guidance Document for determining what constitutes "new and revised" marketing materials that require ODM's review and prior approval. The MCO must submit all direct member contact materials (e.g., phone scripts and text messages) to ODM for review and approval.

iii. The MCO must include an attestation with each marketing submission that the material is accurate and not intended to mislead, confuse, or defraud eligible individuals or ODM.

iv. In accordance with 42 CFR 438.104(c), ODM will consult with the Medical Care Advisory Committee or an advisory committee of similar membership on the review process for MCO-submitted marketing materials.

v. The MCO must cease use of any marketing or member materials upon notification from ODM. Failure to cease use of marketing or member materials within the timeframe established by ODM will result in the assessment of sanctions as specified in Appendix N, Compliance Actions.

g. Alleged Marketing Violations

i. The MCO must immediately notify ODM in writing of its discovery of an alleged or suspected marketing violation. ODM will forward information pertaining to alleged marketing violations to the ODI and the Medicaid Fraud Control Unit (MCFU) as appropriate.

2. ODM-Requested Member Notifications

a. The MCO must provide written notice to members as specified by ODM, including notification of a change to member services or access to network providers.

3. Member Materials

a. General

i. The MCO must ensure that all member materials meet the member information requirements as stated in Appendix A, General Requirements.

ii. Member materials are those items developed by or on behalf of the MCO to fulfill MCO program requirements or to communicate to all members or a group of members. Member materials include member education, member appreciation, and member incentive program information. Member health education materials produced by a source other than the MCO and that do not include any reference to the MCO are not considered to be member materials.

iii. Pursuant to OAC rule 5160-26-05.1, the MCO must ensure that the MCO adopts and provides a copy of the MCO's practice guidelines to eligible individuals and members upon their request.

iv. The MCO must ensure that member materials do not include statements that are inaccurate, misleading, confusing, or otherwise misrepresentative, or that defraud eligible individuals or ODM.

v. The MCO can distribute approved member material for a duration of five years, based on the date of ODM approval. After the five year period, the MCO must resubmit the material for ODM review if it has not been reviewed and approved in the five year period.

vi. No information or text that identifies the addressee as a Medicaid recipient may appear on the outside of any MCO or MCO subcontractor member material mailing.

b. New Member Materials

i. *General*

1. The MCO must provide each member or assistance group that selects or is auto-assigned to the MCO, an MCO ID card, new member letter, notice of advance directives, provider directory postcard, the quick guide, and postcard providing the link to the member handbook, if sent in lieu of the full member handbook.

2. The MCO must coordinate with the single pharmacy benefit manager (SPBM) to include SPBM-prepared, ODM-approved, new member materials, including an SPBM insert for pharmacy benefits information, information about the SPBM for the MCO Quick Guide, and information to include about the SPBM on the MCO's postcard.

3. In accordance with 42 CFR 438.10(c)(6), the MCO must meet all of the following if the MCO provides required member information or the member handbook electronically:

   a. The format is readily accessible.

   b. The information is located in a prominent and readily accessible place on the member page of the MCO's website.

   c. The information is provided in an electronic form, which can be electronically retained and printed.

   d. The information provided electronically meets the member information requirements as stated in Appendix A, General Requirements.

   e. The information is consistent with the content requirements in this appendix.

   f. The member is informed that the information is available in paper form without charge upon request and provides it upon request within five business days.

ii. *MCO ID Card*

1. The MCO must provide MCO ID cards in accordance with ODM specifications to each member or assistance group that selects or is auto-assigned to the MCO. The MCO is responsible for the production, distribution, and costs of MCO ID cards.

2. The MCO ID card must include:

a. The MCO's name as stated in its article of incorporation and any other trade or DBA name used;

b. The name of the member enrolled in the MCO and the member's medical management information system billing number;

c. The name and telephone numbers of the PCP assigned to the member;

d. Information on how to obtain the current eligibility status of the member;

e. Coordinated Services Program information as specified by ODM;

f. Pharmacy benefit and SPBM contact information as specified by ODM;

g. The MCO's emergency procedures, including the toll-free call-in system phone numbers;

h. Information as specified by ODM about the OhioRISE Plan, if the member is enrolled in the OhioRISE Plan; and

i. Any other information required by ODM.

iii. *New Member Letter*

1. The MCO must use the model language specified by ODM for the new member letter. The MCO New Member Letter must inform each member of the following:

a. The new member materials issued by the MCO, what action to take if the member did not receive those materials, and how to access the MCO's provider directory;

b. How to access MCO-provided transportation services;

c. How to change PCPs;

d. The population groups not required to select MCO membership and the action to take if a member believes they meet this criteria and does not want to be an MCO member;

e. The need and timeframe for a member to contact the MCO if the member has a health condition that the MCO should be aware of to allow the MCO to most appropriately manage or transition the member's care; and

f. The need and how to contact the SPBM to access information on pharmacy services, including medications that require prior authorization.

iv. *Member Handbook*

1. The MCO must use the model language specified by ODM for the member handbook. The MCO's member handbook must be clearly labeled as such and include "Ohio Medicaid Managed Care" to clearly distinguish the applicability of the member handbook to members covered under this Agreement from other MCO lines of business. The MCO must ensure the member handbook table of contents precedes all content, with the exception of the tagline to comply with Section 1557 of the Patient Protection and Affordable Care Act. The member handbook must include ODM definitions of managed care terminology in accordance with 42 CFR 438.10. The MCO must ensure the member handbook includes:

    a. The rights of members, including all rights found in OAC rule 5160-26-08.3 and any member responsibilities specified by the MCO:

        i. With the exception of any prior authorization requirements the MCO describes in the member handbook, the MCO cannot establish any member responsibility that would preclude the MCO's coverage of a Medicaid-covered service.

    b. Information regarding services excluded from MCO coverage and the services and benefits available through the MCO and how to obtain them including, at a minimum:

        i. All services and benefits requiring prior authorization or referral by the MCO or the member's PCP;

        ii. Self-referral services, including Title X services, and women's routine and preventative health care services provided by a women's health specialist as specified in OAC rule 5160-26-03; and

        iii. Federally qualified health center (FQHC), rural health clinic (RHC), and certified nurse practitioner services specified in OAC rule 5160-26-03.

    c. Information regarding available emergency services, the procedures for accessing emergency services and directives as to the appropriate utilization, including:

        i. An explanation of the terms "emergency medical condition," "emergency services," and "post-stabilization services," as defined in OAC rule 5160-26-01;

        ii. A statement that prior authorization is not required for emergency services;

iii. An explanation of the availability of the 911 telephone system or its local equivalent;

iv. A statement that members have the right to use any hospital or other appropriate setting for emergency services; and

v. An explanation of the post-stabilization care services requirements specified in OAC rule 5160-26-03.

d. Information required by ODM to promote member awareness and understanding of their rights under the Mental Health Parity and Addiction Equity Act;

e. The procedure for members to express their recommendations for change to the MCO;

f. Identification of the categories of Medicaid recipients eligible for MCO membership;

g. Information stating that the MCO's ID card replaces the member's monthly Medicaid card, how often the card is issued, and how to use it;

h. A statement that medically necessary health care services must be obtained through the providers in the MCO's provider network with any exceptions that apply, such as emergency care;

i. Information related to the selection of a PCP from the MCO provider directory, how to change PCPs at least monthly, the MCO's procedures for processing PCP change requests after the initial month of MCO membership, and how the MCO will provide written confirmation to the member of any new PCP selection prior to or on the effective date of the change;

j. A description of Healthchek services, including who is eligible and how to obtain Healthchek services through the MCO;

k. Information on services available to members, including care management and care coordination;

l. A description of the MCO's policies regarding access to providers outside the service area for non-emergency services and, if applicable, access to providers within or outside the service area for non-emergency after hours services;

m. An explanation of how to access information on the MCO's website describing programs that reward members for meeting certain health goals;

n. Information on member-initiated termination options in accordance with OAC rule 5160-26-02.1;

o. Information about MCO-initiated termination;

p. An explanation of automatic MCO membership renewal in accordance with OAC rule 5160-26-02;

q. The procedure for members to file a grievance, an appeal, or state hearing request pursuant to OAC rule 5160-26-08.4, the MCO's mailing address, and copies of the optional forms that members may use to file an appeal or grievance with the MCO:

    i. Copies of the forms to file an appeal or grievance must also be made available through the MCO's member services program.

r. The standard and expedited state hearing resolution timeframes as outlined in 42 CFR 431.244;

s. The member handbook issuance date;

t. A statement that the MCO is prohibited from discriminating on the basis of race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, veteran status, ancestry, genetic information, health status, or need for health services in the receipt of health services;

u. An explanation of subrogation and coordination of benefits;

v. A clear identification of corporate or parent identity when a trade name or DBA is used for the Medicaid product;

w. Information on the procedures for members to access behavioral health services, including information about the assessment, eligibility, and enrollment of children for behavioral health service through the OhioRISE Plan;

x. Information on the MCO's advance directives policies, including a member's right to formulate advance directives, a description of state law, and a statement of any limitation regarding the implementation of advance directives as a matter of conscience;

y. A statement that the MCO provides covered services to members through a provider agreement with ODM, and how members can contact ODM;

z. The toll-free call-in system phone numbers;

aa. A statement that additional information is available from the MCO upon request including, at a minimum:

i. The structure and operation of the MCO and any physician incentive plans the MCO operates.

bb. Process for requesting or accessing additional MCO information or services including, at a minimum:

i. Oral interpretation, oral translation, and auxiliary aids and services for persons with disabilities;

ii. Written information in the non-English language identified as the member's primary language; and

cc. Written information in alternative formats. If applicable, detailed information on any member co-payments the MCO has elected to implement in accordance with OAC rule 5160-26-12;

dd. How to access the MCO's provider directory;

ee. Access to provider network information to members via the MCO's website and printed provider directories; and

ff. If In Lieu of Services and Settings (ILOS) are added to an MCO's contract, the rights and protections in 42 CFR 438.3(e)(2)(ii) must be included in the member handbook.

v. *MCO Quick Guide*

1. The MCO must create a quick guide version of its member handbook that includes but is not limited to the following information:

a. Taglines compliant with 42 CFR 438.10;

b. The process for requesting or accessing additional MCO information or services including, at a minimum:

i. Oral interpretation, oral translation, and auxiliary aids and services for persons with disabilities;

ii. Written information in the prevalent non-English languages in the MCO's service areas; and

iii. Written information in alternative formats.

c. A statement that the MCO provides covered services to members through a provider agreement with ODM, and how members can contact ODM;

d. Toll-free phone numbers critical to accessing care, including the MCO 24-hour nurse line, member services, behavioral health crisis services, transportation services, and the SPBM's member services number;

e. The benefits available through the MCO, how to obtain them, and any limits or prior authorization applied;

f. Information regarding emergency services, the procedures for accessing emergency services, and that emergency services do not require prior authorization;

g. Information that indicates medically necessary health care services must be obtained through the providers in the MCO's provider network with any exceptions that apply, such as emergency care;

h. How to access the MCO's provider directory;

i. How to access the SPBM handbook, prescription drug list, and pharmacy provider directory; and

j. The quick guide issuance date.

vi. *Provider Network Information and Advance Directives*

1. In addition to the MCO ID card, a new member letter, quick guide, and a member handbook, the MCO must provide to each member or assistance group, as applicable, provider network information and information on advance directives, as specified by ODM.

vii. *Information Required for Enrollment Changes*

1. If a member's demographic information or enrollment changes, the MCO must issue a new MCO ID card and a new member handbook postcard to the member if the member handbook has been revised since the initial MCO membership date.

c. Issuance of Member Materials

i. The MCO must mail the MCO ID card, new member letter, quick guide, and request postcard within ten business days of receiving the 834C enrollment file, except during state cutoff when MCOs have the option to follow the 834 file loading process as specified by ODM.

ii. The MCO may mail ODM prior-approved postcards in lieu of mailing printed advance directives, directories, and member handbooks. At a minimum, the postcards must advise members to call the MCO or return the postcards to request a printed advance directive, provider directory and/or member handbook.

iii. If the MCO does not use an ODM prior-approved postcard, the MCO must mail printed advance directives, provider directories, and member handbooks to all new members within five calendar days of receiving the 834C.

iv. If requested by a member, the MCO must send a printed advance directive, provider directory and member handbook within seven calendar days of the request.

v. The MCO must review the consumer contact record (CCR) upon receipt to verify if any member has requested a member handbook or provider directory.

vi. The MCO must designate two MCO staff members to receive a copy of the new member materials on a monthly basis to monitor the timely receipt of these materials. At least one of the staff members must receive the materials at their home address. The MCO must provide documentation to ODM upon request that demonstrates compliance with this requirement.

APPENDIX F – PROVIDER NETWORK

1. General

a. The MCO must comply with all state and federal provider network requirements, including but not limited to OAC rule 5160-26-05, 42 CFR 438.206, 42 CFR 438.207, and the requirements of this appendix.

b. In accordance with 42 CFR 438.206, the MCO must maintain a provider network that is sufficient to provide timely access to all medically necessary covered services to all members, including those with limited English proficiency or physical or mental disabilities. The MCO must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities.

c. The MCO must monitor compliance with provider network requirements and take corrective action as needed.

d. ODM will monitor access and availability using multiple data sources, including but not limited to member complaints, member grievances, appeals, member satisfaction surveys, provider complaints, quality data, performance measures, utilization data, demographic data, MCO reports, and results from other oversight and monitoring activities.

2. Documentation of Network Capacity

a. In accordance with 42 CFR 438.207, the MCO must give assurance to ODM and provide supporting documentation that demonstrates it has the capacity to serve the expected membership in accordance with the requirements of this Agreement.

b. In accordance with 42 CFR 438.207, the MCO must submit documentation to ODM, in a format specified by ODM, that demonstrates it:

i. Offers an appropriate range of preventive, primary care, behavioral health, family planning, and specialty services adequate for the anticipated number of members; and

ii. Maintains a provider network sufficient in number, mix, and geographic distribution to meet the needs of the number of anticipated members.

c. In accordance with 42 CFR 438.207, the MCO must submit such documentation at each of the following:

i. At the time the MCO enters into a contract with ODM;

ii. On an annual basis thereafter;

iii. At any time there is a significant change (as defined by ODM) in the MCO's operations that would affect adequate capacity and services, including but not limited to changes in services, benefits, service area, provider network, or payments;

iv. Any time there is enrollment of a new population in the MCO; or

v. As otherwise directed by ODM.

d. The MCO must develop and maintain a Network Development and Management Plan to demonstrate that it maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area and ensures the provision of covered services.

i. The Network Development and Management Plan must include the information specified by ODM, which may include but is not limited to:

1. Monitoring activities to ensure that access standards are met and that members have timely access to services;

2. Provider capacity issues by service and county, the MCO's remediation and quality improvement (QI) activities, and the targeted and actual completion dates for those activities;

3. For areas where the MCO is deficient, including those with approved exceptions to network access standards or with known gaps in coverage, provider recruitment strategies and implementation plans;

4. Provider network deficiencies by service and by county and interventions to address the deficiencies; and

5. Ongoing activities for provider network development and expansion taking into consideration identified network provider capacity, network deficiencies, service delivery issues, and current and future member needs.

ii. The MCO must evaluate and update its Network Development and Management Plan on an annual basis, and submit it to ODM as specified in Appendix P, Chart of Deliverables.

iii. The MCO's annual submission of the Network Development and Management Plan satisfies the annual documentation requirement for network capacity.

3. Provider Contracting

a. Provider Selection

i. In accordance with 42 CFR 438.214 and OAC rule 5160-26-05, the MCO must have policies and procedures for selection and retention of network providers.

b. Written Contracts and Medicaid Addendum

i. In accordance with 42 CFR 438.206 and OAC rule 5160-26-05, the MCO must enter into written contracts with network providers.

ii. Pursuant to OAC rule 5160-26-05, network provider contracts must include the appropriate ODM-approved Model Medicaid Addendum, which incorporates all applicable OAC rule requirements. The MCO must not modify the Model Medicaid Addendum except to add personalizing information such as the MCO's name.

iii. The MCO must submit network provider contract templates to ODM for review prior to executing contracts using the applicable template.

iv. The MCO must completely and accurately respond to ODM's questions and requests for information about network provider contracts within the timeframes established by ODM.

v. Upon ODM's request, the MCO must disclose to ODM all financial and other terms that apply between the MCO and any network provider.

c. Contracting with ODM-Enrolled Providers

i. In accordance with 42 CFR 438.608 and this Agreement, the MCO must contract only with providers that are enrolled with ODM and are active providers in ODM's provider network management system.

ii. Prior to contracting with a provider or listing the provider as a network provider, the MCO must validate that the provider is active in ODM's provider network management system and enrolled for the applicable service and/or specialty. If a provider is not active in ODM's provider network management system, the MCO must direct the provider to ODM's portal to submit an application for screening, enrollment, and credentialing prior to contracting. Providers operating under single-case agreements with the MCOs are not considered network providers.

iii. The MCO must conduct a daily (seven days per week) reconciliation of the MCO's provider network, and ODM's PNM system. The MCOs must use PNM system data, the PMF, supplemental files generated by ODM systems, and any data elements as directed by ODM. Network providers and staff affiliations must remain active and in alignment with ODM's PNM system.

d. Excluded Providers

i. The MCO may not employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

ii. The MCO must terminate any persons or providers of service terminated from participation under title XIX, title XVIII, or title XXI from participating in their provider network.

e. Centralized Credentialing

i. If credentialing is required for a specific provider type, the MCO must only use providers credentialed or approved through ODM's process.

ii. A provider's credentialing status will be indicated in ODM's provider network management system.

iii. The MCO must accept ODM's credentialing status.

iv. The MCO must not request any credentialing or re-credentialing information from an ODM-enrolled provider. The MCO may request information for initial and ongoing contracting and ongoing network management provided that the requested information is not available in ODM's provider network management system.

v. The MCO must not credential or re-credential any ODM-enrolled providers for provision of services under this Agreement, including provider types that are not credentialed by ODM.

vi. The MCO must coordinate and cooperate with ODM in the credentialing and re-credentialing of the MCO's network providers.

vii. The MCO's Medical Director/Chief Medical Officer (CMO) must participate in ODM's credentialing committee, if requested by ODM.

viii. As specified in Appendix P, Chart of Deliverables, the MCO must submit a monthly report (Centralized Credentialing Member Grievances) of member grievances regarding providers. The report must include NPI/Medicaid ID of the provider, grievance receive date, grievance resolution date, and a narrative.

ix. The MCO must provide to ODM, in the format and at the frequency specified by ODM, the information specified by ODM to inform ODM's credentialing and re-credentialing process. This information may include but is not limited to:

1. The MCO's credentialing and re-credentialing files, including provider demographic information, primary source verification, and results of any site surveys;

2. Changes in a provider's demographic information;

3. Changes in a provider's contracting status for any line of business;

4. Changes in a provider's credentialing status for other lines of business;

5. Findings from the MCO's ongoing monitoring of network providers, including but not limited to complaints, adverse events, and quality of care issues; and

6. Information about the provider maintained by the MCO for credentialing or re-credentialing the provider for other lines of business.

f. <u>MCO Provider Network Information</u>

i. The MCO must submit provider network information, including provider additions and deletions, to ODM in the format and at the frequency specified by ODM to ODM's provider network management system.

ii. As directed by ODM, the MCO must provide documentation verifying the accuracy of information submitted to ODM's provider network management system.

iii. ODM will use the information provided by MCO and uploaded into ODM's provider network management system to determine if the MCO meets the provider network access standards specified in this Agreement.

iv. The MCO must immediately notify ODM of any discrepancy between the MCO's provider network information in ODM's provider network management system and the MCO's system and resubmit the correct information within one business day of becoming aware of the discrepancy.

g. Sole Source Contracting

i. The MCO must receive ODM's approval prior to executing a sole source contract for any covered services or otherwise limiting the availability of any service to one provider.

ii. As part of its request for ODM's prior approval, the MCO must include the information and documentation specified by ODM.

iii. If ODM approves a sole source contract, the MCO must ensure that providers and members are notified of the sole source contract and ensure an effective transition for members receiving services from another provider.

4. Provider Network Access Requirements

a. General

i. The MCO must comply, at a minimum, with the provider network access requirements specified in this appendix applicable to the MCO's service area.

ii. If ODM determines that changes have occurred in the availability of specific provider types and/or the number and composition of the eligible population, ODM will, via amendment to this Agreement, revise the provider network access requirements.

iii. The MCO must monitor compliance with provider network access requirements and take corrective action as needed to comply with this appendix.

iv. As specified in Appendix P, Chart of Deliverables, the MCO must submit quarterly time and distance reports (Time and Distance Report) to ODM in the format specified by ODM.

v. ODM will use a time and distance geo mapping and statistical software that uses the Euclidean metric to measure the maximum time and distance for the MCO's membership and provider network. The MCO must ensure that at least 90% of the MCO's membership residing in a given county have access to at least one provider/facility of each specialty type within the time and distance standards in Table F.2 as determined by ODM.

vi. The MCO must notify ODM within one business day of determining that the MCO is not in compliance with the provider network access requirements specified in this appendix.

b. Primary Care Providers

i. *Primary Care Provider County Capacity Standard*

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

2. In order for a PCP to count toward the minimum PCP capacity, the MCO must ensure that the PCP does not have a caseload of more than 2,000 Medicaid members for that MCO.

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

ii. *Primary Care Provider Time and Distance Standards*

1. In addition to complying with the minimum primary care provider (PCP) capacity requirements, the MCO must comply with the time and distance standards for Adult Primary Care and Pediatrics specified in Table F.2

2. To count as a pediatric PCP for purposes of the time and distance standards in Table F.2, the provider must maintain a general pediatric practice (e.g., a pediatric neurologist would not meet this definition unless this physician also operated a practice as a general pediatrician) and be listed as a pediatrician with the Ohio State Medical Board. In addition, half of the required number of pediatric PCPs must also be certified by the American Board of Pediatrics.

c. Specialty Physicians

i. The MCO must ensure members have adequate access to specialty physicians, including but not limited to the specialties listed in Table F.2.

ii. The MCO must comply with the time and distance standards for specialty physicians as specified in Table F.2.

iii. In order to be counted toward meeting the applicable time and distance standard, the specialty physician must maintain a full-time practice at a site or sites located in the service area. For purposes of this appendix, a full-time practice is defined as one where the provider is available to patients at their practice site or sites for at least 25 hours a week.

iv. If a provider must have hospital admitting privileges to meet credentialing standards, the provider must have hospital admitting privileges in order for the provider to be included in ODM's provider network management system, listed in the MCO's

provider directory, or counted toward meeting the applicable time and distance standard.

d. Certified Nurse Midwives and Certified Nurse Practitioners

i. The MCO must ensure access to certified nurse midwife and certified nurse practitioner services in the service area if such provider types are present within the service area.

ii. The MCO may contract directly with the certified nurse midwife or certified nurse practitioner providers or with a physician or other provider entity that is able to obligate the participation of a certified nurse midwife or certified nurse practitioner.

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

iv. In order to be included in ODM's provider network management system, the MCO's provider directory, or counted toward meeting the time and distance standard for Gynecology, OB/GYN, a network certified nurse midwife must have current hospital privileges at a hospital under contract with the MCO in the service area.

e. Hospitals

i. The MCO must comply with the time and distance standards for hospitals as specified in Table F.2.

ii. The MCO must contract with at least the minimum number of hospitals by type per county as specified in Table F.3.

iii. In order to meet these access requirements, the MCO might have to contract with an out-of-state hospital located in a state bordering Ohio.

iv. If a hospital in the MCO's network elects not to provide specific covered services because of an objection on moral or religious grounds, the MCO must ensure these hospital services are available to its members through another network hospital in the specified county.

f. Nursing Facilities

i. The MCO must contract with at least the minimum number of nursing facilities per county as specified in Table F.4. In order to meet these requirements, the MCO might have to contract with an out-of-state nursing facility located in a state bordering Ohio.

g. Behavioral Health Providers

i. *Child and Adolescent Needs and Strengths Providers*

1. The MCO must contract with all providers identified by ODM in ODM's provider network management system as eligible to complete the initial

Child and Adolescent Needs and Strengths (CANS) assessments for eligibility for OhioRISE enrollment (CANS providers) in the MCO's service area, except where there are documented instances of quality concerns. The MCO must notify ODM if it is not willing to contract with a particular CANS provider and must collaborate with ODM on next steps.

2. For CANS providers identified by ODM after the effective date of this Agreement, the MCO must contract with the identified provider no later than 90 calendar days from the provider being identified as a CANS provider in ODM's provider network management system.

3. The MCO must monitor CANS providers for compliance with ODM standards and guidance using a standardized protocol as specified by ODM. As directed by ODM, the MCO must coordinate monitoring activities with other MCOs and the OhioRISE Plan.

4. The MCO must ensure an initial CANS assessment appointment for the purpose of determining OhioRISE eligibility is scheduled within 72 hours of referral to the MCO, as described in Table F-1, Appointment Standards. The MCO must have a process in place to ensure the initial CANS assessment is completed within 10 business days after scheduling, and must assist the CANS assessor or member as necessary to support timely completion. If it is in the best interest of the member to allow for more than 10 business days for the completion of the CANS assessment, the MCO must assist in facilitating completion as expeditiously as possible.

ii. *Providers of Mobile Response and Stabilization Services*

1. Prior to the implementation of the Regional Mobile Response and Stabilization Services Provider (RMP) structure, the MCO must contract with all providers identified by ODM as eligible to provide Mobile Response and Stabilization Services (MRSS) in the MCO's service area, except where there are documented instances of quality concerns. The MCO must notify ODM if it is not willing to contract with a particular MRSS provider and must collaborate with ODM on next steps. Upon implementation of the Regional Mobile Response and Stabilization Services Provider (RMP) structure, MCO must only contract with RMPs identified by ODM.

2. The MCO must monitor MRSS providers and RMPs for compliance with ODM standards and guidance using a standardized protocol as specified by ODM. As directed by ODM, the MCO must coordinate monitoring activities with other MCOs, the OhioRISE Plan, and the state.

iii. *Behavioral Health Care Coordination Entities*

1. The MCO must contract with all providers identified by ODM in ODM's provider network management system as Behavioral Health Care Coordination Entities (BHCCEs) in the MCO's service area, except where there are documented instances of quality concerns. The MCO must

notify ODM if it is not willing to contract with a particular BHCCE provider and must collaborate with ODM on next steps.

2. For BHCCEs identified by ODM after the effective date of this Agreement, the MCO must contract with the identified provider no later than 90 calendar days from the provider being identified as a BHCCE in ODM's provider network management system.

3. The MCO must monitor BHCCEs for compliance with ODM standards and guidance using a standardized protocol as specified by ODM.

iv. *Community Mental Health Services Providers*

1. The MCO must contract with Ohio Department of Mental Health and Addiction Services- (OMHAS)-certified community mental health services providers (CMHSPs) and ensure adequate provider network capacity to provide its members with reasonable and timely access to all covered mental health services.

2. Community mental health services providers count toward the time and distance standard in Table F.2 for Behavioral Health and Pediatric Behavioral Health providers.

v. *Substance Use Disorder Treatment Providers*

1. The MCO must contract with OMHAS-certified substance use disorder treatment providers and ensure adequate provider network capacity to provide its members with reasonable and timely access to all covered substance use disorder treatment services.

2. MCO network providers that are OMHAS-certified substance use disorder treatment providers count toward the time and distance standard in Table F.2 for Behavioral Health, Pediatric Behavioral Health, SUD-Outpatient, and SUD-Residential, as applicable.

vi. *Medication Assisted Treatment Prescribers*

1. The MCO must contract with at least the minimum number of Medication Assisted Treatment (MAT) prescribers per county as specified in Table F.5, including all willing Opioid Treatment Programs (OTPs) licensed by OMHAS and certified by the United States Substance Abuse and Mental Health Services Administration (SAMHSA).

2. The MCO must report any additional providers prescribing MAT not previously identified by ODM in the format and frequency specified by ODM.

vii. *Other Behavioral Health Providers*

1. The MCO must contract with at least the minimum number of other behavioral health providers per county as specified in Table F.6.

2. For purposes of this standard, other behavioral health providers include independent marriage and family therapists, licensed independent chemical dependency counselors, licensed independent social workers, and psychologists who are contracted with the MCO to provide behavioral health services privately and unrelated to the community mental health services providers or OMHAS-certified substance use disorder treatment providers.

h. Vision Care Providers

i. The MCO must contract with at least the minimum number of vision care providers (ophthalmologists and optometrists) per county as specified in Table F.7.

ii. In order to be counted toward meeting this access standard, the ophthalmologist/optometrist must maintain a full-time practice at a site or sites located in the county and regularly perform routine eye exams.

iii. The MCO must contract with an adequate number of ophthalmologists as part of its provider network, but only ophthalmologists who regularly perform routine eye exams can be used to meet the vision care access requirement.

iv. If optical dispensing is not sufficiently available in a county through the MCO's contracting ophthalmologists/optometrists, the MCO must separately contract with an adequate number of optical dispensers located in the county.

i. Dental Care Providers

i. The MCO must contract with at least the minimum number of dental care providers per county as specified in Table F.7.

ii. In order to be counted toward meeting this access standard, the dental provider must maintain a full-time practice at a site or sites located in the county and serve all ages (adults and children).

j. Federally Qualified Health Centers/Rural Health Clinics

i. The MCO must ensure member access to any federally qualified health center (FQHC) and/or rural health clinic (RHC), regardless of whether the FQHC/RHC is a network provider.

ii. Even if no FQHC/RHC is available within a county, the MCO must cover services provided by an FQHC/RCH outside of the county.

k. Qualified Family Planning Providers

i. The MCO must permit members to self-refer for services and supplies allowed under Title X of the Public Health Services Act (Title X services) provided by a qualified family planning provider. A description of Title X services is available on the Ohio Department of Health website.

ii. A qualified family planning provider is defined as any public or not-for-profit health care provider that complies with Title X guidelines/standards and receives either Title X funding or family planning funding from the Ohio Department of Health.

iii. The MCO must reimburse a qualified family planning provider for all Title X services provided to a member that are medically necessary covered services (including on-site diagnostic services), regardless of whether the qualified family planning provider is a network provider.

iv. The MCO must work with qualified family planning providers in the service area to develop mutually-agreeable Health Insurance Portability and Accountability Act (HIPAA) compliant policies and procedures to preserve patient/provider confidentiality and convey pertinent information to the member's PCP and/or the MCO.

l. Specialty Treatment Centers

i. The MCO must provide reasonable and timely access to specialty treatment centers, including Hemophilia Treatment Centers supported and funded by the United States Centers for Disease Control and Prevention (CDC), Cystic Fibrosis Care Centers accredited by the Cystic Fibrosis Foundation, and Ohio metabolic centers approved by the Ohio Department of Health.

m. Other

i. The MCO must provide reasonable and timely access to all medically necessary covered services to its members; therefore, the MCO's provider network must include additional specialists and provider types not listed in this appendix.

ii. The MCO must provide reasonable and timely access to services provided by pharmacist providers in accordance with OAC rule 5160-8-52; therefore, the MCO's provider network must include pharmacies.

5. Exception Process for Provider Network Access Requirements

a. Upon written request of the MCO, and in accordance with the exception request process outlined by ODM, ODM may grant an exception to a provider network access requirement if one or both of the following have occurred:

i. Action taken by ODM adversely impacted the MCO's ability to meet the requirement; or

ii. If there is no provider available to meet the requirement.

b. If ODM grants an exception to a provider network access requirement, the MCO must attempt to recruit new or contract with existing Medicaid enrolled providers/ facilities within the time/ distance and/or county-based requirements during the approved exception request period. The provider strategy must be submitted as part of the exception request.

c. Exception requests will be approved in either 90-day or 180-day increments as determined by ODM.

6. Provider Network Changes

a. The MCO must comply with the provider network notification requirements in OAC rule 5160-26-05.

b. In addition to the notification requirements in OAC rule 5160-26-05, the MCO must notify ODM within one business day of becoming aware that a network provider that served 500 or more of the MCO's members in the previous 12 months failed to notify the MCO that they are no longer available to serve as an MCO network provider.

c. In addition to the notification requirements in OAC rule 5160-26-05, the MCO must notify ODM no less than 90 calendar days before the end date of an MCO-initiated termination of a network provider contract when the provider has served 500 or more of the MCO's members in the previous 12 months. This includes individual practitioners in group practices that cumulatively have served 500 or more members in the previous 12 months. Unless otherwise approved by ODM, MCO-initiated terminations of network provider contracts that have served 500 or more of the MCO's members shall not take effect during the 90 calendar days after the open enrollment month ends.

d. In addition to the notification requirements in OAC rule 5160-26-05, the MCO must notify ODM at least 90 calendar days prior to implementing any MCO-initiated changes that may foreseeably result in the provider network being reduced by 10% or more of available network providers for one or more services or provider types. MCO-initiated changes include but are not limited to terminating or not renewing contracts, restricting or limiting contracts for a service or provider type, sole source contracting for a service or provider type, terminating or restricting a provider type or group of providers, or reducing payment rates for a service or provider type. Unless otherwise approved by ODM, MCO-initiated changes that could reduce the MCO's provider network by 10% or more may not take effect during the 90 calendar days after the open enrollment month ends.

e. In addition to the provisions in OAC rule 5160-26-05, the MCO must notify ODM within one business day of becoming aware of a provider-initiated hospital unit closure.

f. When the MCO has been notified of a hospital termination, the MCO may request ODM authorize an alternative notification area (other than the service area), in accordance with OAC rule 5160-26-05. Upon request, ODM will determine the authorized notification area no later than seven business days after receipt of the MCO's submission. The MCO must comply with the notification timelines outlined in OAC rule 5160-26-05.

g. When submitting notification to ODM about provider network changes, the MCO must include, at a minimum, the following:

    i. For all terminations:

        1. Provider information, including name, provider type, address, and county where services were rendered;

        2. Copy of the termination notice, including the termination reason and the termination date;

3. Number of members who used services from, or were assigned to, the provider in the previous 12 months; and

4. Results of an evaluation of the remaining provider network contracts to assure adequate access, including the average and longest distance a member will need to travel to another provider, and the name, provider type, address, and county of the remaining network providers that can meet the access requirements.

ii. For hospital terminations or hospital unit closures:

1. Zip codes or counties of residence for members who used services in the previous 12 months;

2. Details for all PCPs and specialists affiliated with the hospital;

3. Percent of the MCO's membership that use the terminating hospital or hospital unit closure and the percent of the MCO's membership that use the next closest network hospital; and

4. Plan to ensure continuity of services for members in their third trimester, receiving chemotherapy, and/or receiving radiation treatment.

h. When the MCO is notified by ODM or otherwise becomes aware of a current or planned loss of provider who delivers ongoing services to its members, the MCO must immediately identify any members being served by that provider and ensure that all health, safety, and welfare needs are met (e.g., securing informal support). The MCO must assist the member with selecting a new provider as expeditiously as possible and ensure documentation in the clinical record reflects the member's choice of network providers.

i. The MCO must provide ODM with the monthly Change in Circumstance Report (formerly Provider Termination Report), as specified in Appendix P, Chart of Deliverables.

7. Timely Access

a. In accordance with 42 CFR 438.206:

i. The MCO must ensure compliance with the appointment availability standards in this appendix.

ii. The MCO must ensure that wait times for members to see a network provider are no longer than wait times for commercial patients.

iii. The MCO must ensure that network providers offer hours of operation no less than the hours of operation offered to commercial members or comparable to ODM fee-for-service (FFS), if the provider serves only Medicaid members.

iv. The MCO must ensure services are available 24 hours a day, seven days a week, when medically necessary.

v. The MCO must establish mechanisms to ensure compliance with the requirements in this section, monitor network providers to determine compliance, and take corrective action as needed.

8. Appointment Availability

a. The MCO must ensure the availability of medical, behavioral health, and dental care appointments.

b. At a minimum, the MCO must ensure compliance with the appointment standards identified in the Table F.1 below.

Table F.1 Appointment Standards

Type of Visit	Description	Minimum Standard
Emergency Service	Services needed to evaluate, treat, or stabilize an emergency medical condition.	24 hours, 7 days/week
Urgent Care (includes medical, behavioral health, and dental services)	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include but are not limited to sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain, and severe, non-resolving headache. Acute illness or substance dependence that impacts the ability to function, but does not present imminent danger.	24 hours, 7 days/week within 48 hours of request
Behavioral Health Non-Life-Threatening Emergency	A non-life-threatening situation in which a member is exhibiting extreme emotional disturbance or behavioral distress, has a compromised ability to function, or is otherwise agitated and unable to be calmed.	Within 6 hours
Behavioral Health Routine Care	Requests for routine mental health or substance abuse treatment from behavioral health providers.	Within 10 business days or 14 calendar days, whichever is earlier
CANS Initial Assessment	Assessment for the purposes of OhioRISE eligibility	Within 72 hours of identification
ASAM Residential/Inpatient Services – 3: 3.1, 3.5, 3.7	Initial screening, assessment and referral to treatment.	Within 48 hours of request
ASAM Medically Managed Intensive Inpatient Services – 4	Services needed to treat and stabilize a member's behavioral health condition.	24 hours, 7 days/week

Type of Visit	Description	Minimum Standard
Primary Care Appointment	Care provided to prevent illness or injury; examples include but are not limited to routine physical examinations, immunizations, mammograms, and pap smears.	Within 6 weeks
Non-Urgent Sick Primary Care	Care provided for a non-urgent illness or injury with current symptoms.	Within 3 calendar days
Prenatal Care – First or Second Trimester	Care provided to a member while the member is pregnant to help keep member and future baby healthy, such as checkups and prenatal testing.	First appointment within 7 calendar days; follow up appointments no more than 14 calendar days after request
Prenatal Care – Third Trimester or High Risk Pregnancy		Within 3 calendar days
Specialty Care Appointment	Care provided for a non-emergent/non-urgent illness or injury requiring consultation, diagnosis, and/or treatment from a specialist.	Within 6 weeks
Dental Appointment	Non-emergent/non-urgent dental services, including routine and preventive care.	Within 6 weeks of request

c. These appointment availability standards do not replace the access requirements established by ODM for Comprehensive Maternal Care (CMC) or Comprehensive Primary Care (CPC) practices.

d. The MCO must disseminate the appointment standards to network providers and must educate network providers about the appointment standards.

e. The MCO must have and implement policies and procedures for triage to assist MCO staff and providers in determining whether a member's need is emergent, behavioral health non-life-threatening emergent, urgent, or routine, and to support member access to needed services based on the urgency of the member's need. The MCO's triage process must be transparent and compliant with Mental Health Parity and Addiction Equity Act (MHPAEA).

9. Telehealth

a. The MCO must offer, promote, support, and expand the appropriate and effective use of telehealth.

b. At a minimum, the MCO must follow OAC rule 5160-1-18 “Telehealth”, including any emergency rule versions of OAC rule 5160-1-18, and any future telehealth rules or services developed during the time that this Agreement is in effect, but the MCO may be less restrictive if appropriate.

c. In addition to OAC rules mentioned above, the MCO must cover telehealth services as specified in the ODM *Telehealth Services: Guidelines for Managed Care Organizations* manual. The MCO must implement any changes outlined in the *Telehealth Services:*

Guidelines for Managed Care Organizations manual within 30 calendar days of being notified by ODM of the change.

d. The MCO must educate members and providers about the availability of telehealth, considerations for using telehealth versus in-person visits, applicable requirements, and how to access telehealth options.

e. The MCO must ensure that telehealth does not replace provider choice and/or member preference for in-person service delivery.

f. ODM will not consider telehealth as an alternative to meeting provider network access requirements.

g. The MCO must support providers in offering telehealth, including providing "how to" guides on the technical requirements, workflows, coding, and billing.

h. The MCO must ensure that providers comply with state requirements regarding telehealth, including but not limited to in OAC rule 5160-1-18.

i. As specified in Appendix P, Chart of Deliverables, the MCO must submit an annual telehealth report (Telehealth Report) to ODM that includes but is not limited to:

   i. The MCO's goals for telehealth and progress on meeting those goals, including performance measures;

   ii. Barriers to increased use of telehealth and the MCO's strategies to overcome those barriers;

   iii. Telehealth utilization, including any changes from the previous year;

   iv. The MCO's activities to support increased use of telehealth, including any provider partnerships; and

   v. Information regarding whether telehealth is improving access to needed services and/or helping make access more equitable.

10. Workforce Development

a. The MCO must work with ODM, ODM-contracted managed care entities, and other stakeholders to develop and implement workforce development initiatives designed to support provider network adequacy and access. This includes but is not limited to providing qualified staff to actively participate in meetings; conducting and sharing a workforce analysis if requested by ODM; providing input to prioritize areas for workforce development; assisting with developing workforce development strategies; and implementing identified workforce strategies, including in partnership with other stakeholders.

11. Out-of-Network Requirements

a. In accordance with 42 CFR 438.206 and OAC rule 5160-26-03, if the MCO is unable to provide medically necessary covered services to a member in a timely manner through its provider network, the MCO must adequately and timely cover these services by an out-of-

network provider for as long as the MCO's provider network is unable to provide the services.

b. In accordance with 42 CFR 438.206 and OAC rule 5160-26-05, the MCO must coordinate with the out-of-network provider with respect to payment and must ensure the cost to the member is no greater than it would be if the services were furnished by a network provider.

c. If the out-of-network provider is not an active provider in ODM's provider network management system, the MCO must verify the provider's licensure and conduct federal database checks in accordance with 42 CFR 455.436, and must execute a single case agreement with the provider that includes the appropriate Model Medicaid Addendum.

d. The MCO must direct all out-of-network providers, whether out-of-state or unenrolled providers, who are not active providers in ODM's provider network management system to the ODM portal to submit an application for screening, enrollment, and credentialing.

   i. If the unenrolled provider refuses to complete an on-line single case agreement provider enrollment application to ODM, the MCO can have them complete the ODM 10282 and 10283 forms to submit to the MCO. The MCO will then submit the completed forms to ODM, as directed by ODM. This will allow the provider to have a 5-year provider agreement.

   ii. If the unenrolled provider refuses to complete enrollment process or refuses to complete the ODM 10282 and 10283 forms, the MCO can have them complete the ODM 10295 form to submit to the MCO. The MCO will then submit the completed form to ODM, as directed by ODM. This will allow the provider to have a 120-day provider agreement. Providers can only have a single 120-day provider agreement. Once the one 120-day provider agreement expires, providers will be required to submit an application.

e. The MCO must report all single case agreements with providers who are not active in ODM's provider network management system to ODM within seven calendar days of becoming aware of the need to execute a single case agreement with such a provider. If a provider who is not active in ODM's provider network management system is not willing or able to become an active provider, the MCO must terminate the single case agreement as directed by ODM and must not reimburse the provider for services provided after termination of the single case agreement.

12. Provider Payment

a. <u>General</u>

   i. Unless otherwise specified in this Agreement, the MCO is free to establish reimbursement methodologies with its network providers that result in payments that are sufficient to enlist enough providers so that medically necessary covered services are available to members as specified in this appendix. To the extent possible, payment arrangements should encourage and reward innovations and positive clinical outcomes (see Appendix H, Value-Based Payment).

ii. If ODM determines that the MCO's reimbursement rate or rates for a program, service, or provider type is not sufficient, the MCO, as directed by ODM, must pay, at a minimum, the rate specified by ODM, which will be no more than 100% of the current Medicaid FFS rate.

iii. If ODM adds a new program, service, or provider type to this Agreement, the MCO must pay, if so directed by ODM, no less than the rate established by ODM, which will be no more than 100% of the current Medicaid FFS rate. If ODM establishes such a rate, it will evaluate the need to continue the rate no less often than every six months.

iv. The MCO must require, as a condition of payment, that a provider (network or out-of-network) accepts the amount paid by the MCO or appropriate denial made by the MCO (or, if applicable, payment by the MCO that is supplementary to the member's third party payer), and, in addition, any applicable co-payment or patient liability amount due from the member as payment in full for the service.

v. The MCO must ensure that members are held harmless by providers for the costs of medically necessary covered services and additional services offered by the MCO, except for applicable co-payment or patient liability amounts.

vi. The MCO must only pay providers for services performed when they are enrolled with ODM and are active in ODM's provider network management system, including the single case agreement options listed in this appendix, in accordance with 42 CFR 438.114. Except for emergency services, the MCO must not pay a provider for services provided when the provider has been terminated or suspended by ODM, or has been terminated by Medicare, Medicaid, or the Children's Health Insurance Program.

vii. The MCO must make timely payments to providers in accordance with the timeliness standards in Appendix L, Payment and Financial Performance.

viii. The MCO must pay certain providers, including but not limited to Comprehensive Primary Care (CPC) practices, Comprehensive Maternal Care (CMC) providers, BHCCEs, and Care Innovation and Community Improvement Program (CICIP) agencies, in accordance with the requirements in Appendix H, Value-Based Payment.

b. Rate Changes

i. The MCO must inform ODM of any rate changes that may adversely impact 50 or more network providers, prior to implementation of the rate change.

c. Retroactive Coverage Requirements

i. The MCO must pay for covered services provided to members during retroactive enrollment periods. For services provided during retroactive enrollment periods that require FFS prior authorization as provided in Appendix DD of OAC rule 5160-1-60 or any other rule regarding ODM FFS prior authorization policy, the MCO may conduct a medical necessity review, in accordance with Appendix B, Coverage and Services, for

payment. If the service was reviewed and approved by ODM's FFS program, the MCO must approve and pay for the service.

d. Medicare Payment Guidelines for Managed Care Members in Receipt of Medicare

i. When a member becomes entitled to Medicare, before the member's termination of enrollment, the member may receive covered benefits that are also covered by Medicare. During that time, unless the provider has agreed in writing to an alternative payment methodology or different secondary claims payment rate, the MCO must adjudicate Medicare secondary claims as set forth in OAC rule 5160-1-05.3 for both network and out-of-network providers. The MCO must apply exemptions to the Part B Medicaid maximum policy in accordance with the OAC and other guidance issued by ODM.

e. Child and Adolescent Needs and Strengths Assessments

i. The MCO must reimburse for Child and Adolescent Needs and Strengths (CANS) assessments conducted by CANS providers or MRSS providers at 100% of the current Medicaid FFS rate.

ii. The MCO must comply with ODM's guidance for coding and billing requirements for CANS assessments.

f. Mobile Response and Stabilization Services

i. The MCO must reimburse for Mobile Response and Stabilization Services (MRSS) rendered by MRSS providers at 100% of the current Medicaid FFS rate until ODM receives approval from CMS for the directed payment in subsection v of this section.

ii. Upon direction of ODM, when the RMP structure is implemented the MCO must enter into a subcontractor arrangement with the Single Funding Source Manager designated by ODM by which the Single Funding Source Manager will administer the directed payment described in subsection v of this section for MRSS rendered by Regional MRSS Providers on behalf of the MCO. The MCO agrees to use their best efforts to contract with the Single Funding Source Manager designated by ODM, and must notify ODM if it is not able to come to an agreement and must collaborate with ODM on next steps.

iii. The MCO must comply with all ODM's guidance for coding and billing requirements for MRSS, and ensure that all relevant subcontractors, including the Single Funding Source Manager, comply with all such guidance.

g. Nursing Facility Payment

i. At a minimum, the MCO must pay nursing facility providers in accordance with the Ohio Revised Code, including ORC sections 5165.15 and 5165.158.

ii. The MCO must ensure accurate claims payment to nursing facility providers by appropriately modifying payment pursuant to OAC rule 5160-3-39.1 when a member has patient liability obligations or lump sum amounts.

iii. The MCO must apply patient liability as an offset against the amount the MCO would otherwise reimburse for the claim. If the patient liability exceeds the amount the MCO would reimburse, the MCO must process the claim with a payment of $0.

iv. The MCO must not pay for nursing facility services during a member's restricted Medicaid coverage period (RMCO).

v. The MCO must utilize HIPAA compliant enrollment files from ODM to determine a member's patient liability obligations and restricted Medicaid coverage period.

h. Ventilator Program

i. The MCO must comply with requirements outlined in OAC rule 5160-3-18 with regard to the alternative purchasing model for the provision of nursing facility services to members who are ventilator dependent.

i. Federally Qualified Health Centers/Rural Health Clinics

i. To ensure a federally qualified health center (FQHC) or rural health clinic (RHC) can submit a claim to ODM for the state's wraparound payment per visit as defined in OAC rule 5160-28-01, the MCO must comply with the following for both network and out-of-network FQHCs/RHCs:

1. The MCO must provide payment on a service-specific basis, by procedure code, in an amount no less than the payment made to other providers for the same or a similar service. Bundled payments are not permissible.

2. If the MCO has no comparable service-specific rate structure, the MCO must pay the FQHC/RHC no less than 100% of the current Medicaid FFS payment schedule for the same or a similar service provided by a non-FQHC/RHC provider.

3. The MCO must provide FQHCs/RHCs the MCO's Medicaid provider number for each region to enable FQHC/RHC providers to bill for the ODM wraparound payment as defined in OAC rule 5160-28-01.

j. Out-of-Network Emergency Services

i. In accordance with 42 CFR 438.114 and OAC rule 5160-26-03, the MCO must reimburse out-of-network providers of emergency services the lesser of billed charges or 100% of the current Medicaid FFS rate.

k. Out-of-Network Hospital Referrals

i. Pursuant to OAC rule 5160-26-03, if ODM approves a member's referral to certain out-of-network hospitals, the MCO must reimburse the hospital at 100% of the current Medicaid FFS rate.

l. Out-of-Network Providers During Transition

i. In accordance with Appendix D, Care Coordination, the MCO must reimburse out-of-network providers who provide services during the transition at 100% of the current Medicaid FFS rate.

m. Out-of-Network Qualified Family Planning Providers

i. Pursuant to OAC rule 5160-26-03, the MCO must reimburse an out-of-network qualified family planning provider for all Title X services provided to a member that are medically necessary covered services (including on-site diagnostic services) at the lesser of billed charges or 100% of the current Medicaid FFS rate.

n. COVID-19 Testing and Treatment

i. The MCO must pay at least 100% of the current Medicaid fee-for-service (FFS) rate for COVID-19 testing codes.

ii. The MCO must pay at least 100% of the current Medicaid FFS rate for all Medicaid covered COVID-19 vaccination codes.

iii. The MCO must reimburse out-of-network providers for COVID-19 vaccinations provided to its members as long as the provider is enrolled with ODM and an active provider in ODM's provider network management system.

o. Hospital Payments

i. Upon directed payment approval from the Centers for Medicare and Medicaid Services (CMS), the MCO must pay in-state hospitals an added payment amount determined by ODM for members receiving hospital services (inpatient and outpatient).

ii. The payment amounts will be calculated on a quarterly basis using utilization data from a timeframe specified by ODM and later adjusted based on actual utilization during the quarter.

iii. The monetary differences resulting from the reconciliation will be adjusted, by hospital, in subsequent quarters. MCO encounter data submitted to ODM will be used to identify service utilization for inpatient and outpatient services for members. The payment will be made as a flat per discharge amount for inpatient services and a percentage increase applied to outpatient payments. Per discharge amounts and percentages will be evaluated each quarter. ODM estimates these payments will increase annual aggregate Medicaid expenditures for inpatient and outpatient hospital services. The directed payments are incorporated through separate payment terms and paid separately by ODM to the MCO outside of the monthly base capitation rate.

iv. The MCO must pay each hospital identified by ODM the allocated payment amount within seven business days of receiving funds from ODM.

p. University of Toledo Medical Center Hospital Payments

i. In accordance with House Bill 110 as passed by the 134th General Assembly and upon directed payment approval from the Centers for Medicare and Medicaid Services (CMS), the MCO must pay the University of Toledo Medical Center (UTMC) an added payment amount determined by ODM for members receiving hospital services (inpatient and outpatient).

ii. The MCO must provide UTMC interim quarterly payments, and the allocated amount must be paid within seven business days of receiving funds from ODM. The interim quarterly payments to UTMC will be a uniform percentage increase of Medicaid for inpatient claims and outpatient claims and will be based on historical inpatient and outpatient utilization and MCO enrollment from a previous period as determined by ODM. Inpatient and outpatient service utilization underlying the interim payment will be reconciled by ODM. Inpatient and outpatient service utilization underlying the interim payment will be reconciled to actual service utilization following the rating period, and differences between interim payments and payments calculated using actual utilization will be reflected in payments for a future quarter.

iii. After reconciliation, ODM will use the actual payment data to amend the MCO capitation rates such that the capitation rates include the actual payments on a per member per month (PMPM) basis. The directed payments are incorporated through separate payment terms and paid separately to the MCO outside of the monthly base capitation rate.

q. Provider Relief Payments

i. In accordance with Amended Substitute House Bill 169 as passed by the 134th General Assembly, and the approved directed payment preprint [OH_Fee_Oth1_New_20210101-20220630] from the Centers for Medicare and Medicaid Services (CMS), the MCO must pay providers of community-based Durable Medical Equipment, Community Behavioral Health Services, State Plan Home Health Services and Hospice services an added payment amount determined by ODM for members receiving these services.

ii. The payments will be made based on historical utilization for services provided to managed care members from a timeframe specified by ODM and later adjusted based on actual utilization. The value of provider one-time payments will be equivalent to a 10% increase in a provider's base rate, based on the total value of claims paid for services rendered during the specified timeframe. The same uniform percentage increase will apply across the eligible class of providers and must be distributed to providers by the MCO as a lump sum. If a provider's calculated amount is less than $100, the minimum payment must be $100.

iii. ODM will provide the MCO a list of the providers receiving these payments along with the amounts that should be paid to each provider. The interim payments will be limited to 50% of the initially calculated amount owed to the provider, and, following the conclusion of the rating period, ODM will reconcile the 12-month payment amount against current year utilization to calculate the additional amount owed to the provider and then direct the MCO to pay the reconciled amount at a later date. A

final reconciliation will be conducted by ODM and take into consideration actual payments made to providers versus the funds received by ODM. ODM will make MCO whole for any payments that exceed initial funding and MCO's must remit any unspent funding back to ODM after reconciliation. The directed payments are incorporated through separate payment terms and paid separately by ODM to the MCO outside of the monthly base capitation rate.

r. American Rescue Plan Act Requirements

i. To ensure ODM's continued compliance with ARPA Section 9817, the MCO must:

1. Follow the Medicaid behavioral health coverage policies described in OAC chapter 5160-27, including utilization management requirements, except that the MCO may implement less restrictive policies than fee-for-service (FFS) for behavioral health services provided by a Community Behavioral Health Center (CBHC).

2. Maintain Medicaid FFS payment rates as a floor for behavioral health services implemented through behavioral health redesign on July 1, 2018, when the MCO provider contracts are based on FFS rates for behavioral health services provided by a CBHC. This does not apply to CBHC Laboratories or services added to the behavioral health benefit package after May 1, 2020.

3. Prior authorize Assertive community treatment (ACT), intensive home-based treatment (IHBT), and substance use disorder (SUD) residential treatment (beginning with the third stay in a calendar year) as expeditiously as the member's health condition requires but no later than 48 hours after receipt of the request in accordance with OAC rules 5160-26-03.1 and 5160-58-01.1.

s. University of Cincinnati Medical Center (UCMC) Hospital Payments

i. In accordance with House Bill 33 as passed by the 135th General Assembly and upon directed payment approval from the Centers for Medicare and Medicaid Services (CMS), the MCO must pay the University of Cincinnati Medical Center (UCMC) an added payment amount determined by ODM for members receiving hospital services (inpatient and outpatient).

ii. The MCO must provide UCMC interim quarterly payments, and the allocated amount must be paid within seven business days of receiving funds from ODM. The interim quarterly payments to UCMC will be a uniform percentage increase of Medicaid for inpatient claims and outpatient claims and will be based on historical inpatient and outpatient utilization and MCO enrollment from a previous period as determined by ODM. Inpatient and outpatient service utilization underlying the interim payment will be reconciled by ODM. Inpatient and outpatient service utilization underlying the interim payment will be reconciled to actual service utilization following the rating period, and differences between interim payments and payments calculated using actual utilization will be reflected in payments for a future quarter.

iii. After reconciliation, ODM will use the actual payment data to amend the MCO capitation rates such that the capitation rates include the actual payments on a per member per month (PMPM) basis. The directed payments are incorporated through separate payment terms and paid separately to the MCO outside of the monthly base capitation rate.

t. University Hospitals - NEOMED Payments

i. Upon directed payment approval from the Centers for Medicare and Medicaid Services (CMS), the MCO must pay University Hospitals – Cleveland an added payment amount determined by ODM for members receiving qualified practitioner services.

ii. The payment amounts will be calculated on a monthly basis using utilization data from a timeframe specified by ODM and later adjusted based on actual utilization. Monthly payments are adjusted on a semi-annual basis to reflect updated estimates of managed care enrollment.

iii. An annual reconciliation will be performed using actual utilization data for participating health systems. Any remaining amounts will be paid as a lump sum to the participating health systems. The size of the reconciliation pool may be a decreased percentage if actual utilization is less than the total monthly amounts paid. ODM will establish an initial per member per month (PMPM) based on historic utilization that will be included in the initial certification. At the end of the rating period and after the annual reconciliation, the state's actuary will use actual payment data to certify the final rates on a PMPM basis for each rate cell. The directed payments are incorporated through separate payment terms and paid separately by ODM to the MCO outside of the monthly base capitation rate.

u. Premier Health Payments

i. Upon directed payment approval from the Centers for Medicare and Medicaid Services (CMS), the MCO must pay Premier Health an added payment amount determined by ODM for members receiving qualified practitioner services.

ii. The payment amounts will be calculated on a monthly basis using utilization data from a timeframe specified by ODM and later adjusted based on actual utilization. Monthly payments are adjusted on a semi-annual basis to reflect updated estimates of managed care enrollment.

iii. An annual reconciliation will be performed using actual utilization data for participating health systems. Any remaining amounts will be paid as a lump sum to the participating health systems. The size of the reconciliation pool may be a decreased percentage if actual utilization is less than the total monthly amounts paid. ODM will establish an initial per member per month (PMPM) based on historic utilization that will be included in the initial certification. At the end of the rating period and after the annual reconciliation, the state's actuary will use actual payment data to certify the final rates on a PMPM basis for each rate cell. The directed payments are incorporated through separate payment terms and paid separately by ODM to the MCO outside of the monthly base capitation rate.

1. Qualified Practitioners

a. For purposes of paragraphs (a) and (b) above qualified practitioners include: physicians, physician assistants, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetists, certified nurse midwives, clinical social workers, clinical psychologists, optometrists, and dentists.

b. The services for the professionals listed are billed under one of the Group National Provider Identifier (NPI) numbers that are affiliated with one of the participating agencies and identified by ODM.

v. Payments under the Regional Mobile Response and Stabilization Service Provider (RMP) structure

i. Upon directed payment approval from CMS, the MCO must reimburse network Regional MRSS Providers in accordance with the directed payment preprint approved via 42 CFR § 438.6(c).

ii. Subject to CMS approval and as detailed in the approved state directed payment preprint, ODM intends that the MRSS directed payment amounts will be paid on a monthly basis using utilization data from a timeframe specified by ODM and later adjusted based on actual utilization during the contract period. A reconciliation will occur at least annually, and any monetary differences based on actual utilization will be adjusted in accordance with the approved directed payment preprint.

iii. The MCO, and all relevant subcontractors, including the Single Funding Source Manager, must comply with all reconciliation requirements, if applicable, described in the approved directed payment preprint and any additional policy and procedure guidance from ODM.

iv. The MCO encounter data submitted to ODM will be used to identify service utilization for MRSS rendered to enrollees. The MCO and ODM will monitor the service delivery reports provided by the Regional MRSS Providers on at least a monthly basis, and the staffing reports on at least a quarterly basis.

v. Pending federal approval, the directed payments will be incorporated through a separate payment term and paid separately to the MCO outside of the monthly base capitation rate.

13. Provider Directory

a. General

i. The MCO's provider directory must include all of the MCO's network providers.

ii. The MCO must ensure that the information in the MCO's provider directory exactly matches the data in ODM's provider network management system for the MCO's network providers. The MCO may supplement ODM provider network management system data with MCO information to the extent needed to comply with the provider directory content requirements in this Agreement.

iii. The MCO's provider directory must be in the format specified by or otherwise prior approved by ODM.

iv. The MCO's provider directory must include information on how the member can locate available pharmacies, including a link to ODM's provider directory, and how to contact the single pharmacy benefit manager (SPBM).

v. The MCO's provider directory must include information on how the member can find OhioRISE Plan network providers, including a link to ODM's provider directory, a link to the OhioRISE Plan's provider directory, and how to contact the OhioRISE Plan.

b. Content

i. In accordance with 42 CFR 438.10 and this Agreement, the MCO's provider directory must include the following information about each provider:

1. Provider's name as well as any group affiliation;
2. Provider's street address or addresses;
3. Provider's telephone number or numbers;
4. Provider's website URL, as appropriate;
5. Provider's specialty, when applicable;
6. Indication of the provider's office/facility accessibility and accommodations (e.g., offices, exam room(s), and equipment), when applicable;
7. Indication of whether the provider offers telehealth, and if so, when telehealth is available;
8. Indication of whether the provider is accepting new members;
9. Indication of the provider's linguistic capabilities, including the specific language or languages offered, including American Sign Language (ASL), and whether they are offered by the provider or a skilled medical interpreter at the provider's office; and
10. Provider's cultural competence training status, when available.

ii. The MCO's provider directory must also include:

1. Instructions on how members may obtain directory information in alternate formats that takes into consideration the special needs of eligible individuals, including but not limited to visually-limited, limited English proficiency (LEP), and limited reading proficiency (LRP) eligible individuals; and
2. Detail on any sole-sourced or selectively contracted network providers (e.g., durable medical equipment). The description must clearly identify:

a. The services, including supplies or equipment, that must be obtained from the provider;

b. How to obtain the services;

c. How to contact the provider; and

d. How to obtain services to meet an urgent need (e.g., additional supplies needed post-surgery or for vacation).

c. Printed Provider Directory

i. The MCO's printed provider directory must be approved by ODM prior to distribution. Once approved, in accordance with 42 CFR 438.10, the provider directory content may be updated with provider additions or deletions by the MCO without ODM prior-approval. Any revisions to the printed provider directory format must be approved by ODM before distribution.

d. Online Provider Directory

i. The MCO's website must have a link to ODM's provider directory and provider network management system.

ii. The MCO must have an internet-based provider directory.

iii. The MCO's internet-based provider directory must comply with 42 CFR 438.242 regarding a publicly-accessible standard-based Application Programming Interface (API).

iv. The MCO's internet-based provider directory must be updated at the same frequency as ODM's online provider directory so that the two are synchronized.

v. The MCO's internet-based provider directory must be in a format prior approved by ODM. Any revisions to the internet provider directory format must be approved by ODM before implementation.

vi. The MCO's internet-based provider directory must be easy to understand and use and allow members to electronically search for MCO network providers based on, at a minimum, name, provider type, provider specialty, geographic proximity, and whether the provider is accepting new Medicaid members.

vii. If the MCO's internet-based provider directory includes information for both members enrolled pursuant to this Agreement and another agreement with ODM, the MCO must ensure that the results of any search by a member enrolled pursuant to this Agreement only include providers available to such members.

14. Verification of Provider Network Information

a. General

i. ODM contracts with an external quality review organization to conduct telephone surveys of a statistically valid sample of providers' offices to verify information

submitted to ODM's provider network management system. ODM will use these results to evaluate MCO performance, including but not limited to the following two measures.

b. PCP Locations Not Reached

i. The "PCP Locations Not Reached" measure identifies the proportion of primary care provider (PCP) locations not reached during the survey. A PCP is considered "not reached" if the provider is no longer practicing at the sampled location or the provider did not return phone calls after the external quality review organization made two attempts at different times during the survey.

ii. In order to meet this performance standard, the MCO's "PCP Locations Not Reached" percent must be 30% or less (at least 70% of PCP locations were reached).

c. Number of PCP Locations Not Contracted with the MCO

i. The "Number of PCP Locations Not Contracted with the MCO" measure reports the proportion of primary care provider (PCP) locations no longer contracted with the MCO at the time of the survey.

ii. In order to meet this performance standard, the MCO's "Number of PCP Locations Not Contracted with the MCO" percent must be 8% or less (92% or more of the PCP locations were contracted with the MCO.

Table F.2 Time and Distance Standards

Specialty	Geographic Type							
	Large Metro		Metro		Micro		Rural	
	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)
Adult Primary Care	10	5	15	10	30	20	40	30
Adult Dental	20	10	30	20	50	35	75	60
Allergy	30	15	53	35	80	60	90	75
Behavioral Health	20	10	30	20	50	35	75	60
Cardiology	20	10	38	25	60	45	75	60
Outpatient Dialysis	20	10	45	30	65	50	55	50
ENT/Otolaryngology	30	15	45	30	80	60	90	75
Gastroenterology	20	10	45	30	60	45	75	60
General Surgery	20	10	30	20	50	35	75	60
Gynecology, OB/GYN	30	15	45	30	80	60	90	75
Hospital	20	10	45	30	80	60	85	70
Nephrology	30	15	53	35	80	60	90	75
Neurology	20	10	45	30	60	45	75	60
Oncology	20	10	45	30	60	45	75	60
Oral Surgery	30	15	98	65	110	80	110	80
Orthopedics	20	10	38	25	50	35	75	60
Pediatrics	20	10	30	20	50	35	75	60
Pediatric Dentistry	20	10	30	20	50	35	75	60
Pediatric Behavioral Health	20	10	30	20	50	35	75	60
Podiatry	20	10	45	30	60	45	75	60
Psychiatry	20	10	45	30	60	45	75	60
Radiology	20	10	45	30	80	60	75	60
SUD – Outpatient	20	10	30	20	50	35	75	60
SUD – Residential	20	10	45	30	80	60	85	70
Surgical Services – Outpatient	20	10	45	30	80	60	75	60
Urology	20	10	45	30	60	45	75	60

Table F.3 Minimum Number of Hospital Providers

Region	County	General Hospital	Hospital System	Inpatient Psych Hospital
W	ADAMS	0	0	0
W	ALLEN	1	0	1
NE	ASHLAND	1	0	0
NE	ASHTABULA	1	0	0
C/SE	ATHENS	1	0	0
W	AUGLAIZE	0	0	0
C/SE	BELMONT	1	0	0
W	BROWN	0	0	0
W	BUTLER	0	0	1
NE	CARROLL	0	0	0
W	CHAMPAIGN	0	0	0
W	CLARK	1	0	0
W	CLERMONT	0	0	1
W	CLINTON	1	0	0
NE	COLUMBIANA	1	0	0
C/SE	COSHOCTON	1	0	0
C/SE	CRAWFORD	1	0	0
NE	CUYAHOGA	1	1	6
W	DARKE	1	0	1
W	DEFIANCE	1	0	1
C/SE	DELAWARE	0	0	0
NE	ERIE	1	0	0
C/SE	FAIRFIELD	1	0	0
C/SE	FAYETTE	1	0	0
C/SE	FRANKLIN	1	2	3
W	FULTON	1	0	1
C/SE	GALLIA	1	0	1
NE	GEAUGA	1	0	1
W	GREENE	1	0	0
C/SE	GUERNSEY	1	0	0
W	HAMILTON	1	2	3
W	HANCOCK	1	0	1
W	HARDIN	0	0	0
C/SE	HARRISON	0	0	0
W	HENRY	0	0	0
W	HIGHLAND	1	0	0
C/SE	HOCKING	0	0	1
NE	HOLMES	1	0	0
NE	HURON	1	0	0
C/SE	JACKSON	0	0	0
C/SE	JEFFERSON	1	0	0
C/SE	KNOX	1	0	0
NE	LAKE	1	0	1
C/SE	LAWRENCE	0	0	0
C/SE	LICKING	1	0	1
C/SE	LOGAN	1	0	0
NE	LORAIN	1	0	0
W	LUCAS	0	1	2
C/SE	MADISON	1	0	0
NE	MAHONING	1	0	1
C/SE	MARION	1	0	1
NE	MEDINA	1	0	0
C/SE	MEIGS	0	0	0
W	MERCER	1	0	0
W	MIAMI	1	0	1
C/SE	MONROE	0	0	0
W	MONTGOMERY	1	1	1
C/SE	MORGAN	0	0	0
C/SE	MORROW	0	0	0
C/SE	MUSKINGUM	1	0	1
C/SE	NOBLE	0	0	0
W	OTTAWA	0	0	0
W	PAULDING	0	0	0
C/SE	PERRY	0	0	0
C/SE	PICKAWAY	1	0	0
C/SE	PIKE	0	0	0
NE	PORTAGE	1	0	0
W	PREBLE	0	0	0
W	PUTNAM	0	0	0
NE	RICHLAND	1	0	0
C/SE	ROSS	1	0	1
W	SANDUSKY	1	0	0
C/SE	SCIOTO	1	0	0
W	SENECA	0	0	0
W	SHELBY	1	0	1
NE	STARK	1	0	1
NE	SUMMIT	1	1	1
NE	TRUMBULL	1	0	1
NE	TUSCARAWAS	1	0	0
C/SE	UNION	1	0	0
W	VAN WERT	1	0	0
C/SE	VINTON	0	0	0
W	WARREN	0	0	1
C/SE	WASHINGTON	1	0	0
NE	WAYNE	1	0	0
W	WILLIAMS	1	0	0
W	WOOD	0	0	0
W	WYANDOT	1	0	0

Table F.4 Minimum Number of Nursing Facility Providers

Region	County	**Nursing** Facility **Requirement**
W	ADAMS	1
W	ALLEN	2
NE	ASHLAND	1
NE	ASHTABULA	3
C/SE	ATHENS	1
W	AUGLAIZE	1
C/SE	BELMONT	2
W	BROWN	1
W	BUTLER	5
NE	CARROLL	0
W	CHAMPAIGN	1
W	CLARK	3
W	CLERMONT	2
W	CLINTON	1
NE	COLUMBIANA	3
C/SE	COSHOCTON	1
C/SE	CRAWFORD	1
NE	CUYAHOGA	19
W	DARKE	1
W	DEFIANCE	1
C/SE	DELAWARE	1
NE	ERIE	2
C/SE	FAIRFIELD	2
C/SE	FAYETTE	1
C/SE	FRANKLIN	11
W	FULTON	1
C/SE	GALLIA	1
NE	GEAUGA	1
W	GREENE	2
C/SE	GUERNSEY	1

Region	County	**Nursing** Facility **Requirement**
W	HAMILTON	14
W	HANCOCK	1
W	HARDIN	0
C/SE	HARRISON	1
W	HENRY	1
W	HIGHLAND	1
C/SE	HOCKING	0
NE	HOLMES	1
NE	HURON	1
C/SE	JACKSON	1
C/SE	JEFFERSON	2
C/SE	KNOX	2
NE	LAKE	2
C/SE	LAWRENCE	1
C/SE	LICKING	2
C/SE	LOGAN	1
NE	LORAIN	4
W	LUCAS	7
C/SE	MADISON	0
NE	MAHONING	5
C/SE	MARION	1
NE	MEDINA	2
C/SE	MEIGS	0
W	MERCER	1
W	MIAMI	1
C/SE	MONROE	0
W	MONTGOMERY	8
C/SE	MORGAN	0
C/SE	MORROW	1
C/SE	MUSKINGUM	1

Region	County	**Nursing Facility** Requirement
C/SE	NOBLE	0
W	OTTAWA	1
W	PAULDING	0
C/SE	PERRY	1
C/SE	PICKAWAY	1
C/SE	PIKE	1
NE	PORTAGE	2
W	PREBLE	1
W	PUTNAM	1
NE	RICHLAND	2
C/SE	ROSS	1
W	SANDUSKY	2
C/SE	SCIOTO	2
W	SENECA	1
W	SHELBY	1
NE	STARK	7
NE	SUMMIT	9
NE	TRUMBULL	4
NE	TUSCARAWAS	2
C/SE	UNION	1
W	VAN WERT	1
C/SE	VINTON	0
W	WARREN	3
C/SE	WASHINGTON	1
NE	WAYNE	2
W	WILLIAMS	1
W	WOOD	2
W	WYANDOT	0

Table F.5 Minimum Number of Medication Assisted Treatment (MAT) Providers

Region	County	MAT
W	ADAMS	0
W	ALLEN	6
NE	ASHLAND	0
NE	ASHTABULA	2
C/SE	ATHENS	3
W	AUGLAIZE	0
C/SE	BELMONT	1
W	BROWN	0
W	BUTLER	8
NE	CARROLL	0
W	CHAMPAIGN	0
W	CLARK	2
W	CLERMONT	4
W	CLINTON	0
NE	COLUMBIANA	3
C/SE	COSHOCTON	0
C/SE	CRAWFORD	1
NE	CUYAHOGA	34
W	DARKE	0
W	DEFIANCE	1
C/SE	DELAWARE	1
NE	ERIE	2
C/SE	FAIRFIELD	3
C/SE	FAYETTE	1
C/SE	FRANKLIN	43
W	FULTON	0
C/SE	GALLIA	2
NE	GEAUGA	1
W	GREENE	5
C/SE	GUERNSEY	1
W	HAMILTON	30
W	HANCOCK	1
W	HARDIN	1
C/SE	HARRISON	0
W	HENRY	0
W	HIGHLAND	1
C/SE	HOCKING	3
NE	HOLMES	0
NE	HURON	1
C/SE	JACKSON	0
C/SE	JEFFERSON	0
C/SE	KNOX	1
NE	LAKE	4
C/SE	LAWRENCE	1
C/SE	LICKING	4
C/SE	LOGAN	2
NE	LORAIN	2
W	LUCAS	14
C/SE	MADISON	1
NE	MAHONING	12
C/SE	MARION	4
NE	MEDINA	1
C/SE	MEIGS	2
W	MERCER	0
W	MIAMI	2
C/SE	MONROE	0
W	MONTGOMERY	18
C/SE	MORGAN	1
C/SE	MORROW	0
C/SE	MUSKINGUM	3
C/SE	NOBLE	0
W	OTTAWA	0
W	PAULDING	0
C/SE	PERRY	2
C/SE	PICKAWAY	2
C/SE	PIKE	1
NE	PORTAGE	2
W	PREBLE	0
W	PUTNAM	0
NE	RICHLAND	6
C/SE	ROSS	3
W	SANDUSKY	1
C/SE	SCIOTO	8
W	SENECA	0
W	SHELBY	0
NE	STARK	6
NE	SUMMIT	14
NE	TRUMBULL	4
NE	TUSCARAWAS	1
C/SE	UNION	0
W	VAN WERT	0
C/SE	VINTON	1
W	WARREN	4
C/SE	WASHINGTON	0
NE	WAYNE	1
W	WILLIAMS	1
W	WOOD	2
W	WYANDOT	0

Table F.6 Minimum Number of Other Behavioral Health (BH) Providers (Not Provider Types 84 or 95)

Region	County	BH
W	ADAMS	0
W	ALLEN	8
NE	ASHLAND	1
NE	ASHTABULA	8
C/SE	ATHENS	5
W	AUGLAIZE	0
C/SE	BELMONT	2
W	BROWN	0
W	BUTLER	17
NE	CARROLL	0
W	CHAMPAIGN	0
W	CLARK	5
W	CLERMONT	4
W	CLINTON	2
NE	COLUMBIANA	7
C/SE	COSHOCTON	2
C/SE	CRAWFORD	0
NE	CUYAHOGA	55
W	DARKE	1
W	DEFIANCE	0
C/SE	DELAWARE	4
NE	ERIE	5
C/SE	FAIRFIELD	3
C/SE	FAYETTE	0
C/SE	FRANKLIN	24
W	FULTON	6
C/SE	GALLIA	1
NE	GEAUGA	3
W	GREENE	14
C/SE	GUERNSEY	1
W	HAMILTON	25
W	HANCOCK	2
W	HARDIN	3
C/SE	HARRISON	0
W	HENRY	1
W	HIGHLAND	0
C/SE	HOCKING	2
NE	HOLMES	0
NE	HURON	3
C/SE	JACKSON	2
C/SE	JEFFERSON	0
C/SE	KNOX	5
NE	LAKE	12
C/SE	LAWRENCE	2
C/SE	LICKING	4
C/SE	LOGAN	1
NE	LORAIN	16
W	LUCAS	25
C/SE	MADISON	2
NE	MAHONING	13
C/SE	MARION	5
NE	MEDINA	13
C/SE	MEIGS	0
W	MERCER	3
W	MIAMI	7
C/SE	MONROE	0
W	MONTGOMERY	20
C/SE	MORGAN	0
C/SE	MORROW	0
C/SE	MUSKINGUM	6
C/SE	NOBLE	0
W	OTTAWA	1
W	PAULDING	0
C/SE	PERRY	0
C/SE	PICKAWAY	2
C/SE	PIKE	0
NE	PORTAGE	5
W	PREBLE	0
W	PUTNAM	0
NE	RICHLAND	6
C/SE	ROSS	5
W	SANDUSKY	9
C/SE	SCIOTO	1
W	SENECA	0
W	SHELBY	0
NE	STARK	16
NE	SUMMIT	29
NE	TRUMBULL	13
NE	TUSCARAWAS	4
C/SE	UNION	0
W	VAN WERT	1
C/SE	VINTON	0
W	WARREN	7
C/SE	WASHINGTON	0
NE	WAYNE	4
W	WILLIAMS	3
W	WOOD	12
W	WYANDOT	0

Table F.7 Minimum Number of Dental and Vision Providers

Region	County	Dental	Vision
W	ADAMS	1	0
W	ALLEN	5	3
NE	ASHLAND	3	0
NE	ASHTABULA	3	3
C/SE	ATHENS	3	3
W	AUGLAIZE	1	1
C/SE	BELMONT	4	4
W	BROWN	1	0
W	BUTLER	13	4
NE	CARROLL	0	0
W	CHAMPAIGN	1	0
W	CLARK	6	3
W	CLERMONT	5	1
W	CLINTON	1	2
NE	COLUMBIANA	3	0
C/SE	COSHOCTON	3	1
C/SE	CRAWFORD	1	2
NE	CUYAHOGA	102	32
W	DARKE	1	1
W	DEFIANCE	0	2
C/SE	DELAWARE	3	3
NE	ERIE	2	2
C/SE	FAIRFIELD	4	3
C/SE	FAYETTE	1	0
C/SE	FRANKLIN	95	20
W	FULTON	0	0
C/SE	GALLIA	1	2
NE	GEAUGA	1	1
W	GREENE	3	3
C/SE	GUERNSEY	3	2
W	HAMILTON	50	14
W	HANCOCK	2	1
W	HARDIN	1	0
C/SE	HARRISON	0	0
W	HENRY	1	0
W	HIGHLAND	3	2
C/SE	HOCKING	1	0
NE	HOLMES	0	0
NE	HURON	0	2
C/SE	JACKSON	1	2
C/SE	JEFFERSON	3	3
C/SE	KNOX	3	2
NE	LAKE	6	6
C/SE	LAWRENCE	3	3
C/SE	LICKING	4	2
C/SE	LOGAN	1	2
NE	LORAIN	11	11
W	LUCAS	29	9
C/SE	MADISON	1	0
NE	MAHONING	14	5
C/SE	MARION	3	2
NE	MEDINA	4	4
C/SE	MEIGS	0	0
W	MERCER	1	0
W	MIAMI	3	0
C/SE	MONROE	0	0
W	MONTGOMERY	25	0
C/SE	MORGAN	0	0
C/SE	MORROW	1	0
C/SE	MUSKINGUM	4	4
C/SE	NOBLE	1	0
W	OTTAWA	1	0
W	PAULDING	0	0
C/SE	PERRY	1	0
C/SE	PICKAWAY	1	1
C/SE	PIKE	1	0
NE	PORTAGE	3	0
W	PREBLE	0	0
W	PUTNAM	1	0
NE	RICHLAND	7	2
C/SE	ROSS	4	2
W	SANDUSKY	3	0
C/SE	SCIOTO	2	2
W	SENECA	2	0
W	SHELBY	1	0
NE	STARK	17	7
NE	SUMMIT	23	13
NE	TRUMBULL	11	4
NE	TUSCARAWAS	4	0
C/SE	UNION	1	1
W	VAN WERT	2	0
C/SE	VINTON	0	0
W	WARREN	1	0
C/SE	WASHINGTON	3	2
NE	WAYNE	3	0
W	WILLIAMS	1	0
W	WOOD	2	0
W	WYANDOT	1	0

APPENDIX G – PROGRAM INTEGRITY

1. General

a. The MCO must comply with all applicable state and federal program integrity requirements, including but not limited to those specified in OAC rule 5160-26-06, 42 CFR Part 455, 42 CFR Part 1002, and 42 CFR Part 438 Subpart H.

b. The MCO must comply with and participate in ODM's program integrity initiatives.

2. Compliance Program

a. In accordance with 42 CFR 438.608(a)(1), the MCO must implement and maintain a compliance program.

b. The compliance program must include, at a minimum, all the following elements:

i. Written policies, procedures, and standards of conduct that demonstrate compliance with requirements and standards under this Agreement, and all applicable federal and state requirements;

ii. A designated Chief Compliance Officer who is responsible for developing and implementing policies and procedures designed to ensure compliance with this Agreement. The Chief Compliance Officer must report to the Chief Executive Officer and the Board of Directors;

iii. A Regulatory Compliance Committee, consisting of members of the Board of Directors and senior management, that is responsible for oversight of the MCO's compliance program and its compliance with this Agreement. This committee to meet at least on a quarterly basis, or more frequently as necessary, to ensure reasonable oversight of the compliance program. Meeting minutes must be available to ODM upon request;

iv. A system for training and education for the Chief Compliance Officer, the MCO's senior management, and the MCO's employees regarding the MCO's compliance program and the requirements of this Agreement;

v. Effective lines of communication between the Chief Compliance Officer and the MCO's employees;

vi. Enforcement of standards through well-publicized disciplinary guidelines;

vii. A system of dedicated staff with established and implemented procedures for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues, investigations of potential compliance problems identified in the course of self-evaluation and audits, prompt and thorough correction of identified compliance problems, and ongoing compliance with the requirements of this Agreement;

viii. Designated staff responsible for administering the plan and clear goals, milestones or objectives, measurements, key dates for achieving identified outcomes, and an explanation of how the MCO will determine the effectiveness of the compliance plan;

ix. Education of staff, subcontractors, and providers about fraud, waste, and abuse and how to report suspected fraud, waste, and abuse to the MCO and ODM;

x. Education of members about fraud, waste, and abuse, and how to report fraud, waste, and abuse to the MCO;

xi. Establishment and/or modification of internal MCO controls to ensure the proper submission and payment of claims; and

xii. Prompt reporting of all instances of suspected fraud, waste, and abuse to ODM.

c. The MCO must develop an Ohio-specific compliance plan that describes the MCO's compliance program for this Agreement and includes the MCO's monitoring and auditing work plan for the upcoming year. As specified in Appendix P, Chart of Deliverables, the MCO must submit its compliance plan (Compliance Plan), including annual updates, to ODM for approval.

3. Employee Education about False Claims Recovery

a. In accordance with 42 CFR 438.608(a)(6), the MCO must provide written policies for all MCO employees, and the employees of any MCO subcontractor or agent that provide detailed information about the Federal False Claims Act and other federal and state laws described in Section 1902(a)(68) of the Social Security Act, including the rights of employees to be protected as whistleblowers.

b. The MCO's policies must include the following whistleblower fraud and/or abuse reporting contacts:

i. Ohio Attorney General's Office Medicaid Fraud Control Unit (MFCU) by phone at 1-800-282-0515 or online at http://www.ohioattorneygeneral.gov/Individuals-and-Families/Victims/Submit-a-Tip/Report-Medicaid-Fraud; and

ii. The Ohio Auditor of State (AOS) by phone at 1-866-FRAUD-OH or by email at fraudohio@ohioauditor.gov.

c. The MCO's policies must include detailed provisions regarding the MCO's policies and procedures for preventing and detecting fraud, waste, and abuse.

d. The MCO's policies must be included in the MCO's employee handbook.

e. The MCO must disseminate its policies to its subcontractors and agents and ensure that its subcontractors and agents abide by these policies.

4. MCO Disclosures

a. In accordance with 42 CFR 438.608, the MCO must disclose to ODM any prohibited affiliations under 42 CFR 438.610.

b. Pursuant to 42 CFR 455.104 and OAC rule 5160-1-17.3, the MCO must disclose ownership and control information, including any change in this information.

c. In accordance with 42 CFR 438.602, the MCO must post on its website the name and title of individuals included in 42 CFR 438.604(a)(6).

d. In accordance with 42 CFR 455.105, the MCO must submit within 35 calendar days of the date requested by ODM or the U.S. Department of Health and Human Services full and complete information about:

   i. The ownership of any subcontractor with whom the MCO has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

   ii. Any significant business transactions between the MCO and any wholly owned supplier, or between the provider and any subcontractor, during the five-year period ending on the date of the request.

e. In accordance with 42 CFR 455.106, the MCO must disclose the identity of any person who:

   i. Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and

   ii. Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

f. In accordance with Section 1903(m)(4)(A) of the Social Security Act, if the MCO is not a federally qualified health maintenance organization (HMO), it must report to ODM a description of certain transactions with parties of interest.

5. ODM-Enrolled Providers

a. As specified in Appendix F, Provider Network, the MCO must only contract with and issue payment to providers for service provided when they are enrolled with ODM and are active providers in ODM's provider network management system.

b. Except as otherwise allowed by federal law or regulations for single case agreements and emergency services, in accordance with 42 CFR 455.410 and this Agreement, the MCO must ensure that any ordering, referring, or prescribing provider is enrolled with ODM and is an active provider in ODM's provider network management system.

c. In accordance with 42 CFR 438.602, an MCO may execute a temporary 120 calendar day network provider agreement pending the outcome of the ODM screening, enrollment and revalidation process. The MCO must terminate the provider immediately upon notification from ODM that the network provider cannot be enrolled, or the expiration of one 120 calendar day period without enrollment of the provider, and notify affected members. In this instance, no advance contract termination notice to the provider is required. If a provider applicant does not identify with a provider type that is available on the web application, they must complete a form specified by ODM and the MCO shall submit the

form to ODM for screening and enrollment. The application can be found at: http://www.medicaid.ohio.gov/Provider/EnrollmentandSupport/ProviderEnrollment .

d. In accordance with 42 CFR 438.608, the MCO must notify ODM when it receives information about a change in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including when a network provider contract is terminated.

e. The MCO must notify ODM when the MCO denies a request for a network provider contract from a provider that is active in ODM's provider network management system, including the reason for the denial. The MCO must indicate the reason or reasons for the denial using ODM-specified reasons.

f. Except as otherwise provided in Appendix F, Provider Network, and as described in OAC 5160-26-05, the MCO must notify ODM prior to the termination/non-renewal of a network provider contract, whether by the MCO or the provider.

   i. The MCO must provide the reason for the termination/non-renewal using ODM-specified reasons.

   ii. The MCO must only terminate/not renew provider contracts for cause, as defined by ODM.

   iii. The MCO must not suspend, terminate, or not renew a provider contract when the MCO suspects fraud, waste, or abuse until it receives permission from ODM to proceed.

g. Except as provided in Appendix F, Provider Network, regarding single case agreements and emergency services, the MCO must not pay a provider for services provided when the provider is not active in ODM's provider network management system. Except for emergency services, the MCO must not pay a provider for services provided when the provider has been terminated or suspended by ODM or has been terminated by Medicare, Medicaid, or the Children's Health Insurance Program.

h. When ODM notifies the MCO that a provider has been suspended, the MCO must immediately suspend the provider, including any payments to the provider. The MCO must continue to suspend the provider until it receives notice from the ODM to lift the suspension. When ODM notifies the MCO that a provider is no longer suspended, the MCO must lift the suspension and process any suspended claims.

i. The MCO’s network provider contracts must include a provision for the return of episode, quality, or other value-based payments to the MCO when the provider is convicted of fraud and the time period of the fraudulent activity overlaps with the time period that the episode, quality, or other value-based payment is based.

j. The MCO must attempt to recover any payment made to a provider for services provided after the provider is terminated pursuant to the requirements in this appendix.

k. In accordance with 42 CFR 455.436, the MCO must routinely monitor the federal exclusion list for providers that have been excluded from Medicaid.

l. The MCO must routinely monitor the Ohio Suspension and Exclusion List maintained on the ODM website for providers that have been excluded from Medicaid.

6. Data Certification

a. General

i. In accordance with 42 CFR 438.604 and 42 CFR 438.606, the MCO must certify data, documentation, and information submitted to ODM.

b. Submissions

i. The MCO must submit the appropriate ODM-developed certification concurrently with the submission of the following data, documentation, or information:

1. Primary care provider (PCP) data as specified in Appendix A, General Requirements;
2. Care coordination data, as specified in Appendix D, Care Coordination;
3. Health Care Effectiveness Data and Information Set (HEDIS) data and Consumer Assessment of Healthcare Providers (CAHPS) data as specified in Appendix C, Population Health and Quality;
4. Encounter data as specified in Appendix K, Information Systems, Claims, and Data;
5. Prompt pay reports, cost reports, and medical loss ratio data, as specified in Appendix L, Payment and Financial Performance;
6. Data submitted to the Ohio Department of Insurance (ODI) to determine that the MCO has made adequate provisions against the risk of insolvency;
7. Documentation used by ODM to certify that the MCO has complied with ODM's requirements for availability and accessibility of services, including the adequacy of the provider network, as specified in Appendix F, Provider Network;
8. Information on ownership and control as specified in this appendix;
9. Information submitted in the program integrity quarterly inventory report as specified in this appendix; and
10. Any other data, documentation, or information related to the MCO's obligations under this Agreement as specified by ODM.

c. Source, Content, and Timing of Certification

i. The above MCO data submissions must be certified by one of the following:

1. The MCO's Chief Executive Officer (CEO);

2. The MCO's Chief Financial Officer (CFO); or

3. An individual who reports directly to the MCO's CEO or CFO with delegated authority to sign for the CEO or CFO so that the CEO or CFO is ultimately responsible for the certification.

ii. The certification must attest that, based on best information, knowledge, and belief, the data, documentation, and information is accurate, complete, and truthful.

iii. The MCO must submit the certification concurrently with the submission of the applicable data, documentation, or information.

7. Explanation of Benefits Mailings

a. In accordance with 42 CFR 455.20, the MCO must have a method for verifying with members whether services billed by providers were received.

b. The MCO must conduct a mailing of explanation of benefits (EOBs) to a 95% confidence level (plus or minus 5% margin of error) to a random sample of the MCO's members once a year and upon request as directed by ODM.

c. As an option, the MCO may meet this requirement by using a strategy targeting services or areas of concern as long as the number of mailed explanation of benefits is not less than the number generated by the random sample described above. If the MCO opts to use a targeted mailing, it must submit the proposed strategy in writing to ODM, and receive written prior approval from ODM.

d. The MCO's explanation of benefits 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 services identified as having been provided to the member, and request that the member report any discrepancies to the MCO.

e. As specified in Appendix P, Chart of Deliverables, the MCO must inform ODM of the date of the explanation of benefits mailing (EOB mailing date) and provide results of the EOB mailing (EOB Results) as specified by ODM, including but not limited to the number mailed and the number of members reporting discrepancies.

8. Special Investigative Unit

a. The MCO must establish a special investigative unit (SIU). The SIU's responsibilities must include preventing and detecting fraud, waste, and abuse; referring potential fraud, waste, and abuse to ODM; conducting fraud, waste, and abuse investigations; coordinating with law enforcement; cooperating with ODM and other state and federal authorities; and implementing the MCO's fraud, waste, and abuse plan.

b. The MCO's proposed SIU staffing must comply with the requirements in Appendix A, General Requirements, and must be included in the MCO's Ohio-specific fraud, waste, and abuse plan described in this appendix.

9. Fraud, Waste, and Abuse Plan

a. The MCO must have a program that includes administrative and management arrangements or procedures to prevent, detect, and report both internal (e.g., MCO staff) and external (e.g., provider, member, subcontractor) fraud, waste, and abuse.

b. The MCO must develop and implement an Ohio-specific fraud, waste, and abuse plan for Ohio's Medicaid program that includes a risk-based assessment, designated staff responsible for administering the plan, clear goals, milestones or objectives, key dates for achieving identified outcomes, and an explanation of how the MCO will determine effectiveness of the plan.

c. The fraud, waste, and abuse plan must include but is not limited to the following:

i. A risk-based assessment that includes the MCO's evaluation of its fraud, waste, and abuse processes and the risk for fraud, waste, and abuse in the provision of services to members;

ii. An outline of activities proposed by the MCO for the next reporting year based on the results of the risk-based assessment, including the MCO's top five risk areas;

iii. A description of the MCO's proposed activities related to provider education of federal and state laws and regulations related to Medicaid fraud, waste, and abuse and identifying and educating targeted providers with patterns of incorrect billing practices and/or overpayments;

iv. A description of the specific controls in place for prevention and detection of potential or suspected fraud, waste, and abuse, such as:

1. A description of all pre-payment review activities, including but not limited to pre-payment claims edits and claim reviews;

2. A list of automated post payment claims edits;

3. A list of claims review algorithms;

4. Frequency and type of desk audits on post payment review of claims;

5. A list of reports of provider profiling used to aid program and payment reviews; and

6. A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services.

v. A description of the MCO's activities to prevent and detect fraud, waste, and abuse by providers who are reimbursed using value-based payment models such as incentive payments, shared savings, episode-based payments, and subcapitation;

vi. A description of how the MCO will manually review all claims for providers placed on prepayment review and how the MCO will identify providers that should be placed on prepayment review and place them on prepayment review if deconfliction approved by ODM;

vii. A description of how the MCO will monitor activities on an ongoing basis to prevent and detect activities involving suspected fraud, embezzlement, and theft (e.g., by staff, providers, contractors);

viii. A description of how the MCO will vet every allegation of fraud, waste, or abuse and will investigate every allegation that passes vetting;

ix. A description of how the MCO will track and ensure that at least 3% of total medical expenditures are subject to a post-payment investigation, including investigations based on an internal (e.g., data mining) or an external referral, over the contract year;

x. A description of how the MCO will identify and correct claims submission and billing activities that are potentially fraudulent, including but not limited to double-billing and improper coding, such as upcoding and unbundling;

xi. A description of how the MCO will use utilization, service denial, appeals, incident reporting, provider complaint, and provider dispute resolution data to detect potential fraud, waste, or abuse;

xii. A description of how the MCO will identify and address over, under, or inappropriate utilization of covered services, including but not limited to review of the MCO's utilization management criteria and processes, service denials, appeals, and utilization data; and

xiii. Work plans and methodology for conducting both announced and unannounced provider site audits for providers identified as high risk by the MCO to ensure services are rendered and billed correctly.

d. As specified in Appendix P, Chart of Deliverables, the MCO must submit its fraud, waste, and abuse plan (Fraud, Waste, and Abuse Plan) to ODM for approval on at least an annual basis.

10. Reporting and Investigating Fraud, Waste, and Abuse

a. General

i. The MCO must promptly report all instances of suspected provider and member fraud, waste, and abuse to ODM.

ii. The MCO must document in its case tracking system, and in the quarterly inventory report, an action or status update at least once every month for each investigation unless it has been sent as a referral to ODM/MFCU. If no new action has occurred in the investigation within the 30-day period, the MCO must document the status of the case and the reason for the lack of action. If a referral has been sent to ODM/MFCU, then the MCO must update the status every 90 days.

b. Reporting and Retention of Recovery

i. If the MCO identifies and properly reports a case of suspected fraud, waste, or abuse before the suspected fraud, waste, or abuse is identified by state or federal authorities, the MCO may share in any recovery from the reported fraud, waste, or

abuse. If the MCO fails to properly report a case of suspected fraud, waste, or abuse before the suspected fraud, waste, or abuse is identified by the state or federal authorities, it may not share in any portion of the recovery from the fraud, waste, or abuse.

c. Reporting Provider Fraud, Waste, or Abuse

i. The MCO must, within one business day of identifying suspected provider fraud, waste, or abuse, submit a referral to ODM using ODM's Fraud Referral and Coordination system.

ii. ODM will review all fraud, waste, and abuse referrals to determine whether there is a credible allegation of fraud or if the allegation evidences abuse or waste.

iii. ODM will submit all fraud referrals to the MFCU and return the abuse and waste referrals to the MCO for additional investigation and recovery, if appropriate. The MCO must request deconfliction before beginning this investigation and/or recovery.

iv. ODM will distribute each fraud referral to all MCOs.

v. The MCO must respond to all fraud referrals distributed by ODM pursuant to Section 10.c.iv above by submitting the ODM Attestation form to ODM through ODM's Fraud Referral and Coordination system within 60 calendar days. The MCO's failure to file an attestation timely, completely, and accurately waives the MCO's right to participate in any MFCU recoveries.

d. Reporting Member Fraud or Abuse

i. The MCO must, within one business day of learning of suspected member fraud or abuse, report suspected member fraud and abuse to ODM's Bureau of Program Integrity (BPI) at Program_Integrity_County_Referral@medicaid.ohio.gov and copy the appropriate County Department of Job and Family Services (CDJFS).

e. Coordination with Law Enforcement

i. *Stand Down*

1. The MCO must stand down upon submission of either a fraud, waste, or abuse referral or a submission of a request for deconfliction. During stand down, the MCO must not take any action related to the referral/request for deconfliction, including but not limited to contacting the subject or any related parties (provider groups, patients, staff, family members, etc.) of the referral or deconfliction request about any matter related to the suspected fraud, waste, or abuse.

ii. *Referrals*

1. Upon MCO submission of a fraud, waste, or abuse referral to ODM, the MCO must stand down until notified by ODM that the stand down period has ended.

2. The stand down time period will last for the shortest of the following events:

    a. ODM determines there is no credible allegation of fraud contained in the referral;

    b. MFCU closes their investigation for lack of prosecutorial merit; or

    c. An initial period of one year, starting when the referral is received by ODM; however, this period may be extended once for an additional six months at ODM's discretion.

iii. *Deconflictions*

1. The MCO must request deconfliction from ODM through ODM's Fraud Referral and Coordination system and stand down until it receives permission from ODM to proceed prior to taking any action that would alert the provider or any related parties (provider groups, patients, staff, family members, etc.) that they are the subject of:

    a. Post payment audit, investigation, or review;

    b. Recovery (recoupment or withhold) for any reason with the exception of normal health plan operations including but not limited to retro-terms, configuration errors, rate changes, administrative type or third-party liability adjustments;

    c. Prepayment claims review for any reason, with the exception of normal health plan operations, including but not limited to claims payment, utilization management, quality assurance or compliance activities. Deconfliction for prepayment review requirements apply when the health plan singles out a provider for prepayment review or similar disruption to claims adjudication/payment for an extended period of time; and

    d. Involuntary provider terminations for any reason.

2. ODM will either grant the deconfliction request or notify the MCO to stand down.

3. The stand down time period or the time period to conduct approved program activities will be valid for six months.

4. After the six month period expires, the MCO must submit another deconfliction request.

5. ODM may extend the stand down for an additional six months upon the request of the MFCU and a showing that the extension is warranted. If requested by ODM, the MCO must stand down for an additional six months.

a. This provision does not apply to federal cases, joint task force cases or other cases that are not under the MFCU's control. In those cases, the MCO must stand down until the case is closed or completed.

6. Should the MCO be found in violation of any parts of this section, the MCO will be subject to compliance actions outlined in Appendix N, Compliance Actions.

f. Coordinating Provider On-Site Audits

i. The MCO must coordinate on-site provider reviews/audits (announced or unannounced) with ODM and must participate in joint reviews/audits as requested by ODM.

g. ODM Investigation and Recovery

i. ODM has the right to audit, review, investigate, and/or recover payment from the MCO's network providers at any time and without notice to the MCO.

11. Recovery of Provider Overpayments

a. Definition of Overpayment

i. In accordance with 42 CFR 438.2, provider overpayment means any payment made to the provider by the MCO to which the provider is not entitled to under Title XIX of the Social Security Act.

b. General

i. In accordance with 42 CFR 438.608, the MCO must require network providers to report to the MCO when it has received an overpayment, to return the overpayment to the MCO within 60 calendar days after the date on which the overpayment was identified, and to notify the MCO in writing of the reason for the overpayment.

ii. The MCO retains the right to recover any overpayments it identified arising out of provider fraud, waste, or abuse, as defined by OAC rule 5160-26-01, in the following circumstance:

1. The MFCU has an open case, and the MCO requested deconfliction and received leave to proceed since there was not a conflict with an active law enforcement investigation; or

2. The date of the deconfliction request occurred prior to the date that the MFCU opened their case on the same provider; and

3. The MCO submitted a referral regarding the same provider after completion of its previously approved audit, investigation, or review.

iii. The MCO must not act to recover overpayments if:

1. The overpayments were recovered from the provider by ODM, the state of Ohio, the federal government, or their designees as part of a criminal prosecution where the MCO had no right of participation;

2. The improperly paid funds are currently being investigated by the state of Ohio, are the subject of pending federal or state litigation or investigation, or are being audited by ODM, the Ohio Auditor of State (AOS), the Centers for Medicare and Medicaid Services (CMS), the Office of Inspector General (OIG), or their agents; or

3. The overpayments relate to fraud, waste, or abuse, and the MCO has not requested a deconfliction and received leave to proceed.

iv. If the MCO obtains funds in cases where recoupment is prohibited by Section 11.b.iii of this appendix, the MCO must notify ODM and take action in accordance with ODM's instructions, which may include forfeiture of the funds.

v. Absent any restrictions on recovery, the MCO may otherwise recover from a provider any amount collected from the MCO by ODM, the Ohio Auditor of State, the federal government, any other regulatory agency, or their designees, relating to an improper payment to such provider by the MCO that resulted from an audit, review, or investigation of the provider. The MCO retains recovery rights to any amount paid to ODM when a provider self-reports an overpayment arising from a payment made by the MCO to the provider or other reason.

vi. The MCO may recover overpayments made to providers if the overpayment is identified and the provider is notified within two years of the date the MCO improperly paid the provider., within 6 months of the MFCU returning a fraud referral to the MCO, within any applicable statute limitations for fraud, or if ODM recovers an overpayment made by the MCO to a provider directly from the MCO, whichever is later. The two-year rule of identification and notification of overpayments stated above still applies to:

1. Referrals declined by the clearinghouse; and

2. Referrals declined by the MFCU at intake.

vii. ODM may recover overpayments (either from the MCO or directly from the provider) made by the MCO to a provider under the time limits in ORC section 5164.57.

c. Notice

i. Prior to recovering an overpayment from a provider, the MCO must provide the provider a notice of intent to recover due to an overpayment.

ii. The MCO must submit the template for its notice of intent to recover an overpayment to ODM for review and approval prior to use.

iii. Consistent with ORC section 5167.22, the notice must include but is not limited to the following:

1. The patient's name, date of birth, and Medicaid identification number;
2. The date or dates of services rendered;
3. The specific claims that are subject to recovery and the amount subject to recovery, including any interest charges, which may not exceed the amount specified in Ohio law or rule;
4. The specific reasons for making the recovery for each of the claims subject to recovery, including a citation to the applicable statute, rule, or manual section;
5. If the recovery is a result of member disenrollment from the MCO, the MCO must provide the effective date of disenrollment;
6. An explanation that if the provider does not submit a written response to the notice within 30 calendar days from receipt of the notice, the overpayments will be recovered from future claims;
7. How the provider may submit a written response disputing the overpayment; and
8. How the provider may submit a written request for an extended payment arrangement or settlement.

d. Overpayment Dispute Process

i. The MCO must allow the provider 30 calendar days from receipt of the notice to submit a written response disputing the overpayment or requesting an extended payment arrangement or settlement. If the provider fails to submit a written response within the time period provided, the MCO may execute the recovery as specified in the notice.

ii. Upon receipt of a written response disputing the overpayment, the MCO must, within 30 calendar days from the date the written response is received, consider the response, including any pertinent additional information submitted by the provider, together with any other material bearing upon the matter, and determine whether the facts justify recovery.

iii. The MCO must provide a written notice of determination that includes the rationale for the determination. If the MCO determines the facts justify the recovery, the MCO may execute the recovery within three business days of sending the notice of determination.

iv. The MCO must submit the template for its notice of determination to ODM for review and approval prior to use.

e. Extended Payment or Settlement

i. Upon receipt of a written response requesting an extended payment arrangement or settlement, the MCO must, within 30 calendar days from the date the written

response is received, consider the response, including any pertinent additional information submitted by the provider, and determine whether to allow an extended payment arrangement or enter into settlement discussions. The MCO must provide a written notice of determination and, as applicable, the proposed extended payment arrangement or settlement terms.

1. The MCO must not settle for less than amount specified in the notice of intent to recover unless there is the inability to collect.

2. The MCO must submit any extended payment arrangement or settlement terms to ODM for prior approval per the separate guideline provided by ODM.

3. The MCO must finalize any extended payment arrangement or settlement terms approved by ODM within 120 calendar days of sending the initial notice of intent to recover.

4. If the MCO settles for less than the amount specified in the notice of intent to recover, the MCO must report to ODM the amount specified in the notice and the settlement amount in the quarterly inventory report.

f. Accounting

i. The MCO must maintain a detailed accounting of identified overpayments by provider and track recoveries, with the ability to report to ODM at any time the status of recovery for individual or cumulative recoveries.

g. Claims Adjustment

i. The MCO must void or adjust (as applicable) all claims to reflect any identified provider overpayments, regardless of whether they have been recovered. This provision does not apply to recoveries due to settlement or statistical sampling of claims and extrapolation, where identification of individual claims is impossible.

h. ODM Recovery of Provider Overpayments from the MCO

i. If ODM identifies a provider overpayment, ODM will notify the MCO of its intent to recover the overpayment from the MCO or from the provider.

1. If ODM recovers directly from the provider, the recovery will get effectuated as a remittance by the provider or as a claim payment offset. ODM will retain the overpayment collected. The MCO will be precluded from adjudicating an audit or taking any other collection action related to the overpayment discovered and recovered by ODM directly from the provider.

2. If ODM directly recovers from the MCO, the recovery will be effectuated as a remittance by the MCO, or a capitation payment offset. The MCO may recover the payment from the provider.

ii. In accordance with 42 CFR 438.608, provisions regarding treatment of recoveries of provider overpayments made by the MCO do not apply to any amount of a recovery to be retained under the federal False Claims Act cases or through other investigations.

i. Program Integrity Provider Audits and Compliance Review Findings

i. Within ODM's Bureau of Program Integrity, the Provider Audits and Compliance Review (PACR) section evaluates Medicaid providers who are either new participants to Ohio Medicaid or whose billing practices have identified them as potential outliers. The PACR section will communicate to the MCO the provider billing errors identified during post-payment review of an identified provider. When these billing errors are identified:

1. ODM will notify the provider and allow 60 days for the provider to submit claim adjustments to the MCO;

2. If the provider has not adjusted the identified claims within 90 days of the provider notification, the MCO should contact ODM at PACRProgramIntegrity@medicaid.ohio.gov for a determination if ODM or the MCO will recover the overpayment;

3. Regardless of ODM or MCO recoupment, the MCO must ensure the identified billing errors are corrected as described in this appendix of this provider agreement; and

4. Identified overpayments and recoupment information shall be included in the program integrity quarterly inventory report.

ii. If the PACR identifies a provider as high-risk for potential fraud, waste or abuse, ODM will notify the MCO and the MCO must complete a review. Within six months of notification, the MCO must provide its review findings to PACRProgramIntegrity@medicaid.ohio.gov. This review, along with any overpayment identified and recouped, and any provider education provided, must be included in the quarterly inventory report.

12. Recovery of MCO Overpayments

a. In accordance with 42 CFR 438.2, MCO overpayment means any payment made to the MCO by the state of Ohio to which the MCO is not entitled to under Title XIX of the Social Security Act. MCO overpayments include but are not limited to capitation payments made for members who are retroactively disenrolled.

b. In accordance with 42 CFR 438.608, the MCO must report any MCO overpayments to ODM within 60 calendar days of identifying the overpayment.

c. ODM may recover overpayments made to the MCO under the time limits in ORC section 5164.57.

d. ODM will recover MCO overpayments. Recovery will, at ODM's discretion, be effectuated as a remittance by the MCO or a reduction to future capitation payments.

e. The MCO may recover payments made to a provider for services rendered to a member who was retroactively disenrolled from the MCO in accordance with the following:

   i. The MCO must initiate such recovery within 30 calendar days of notice of the capitation recovery.

   ii. If the recovery is for payments made more than two years from the date of payment of the provider, the MCO must notify ODM and receive permission to proceed with the recovery.

   iii. The MCO's recovery process must comply with the requirements for recovery of overpayments as described in this appendix. In addition, the MCO must notify the provider of the option to submit a claim to ODM for services rendered to a member who was retroactively disenrolled from the MCO.

   iv. The MCO must not recover payments from a provider beyond two years from the date of payment of the claim due to a member's retroactive disenrollment from the MCO, unless the MCO is directed to do so by CMS or ODM.

13. Cooperation with State and Federal Authorities

a. The MCO must cooperate fully and promptly with state and federal authorities, including but not limited to ODM, the Ohio Attorney General, the Ohio Auditor of State, law enforcement, and the U.S. Department of Health and Human Services.

b. The MCO must respond to requests from state or federal authorities within one business day of such request.

c. At the request of a state or federal authority, the MCO must produce copies of all MCO fraud, waste, and abuse investigatory files and data (including, but not limited to records of member and provider interviews) in the manner and format requested at no charge to the requestor. Unless otherwise specified in the request, the MCO must provide this information within 30 calendar days of the request.

d. The MCO must provide all other data, documentation, and other information requested by state or federal authorities, in the manner and format requested at no charge to the requestor. Unless otherwise specified in the request, the MCO must provide the requested data, documentation, or other information within 30 calendar days of the request.

e. The MCO must cooperate fully in any investigation or prosecution by any state or federal authority, whether administrative, civil, or criminal at no charge to the requestor. This includes but is not limited to:

   i. Actively participating in meetings;

   ii. Providing requested information and access to requested records;

   iii. Providing access to interview MCO employees, subcontractors, and consultants; and

iv. Providing qualified individuals to testify at or be a witness at any hearings, trials, or other judicial or administrative proceedings.

v. Assuring confidentiality with regard to law enforcement records and discussions held at MCO/ODM/ Law Enforcement meetings.

f. Upon request, the MCO must make available to state and federal authorities all administrative, financial, and medical data, documentation, and other information relating to the delivery of items or services under this Agreement. The MCO must provide such data, documentation, and other information at no cost to the requesting entity. The MCO must inform ODM before providing Ohio Medicaid related information to state and federal authorities.

14. Additional Reporting Requirements

a. Pursuant to OAC rule 5160-26-06 and as specified in Appendix P, Chart of Deliverables, the MCO must submit an annual fraud, waste, and abuse report (Fraud, Waste, and Abuse Report) to ODM that summarizes the MCO's fraud, waste, and abuse activities for the year and identifies any proposed changes for the coming year. This report must include the information specified by ODM, including but not limited to the MCO's prevention actions; referrals, reviews, and recoveries; provider terminations; and meeting attendance.

b. As specified in Appendix P, Chart of Deliverables, the MCO must provide to ODM a quarterly "inventory" report on fraud, waste, and abuse activities (the Fraud, Waste, and Abuse Inventory Report). The report must include the information specified by ODM, including but not limited to tips received; investigations and audits started; provider referrals; overpayments identified; overpayments recovered; program integrity actions taken against providers; denied network applications; member fraud referrals; cost avoidance as a result of prepayment review activities; and planned fraud, waste, and abuse activities for the upcoming quarter.

c. The MCO must regularly communicate with ODM about the MCO's program integrity work through the MCO's annual and quarterly reports, regular meetings, and, as needed, additional communications. Specifically, the MCO’s SIU Lead must attend, or send a representative, to the Managed Care Program Integrity Group meetings and must hold at least one monthly Special Investigative Lead meeting with ODM and law enforcement. The MCO must adjust its program integrity work based on ODM's directions and feedback following ODM's review of the annual and quarterly reports, meetings, or otherwise.

APPENDIX H – VALUE-BASED PAYMENT

1. Value-Based Payment

a. The MCO must design and implement value-based care and payment reform initiatives to drive the transformation of the health care delivery system to improve individual and population health outcomes, improve member experience, and contain the cost of health care through the reward of innovation and results over volume of services provided.

b. The MCO's value-based payment efforts must include the following:

i. *Value-Oriented Payment*

1. The MCO must design and implement payment methodologies with its network providers to enhance population health and wellness outcomes for its members in alignment with ODM's population health strategy by improving all of the following:

    a. Delivery of effective and efficient health care;

    b. Opportunities for practice transformation and new flexibilities for network providers; and

    c. Value for the Medicaid program.

2. For the purposes of this Agreement, payments that cut waste are those that by their design reduce unnecessary payment and unnecessary care (e.g., elective cesarean deliveries, unnecessary medical testing, and unnecessary medical procedures).

3. For the purposes of this Agreement, "opportunities for practice transformation and new flexibilities for network providers" involve the use of financial incentives, including risk arrangements that can help providers improve outcomes and reduce costs in sustainable ways.

4. For purposes of this Agreement, "value" means the level of the quality of care in return for the amount of payment to the provider. Payments designed to reflect value are those tied to provider performance or efficiency payments may rise or fall in a pre-determined fashion commensurate with the level of performance assessed against standard quality measures.

ii. *Market Competition and Consumerism*

1. The MCO must design contracting and payment methodologies that enhance competition among providers and reduce unwarranted price and quality variation.

2. The MCO must stimulate additional provider competition by establishing mechanisms to engage members to make informed provider and care choices, and to select evidence-based, cost-effective care.

iii. *Transparency*

1. The MCO must participate in ODM initiatives to design and implement member-accessible comparisons of provider information, including quality, cost, and member experience.

2. The MCO must contribute to the design of initiatives, provide data as specified by ODM, and publish results in accordance with standards established by ODM.

iv. *Provider Partnerships*

1. The MCO must encourage provider participation in, and partner with providers to support the success of, value-based payment initiatives. Provider partnership includes but is not limited to:

    a. Supporting provider-led innovation by:

        i. Working directly with providers to develop and implement value-based purchasing pilots; and

        ii. Soliciting new value-based payment initiative and implementation ideas from the Provider Advisory Council.

        iii. Sponsoring provider cultural transformation and workforce development;

        iv. Developing APM funding arrangements to retain and train providers, especially related to certification to advance their technical skills; and

        v. Building capacity for value-based arrangements in underserved and at-risk regions.

    b. Supporting provider readiness (e.g., data and analytic capabilities, financial stability);

    c. Recognizing that the MCO's payment reform strategies must be different for different types (e.g., behavioral health providers, hospital providers, dental providers) and sizes of providers (e.g., small providers, rural providers, hospital systems, federally qualified health centers [FQHCs]);

    d. Assisting providers to identify and address barriers; and

    e. Encouraging member utilization of providers demonstrating value and quality.

v. *Payer Partnerships*

1. The MCO may initiate, or ODM may require, value-based payment initiatives in coordination with ODM, the OhioRISE Plan, and/or the single pharmacy benefit manager (SPBM) for special projects or pilot programs that require participation across ODM-contracted managed care entities. MCO-initiated value-based payment initiatives that involve the OhioRISE Plan and/or the SPBM require prior approval by ODM.

2. Alternative Payment Methodology Targets

a. Target Requirements

i. The MCO must meet the alternative payment methodology (APM) target requirements identified in Table H.1 below for each measurement year. The MCO must submit APM arrangements, using the ODM-provided template, prior to classifying expenditures as 3A+ according to the Health Care Payment Learning and Action Network (HCP-LAN) framework in the quarterly APM Data Set. APM targets represent the percentage of payments, which include the ODM-required value-based initiatives described in this appendix, and in accordance with The Ohio Department of Medicaid's APM Measure Methodology.

Table H.1 APM Target Requirements

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

b. Strategy for Meeting the Requirements

i. The MCO must develop a written *APM Strategy* to meet APM target requirements, using the ODM-provided template, and submit the strategy to ODM as specified in Appendix P, Chart of Deliverables. Beginning in 2025, the *APM Strategy* will be submitted every three years, and will cover CY's 2026-2028. The MCO should submit updates to the *APM Strategy* based on the APM evaluation/learnings on an annual basis in the interim years.

1. The MCO's strategy must include but are not limited to the following:

    a. Paying providers differentially according to performance (and reinforcing with benefit design);

    b. Designing approaches to payment that maintain or improve quality and/or reduce waste;

    c. Designing payments to encourage adherence to clinical guidelines; and

    d. Developing payment strategies to reduce unwarranted price variation, such as reference or value pricing (e.g., analyzing price variation among network providers by procedure and service types, piloting value pricing programs, promoting center of excellence pricing, and rebalancing payment between primary and specialty care).

        i. Prior to implementation of strategies to reduce price variation, the MCO must inform ODM of service-specific fee schedule changes that may adversely impact 50 or more network providers.

ii. The MCO must consider the following when developing its APM LAN 3B strategies:

    1. Balancing what is necessary for network adequacy and reasonable non-hospital access; and

    2. Carefully considering which providers can take on risk to ensure that the MCO maintains network adequacy standards across its entire service area.

c. <u>Unmet Alternative Payment Methodology Targets</u>

i. The MCO's failure to meet one or more of the alternative payment methodology (APM) targets listed in Table H.1 will result in a single penalty based on the MCO's after-tax underwriting margin for the measurement year as delineated below. ODM will calculate the MCO's annual underwriting margin based on the MCO's annual cost report.

    1. If the MCO's annual underwriting margin is equal to or less than 1.5% of net revenue, the MCO's member assignments will be reduced through ODM's auto-assignment algorithm.

    2. If the MCO's annual underwriting margin is greater than 1.5% of net revenue, the MCO must invest the amount in excess of 1.5% (up to a maximum total investment of 1.5% of net revenue) in primary care, behavioral health, or other providers in a manner that supports the MCO's Population Health Management Strategy and/or priorities established by ODM. The MCO must submit a written plan to ODM for ODM's approval that describes the MCO's proposed allocation of

expenditures and the associated rationale. The MCO must submit associated financial reporting as directed by ODM.

3. Reporting

a. The MCO must submit a Value-Based Payment Progress Report annually that addresses the MCO's progress towards meeting the requirements for value-based payment and APM targets outlined above. The MCO must use the report template provided by ODM, and submit the report as specified in Appendix P, Chart of Deliverables. Reporting elements for each Value-Based Payment Progress Report include the:

i. Description of the MCO's value-based payment strategy;

ii. Summary of the MCO's performance regarding:

1. Reaching objectives of the MCO's value-based payment strategy; and

2. Meeting the APM measure targets.

iii. An effectiveness evaluation of all ODM-approved APMs completed as part of the Value-Based Payment Progress Report;

iv. Insights learned to inform future value-based activities; and

v. Changes to the MCO's value-based payment strategy based on insights learned.

b. In order to determine compliance with the APM targets in Table H.1., the MCO must submit the APM Data Set quarterly to ODM as specified in Appendix P, Chart of Deliverables, in accordance with *The Ohio Department of Medicaid's Alternative Payment Model (APM) Measure Methodology*.

4. Value-Based Initiatives

a. General

i. The MCO must implement the value-based initiatives as required in this section of this appendix and other APMs as directed by ODM.

b. Comprehensive Primary Care Practice Requirements

i. The MCO must implement patient centered medical home payments pursuant to OAC rules 5160-19-01 and 5160-19-02.

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

iii. The MCO must support each of the CPC's activities and the overall CPC initiative as follows:

1. Submit the CPC member attribution files to ODM as specified in Appendix P, Chart of Deliverables, to meet data quality assurance standards in accordance with ODM's CPC Attribution File Submission Specifications and Standards Methodology;

2. Generate and provide ODM a list of attributed members for each CPC entity;

3. Track members who are attributed to each CPC entity;

4. Reimburse CPC entities per member per month (PMPM) payment specified by ODM for attributed members for meeting model requirements in accordance with requirements set forth by ODM. The MCO must send the PMPM payment to CPC entities within 15 business days of receipt from ODM, unless otherwise specified by ODM;

5. Distribute any shared savings due, as determined under the agreement between the MCO and the CPC entity, within 90 calendar days from the time fee-for-service shared savings payments are dispersed, unless otherwise specified by ODM;

6. Reconcile payment data for each CPC entity;

7. Amend contracts, as necessary, with CPC entities to reflect the reimbursement of the PMPM payment and the shared savings payment;

8. Provide technical support, as needed, to the CPC entity to assist with its understanding and use of data files provided by the MCO;

9. Receive and integrate data provided by the CPC entity and implement throughout the MCO's systems and operations;

10. Integrate results from CPC metrics into the MCO's overall quality improvement (QI) program;

11. Use community population health priorities to develop a clear improvement population health strategy in partnership with CPC entities;

12. Ensure provider- and member-facing departments (e.g., provider services, member services, 24/7 medical advice line, and utilization management) are able to identify when a member is attributed to a CPC entity and use related information (e.g., the attributed CPC, expanded access offered by the CPC, explanation of why a member was attributed to a CPC) when interacting with members and providers;

13. Identify integrated care providers within a CPC entity and assist the CPC with linking members to those providers as needed (e.g., pharmacists, dentists, and behavioral health specialists at a co-located site);

14. Coordinate care with CPC entities for attributed members as described in Appendix D, Care Coordination;

15. Provide quantitative and qualitative data (e.g., input from the MCO member advisory group, satisfaction surveys, grievances and appeals) to the CPC that may be used by the CPC to improve member experience; and

16. As requested by the CPC, participate in the CPC's improvement opportunities aimed at reducing health care disparities and improving outcomes and member experience.

c. Behavioral Health Care Coordination Requirements

i. The MCO must comply with Behavioral Health Care Coordination (BHCC) related MCO requirements once the BHCC service and program details are finalized.

d. Comprehensive Maternal Care Requirements

i. The MCO must support the Comprehensive Maternal Care (CMC) care coordination entities (CCEs) with achieving optimal maternal and infant health outcomes by supporting program activities that are performed by the CCE (e.g., member identification, team-based care) pursuant to OAC rule 5160-19-03.

ii. The MCO must perform the administrative activities, including CMC reimbursements, as specified by ODM.

iii. The MCO must play a key role in supporting CMC coordination entities with achieving optimal population health outcomes. The MCO must establish a relationship with each contracted CMC entity and work collaboratively with the CMC to determine the level of support to be provided by the MCO based on the CMC entities' infrastructure, capabilities, and preferences for MCO assistance (e.g., addressing social determinants of health, data sharing).

iv. The MCO must support each of the CMC's activities and the overall CMC initiative as follows:

1. Review monthly ODM attribution files;

2. Track members who are attributed to each CMC practice;

3. Reimburse CMC practices per member per month (PMPM) payment specified by ODM for attributed members for meeting model requirements in accordance with requirements set forth by ODM. The MCO must send the PMPM payment to CMC practices within 15 business days of receipt from ODM, unless otherwise specified by ODM;

4. Reconcile payment data for each CMC practice;

5. Amend contracts, as necessary, with CMC practices to reflect the reimbursement of the PMPM payment and any other administrative requirements associated with CMC;

6. Provide technical support, as needed, to the CMC practice to assist with its understanding and use of data files provided by the MCO;

7. Provide education and technical support, as needed, to the CMC practices to assist with Pregnancy Risk Assessment Form (PRAF) submission;

8. Provide billing and coding education and technical support, as needed, to the CMC practices;

9. Receive and integrate data provided by the CMC practice and implement throughout the MCO's systems and operations;

10. Integrate results from CMC metrics into the MCO's overall quality improvement (QI) program;

11. Work with CMC practices to ensure members, as needed, receive comprehensive care coordination and supportive services including transportation benefits for expectant and postpartum Medicaid eligible individuals to reduce adverse birth and infant outcomes;

12. Ensure provider- and member-facing departments (e.g., provider services, member services, 24/7 medical advice line, and utilization management) are able to identify when a member is attributed to a CMC practice;

13. Work with CMCs to support coordination of services with linking members to prevent gaps across the care continuum as needed (e.g., pharmacists, primary care, and behavioral health specialists); as described in Appendix D;

14. Support Patient Experience and Patient Engagement program activity requirements including but not limited to offering cultural competency trainings and translation supports to the CMC practices as needed;

15. Provide quantitative and qualitative data (e.g., input from the MCO member advisory group, satisfaction surveys, grievances and appeals) to the CMC entity that may be used by the CMC entity to improve member experience;

16. Provide follow-up after hospital discharge supports, as needed, to CMC practices;

17. Assist CMC entities with community integration including but not limited to MCO community events, connection to community agencies and HUBs, and supporting the Doula community’s integration into traditional maternal care services;

18. Support population health activities including best practice sharing among CMC practices, direct member programs and supports, member incentives, and redetermination support as needed; and

19. As requested by the CMC entity, participate in the CMC entity’s improvement opportunities aimed at reducing health care disparities and improving outcomes and member experience.

e. Care Innovation and Community Improvement Program Requirements

i. The MCO must comply with the following ODM-established, Care Innovation and Community Improvement Program (CICIP) requirements:

1. *Care Innovation and Community Improvement Program Goals*

a. The Care Innovation and Community Improvement Program (CICIP) was developed to increase alignment of QI strategies and goals among ODM, MCOs, and four public and nonprofit hospital participating agencies (agencies).

b. The four hospital agencies are large Medicaid safety net and academic medical centers. CICIP goals align with ODM goals to improve health care for Medicaid beneficiaries at risk of or with an opioid or other substance abuse disorder (SUD), along with improving care coordination.

2. *CICIP PMPM Payment*

a. ODM's actuary will estimate a per member per month (PMPM) amount associated with CICIP. This amount will be reduced by a pre-determined percentage, with the difference being allocated to annual bonus payments (see below).

b. The estimated CICIP payment, less the amount allocated to bonus payments, will be included in the MCO's capitation rates for each program year. The capitation rates will include a fixed PMPM amount for CICIP, with potential variation by region and rate cell.

c. The CICIP PMPM amounts included in the capitation rates will then be allocated to the agencies based on historical Medicaid utilization. ODM will notify the MCO of the payment amount for each agency based on the agreed upon payment schedule with the agencies. The MCO must make payment to CICIP participating agencies as directed by ODM.

3. *CICIP Bonus Payments*

a. ODM will calculate the bonus payments to the agencies based on the agreed upon quality measures.

b. ODM will provide the bonus payments to the MCO. The MCO must distribute bonus payments to CICIP participating agencies as directed by ODM.

4. *Reconciliation and Payment Adjustments*

a. CICIP PMPM allocations by participating agency will be reconciled by ODM based on actual utilization, and future payments will be adjusted based on a semi-annual process.

b. ODM anticipates updating the CICIP payments included in the MCO's capitation rates annually, with the option for mid-year adjustments.

5. *Participating Agencies*

   a. For the purpose of this requirement, a participating agency is defined as either a public hospital agency as defined in Ohio Revised Code section 140.01, or a nonprofit hospital agency as defined in Ohio Revised Code section 140.01 that is affiliated with a state university as defined in Ohio Revised Code section 3345.011.

   b. The participating agencies are:

      i. The MetroHealth System;

      ii. UC Health;

      iii. University of Toledo Medical Center; and

      iv. The Ohio State University Wexner Medical Center.

6. *Qualified Practitioners*

   a. For the purposes of the CICIP, qualified practitioners include: physicians, physician assistants, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetists, certified nurse midwives, clinical social workers, clinical psychologists, optometrists, and dentists.

   b. The services for the professionals listed are billed under one of the Group National Provider Identifier (NPI) numbers that are affiliated with one of the participating agencies and identified by ODM.

7. *Quality Measures*

   a. The MCO must collaborate with CICIP providers and support improvement efforts to meet the standards for the quality measures listed in the CMS-approved CICIP preprint.

8. *CICIP and CPC*

   a. CICIP will not have an impact on payments to Comprehensive Primary Care (CPC) practices. ODM will not include CICIP payments when calculating CPC shared savings.

9. *Health Insuring Corporation Tax*

   a. Federal law permits the state to impose health insuring corporation (HIC) taxes on certain health care items and services. ODM will increase the HIC tax amounts included in the MCO's capitation rates to account for CICIP payments.

b. ODM will provide the MCO advance notice of when CICIP payments will be due and the amount of the payment to the CICIP participating agencies.

c. ODM will instruct the MCO to make payment as instructed in ODM's advance notice.

APPENDIX I – QUALITY MEASURES

1. General

a. ODM uses the quality measures and standards within this appendix to evaluate MCO performance in key program areas (e.g., access, clinical quality, member satisfaction). The selected measures align with specific priorities, goals, and/or focus areas of ODM's Quality Strategy. Most measures have one or more minimum performance standards (MPS).

b. ODM uses specific measures and standards to determine MCO performance incentives. Tables I.1a – I.1g in this appendix identifies the measures and standards used by ODM to determine MCO performance incentives.

c. ODM uses measures with an MPS to determine MCO sanctions for noncompliance.

d. ODM requires MCO reporting on a limited number of measures that are informational/reporting only and have no associated standards, incentives, or sanctions.

e. Most measures utilized for performance evaluation derive from national measurement sets (e.g., Health Care Effectiveness Data and Information Set [HEDIS], Agency for Healthcare Research and Quality [AHRQ]), widely used for evaluation of Medicaid and/or managed care industry data.

f. ODM requires a smaller subset of measures developed by ODM to measure the MCO's performance specific to the Ohio Medicaid managed care program's service delivery system. For those measures, the MCO must collect and report valid and reliable data in accordance with associated measure specifications, as well as technical guidance and instructions provided by ODM or ODM's External Quality Review Organization conducting validation activities.

g. MCO performance measures and standards are subject to ODM change based on the revision or update of applicable national measures, methods, benchmarks, or other factors as determined by ODM.

h. The establishment of quality measures and standards in this appendix does not limit ODM's evaluation and compliance assessments of other indicators of MCO performance under this Agreement (e.g., appropriate use of telehealth).

i. ODM will assess MCO's performance on multiple measures and report performance to the MCO and others, including Medicaid members.

2. Quality Measures

a. <u>Quality Measures with Minimum Performance Standards and OAK Standards</u>

i. The MCO must meet the minimum performance standards (MPS) for measures that include an MPS. MCO failure to meet the MPS will result in the assessment of sanctions as specified in Appendix N, Compliance Actions.

ii. OAK (Outcomes Acceleration for Kids) SMAR Aim Goals (SAG) will be used to assess MCO performance for Quality Withhold measures as specified in Appendix J -Quality

Withhold. MCO performance for measures that include an SAG will not be subject to MPS compliance assessment as specified in Appendix N, Compliance Actions.

b. Reporting Only

i. The MCO must report, as applicable, on measures that are informational/reporting only. Informational/reporting only measures do not have associated standards, incentives, or sanctions.

c. Results Methodology

i. ODM will evaluate the MCO's performance on each measure by region for each region in which the MCO has membership under this Agreement.

ii. ODM will use performance measure results to assess the quality of care provided by the MCO to the managed care population and ODM may use MCO results for federal reporting and ODM public reporting purposes (e.g., MCO report card).

iii. The MCO must submit aggregated and member-level self-reported and audited HEDIS data to ODM as described in this appendix and/or specified in the *ODM Specifications for the Submission of MCO Self-Reported, Audited HEDIS Results*.

iv. The MCO must stratify certain measures by race, in accordance with HEDIS specifications or as specified by ODM, for applicable measures.

v. ODM will use the measures in Table I.1a – I.1g below to assess MCO performance.

vi. ODM posts the methodology for the Children's Health Insurance Program Reauthorization Act (CHIPRA), AHRQ, and American Medical Association/Physician Consortium for Performance Improvement (AMA/PCPI) measures ODM's website.

vii. The HEDIS measures and HEDIS/CAHPS survey measures in Table I.1a – I.1g are in accordance with National Committee for Quality Assurance's (NCQA's) Volume 2: Technical Specifications and NCQA's Volume 3: Specifications for Survey Measures, respectively.

d. Measures, Measurement Sets, Standards

i. ODM will evaluate the MCO's performance on the measures, accompanying MPS, and measurement sets listed in Table I.1a – I.1g below.

ii. No MPS standard appears for measures designated "reporting only" for the corresponding year.

iii. Member level data, by measure and measurement year, for HEDIS measures must be provided to ODM on request.

Table I.1a State Fiscal Year 2023, State Fiscal Year 2024, and State Fiscal Year 2025 Performance Measures, Measurements Sets, Standards, and Measurement Years

Table I.1a State Fiscal Years 2024, 2025, 2026 & 2027 Performance Measures, Measurements Sets, Standards, and Measurement Years (MY)		Minimum Performance Standards (MPS) /SMART Aim Goal (SAG)			
Healthy Children	Measurement Set	SFY 2024 / MY 2023	SFY 2025 / MY 2024	SFY 2026 / MY 2025	SFY 2027 / MY 2026
Well-Child Visits in the First 30 Months of Life Well-Child Visits in the First 15 Months of Life, Six or More Well Child Visits	NCQA/HEDIS	MPSO	Overall (All Children) Reporting Only	Overall (All Children) ≥ 63.44%[STW] SAG	Overall (All Children) ≥ 66.32%[STW] SAG
			Population-specific (Black Children) Reporting Only	Population-specific (Black Children) ≥ 53.04% SAG	Population-specific (Black Children) ≥ 54.70% SAG
Well-Child Visits in the First 30 Months of Life – Well Child Visits for Age 15 Months–30 Months, Two or More Visits	NCQA/HEDIS	MPSO	Reporting Only	Reporting Only	TBD MPS
Child and Adolescent Well-care visits, 3-11 years	NCQA/HEDIS	MPSO	Reporting Only	Reporting Only	TBD MPS
Child and Adolescent Well-care visits, 12 – 17 years	NCQA/HEDIS	MPSO	Overall (All Children) Reporting Only	Overall (All Children) ≥ 53.10%[STW] SAG	Overall (All Children) ≥ 54.76%[STW] SAG
			Population-specific (Black Children) Reporting Only	Population-specific (Black Children) ≥ 54.81% SAG	Population-specific (Black Children) ≥ 55.97% SAG
Child and Adolescent Well-care visits, 18 – 21 years	NCQA/HEDIS	MPSO	Reporting Only	Reporting Only	TBD MPS
Child and Adolescent Well-care visits, Total	NCQA/HEDIS	Reporting Only	Reporting Only	Reporting Only	TBD MPS
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Percentile Documentation, Counseling for Nutrition, Counseling for Physical Activity	NCQA/HEDIS	MPSO	Reporting Only	Reporting Only	TBD MPS

Table I.1a State Fiscal Years 2024, 2025, 2026 & 2027 Performance Measures, Measurements Sets, Standards, and Measurement Years (MY)		Minimum Performance Standards (MPS) /SMART Aim Goal (SAG)			
Healthy Children	Measurement Set	SFY 2024 / MY 2023	SFY 2025 / MY 2024	SFY 2026 / MY 2025	SFY 2027 / MY 2026
General Child - Rating of Health Plan (CAHPS Health Plan Survey)	NCQA/HEDIS/ CAHPS	MPSO	Reporting Only	≥ 85.23% MPS	TBD MPS
General Child - Customer Service Composite (CAHPS Health Plan Survey)	NCQA/HEDIS/ CAHPS	MPSO	Reporting Only	≥ 89.87% MPS	TBD MPS
Topical Fluoride for Children	NCQA/HEDIS	Reporting Only	Reporting Only	Reporting Only	TBD MPS
Oral Evaluation, Dental Services	NCQA/HEDIS	Reporting Only	Reporting Only	Reporting Only	Reporting Only
Sealant Receipt on Permanent First Molars	ADA	Reporting Only	Reporting Only	Reporting Only	TBD MPS
Childhood Immunization Status (Combo 3)	NCQA/HEDIS	MPSO	Reporting Only	Reporting Only	TBD MPS
Childhood Immunization Status (Combo 10)	NCQA/HEDIS	Reporting Only	Reporting Only	Reporting Only	Reporting Only
Immunization for Adolescents (Combo 1)	NCQA/HEDIS	Reporting Only	Reporting Only	Reporting Only	Reporting Only
Immunization for Adolescents (HPV)	NCQA/HEDIS	Reporting Only	Reporting Only	Reporting Only	Reporting Only
Immunization for Adolescents (Combo 2)	NCQA/HEDIS	MPSO	Reporting Only	Reporting Only	TBD MPS
Sickle Cell: Transcranial Ultrasound	ODM	n/a	Reporting Only	≥ 60.00% SAG	≥70.00% SAG
Lead Screening in Children	NCQA/HEDIS	MPSO	Reporting Only	Reporting Only	TBD MPS
Appropriate Testing for Pharyngitis (Ages 3- 17)	NCQA/HEDIS	Reporting Only	Reporting Only	Reporting Only	TBD MPS
Tobacco Use: Screening and Cessation (Ages 12 – 17)	AMA-PCPI	Reporting Only	Reporting Only	Reporting Only	Reporting Only
Infant Well-Care Visit With a Primary Care Provider	ODM	Reporting Only	Reporting Only	Reporting Only	TBD MPS
Contraceptive Care: All Women (Ages 15 – 20)	US Office of Population Affairs (OPA)	Reporting Only	Reporting Only	Reporting Only	TBD MPS
Contraceptive Care: Postpartum Women (Ages 15 – 20)	OPA	Reporting Only	Reporting Only	Reporting Only	TBD MPS
Developmental Screen First Three Years	Oregon University	Reporting Only	Reporting Only	Reporting Only	TBD MPS
`Depression Screening and Follow-Up for Adolescents and Adults (Ages 12 – 17)	NCQA/HEDIS	Reporting Only	Reporting Only	Reporting Only	TBD MPS
Chlamydia Screening in Women (Chlamydia Screening, eff. MY 2025) Ages 16 to 20	NCQA/HEDIS	n/a	Reporting Only	Reporting Only	TBD MPS
Asthma Medication Ratio, Ages 5 – 11	NCQA/HEDIS	n/a	Overall	Overall	Overall

Table I.1a State Fiscal Years 2024, 2025, 2026 & 2027 Performance Measures, Measurements Sets, Standards, and Measurement Years (MY)		Minimum Performance Standards (MPS) /SMART Aim Goal (SAG)			
Healthy Children	Measurement Set	SFY 2024 / MY 2023	SFY 2025 / MY 2024	SFY 2026 / MY 2025	SFY 2027 / MY 2026
			Reporting Only	≥ 79.70%^{STW} SAG	≥ 82.19%^{STW} SAG
			Population-specific (Black Children) Reporting Only	Population-specific (Black Children) ≥ 74.50% SAG	Population-specific (Black Children) ≥ 76.08% SAG
Asthma Medication Ratio, Ages 12 – 18	NCQA/HEDIS	n/a	Overall (All Children) Reporting Only	Overall (All Children) ≥ 73.37%^{STW} SAG	Overall (All Children) ≥ 75.66%^{STW} SAG
			Population-specific (Black Children) Reporting Only	Population-specific (Black Children) ≥ 71.22% SAG	Population-specific (Black Children) ≥ 72.74% SAG
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis, Age 3 months to 17 years	NCQA/HEDIS	n/a	Reporting Only	Reporting Only	TBD MPS
STW= Overall managed care statewide rate. SAG = SMART Aim Goal					

Table I.1b State Fiscal Year 2023, State Fiscal Year 2024, and State Fiscal Year 2025 Performance Measures, Measurements Sets, Standards, and Measurement Years

Table I.1b State Fiscal Years 2024, 2025, 2026 & 2027 Performance Measures, Measurements Sets, Standards, and School Years (SY – measurement year is the school year)		Minimum Performance Standards (MPS)			
Academic Measures for Children	Measurement Set	SFY 2023/ SY 2023	SFY 2024/ SY 2024	SFY 2025/ SY 2025	SFY 2026/ SY 2026
Kindergarten Readiness	ODM	Reporting Only	Reporting Only	Reporting Only	TBD MPS
Chronic Absenteeism	ODM	Reporting Only	Reporting Only	Reporting Only	TBD MPS
3rd Grade Reading	ODM	Reporting Only	Reporting Only	Reporting Only	TBD MPS

Table I.1b State Fiscal Years 2024, 2025, 2026 & 2027 Performance Measures, Measurements Sets, Standards, and School Years (SY – measurement year is the school year)		Minimum Performance Standards (MPS)			
Academic Measures for Children	Measurement Set	SFY 2023/ SY 2023	SFY 2024/ SY 2024	SFY 2025/ SY 2025	SFY 2026/ SY 2026
Graduation Rates	ODM	Reporting Only	Reporting Only	Reporting Only	TBD MPS

Table I.1c State Fiscal Year 2023, State Fiscal Year 2024, and State Fiscal Year 2025 Performance Measures, Measurements Sets, Standards, and Measurement Years

Table I.1c State Fiscal Years 2024, 2025, 2026 & 2027 Performance Measures, Measurements Sets, Standards, and Measurement Years (MY)		Minimum Performance Standards (MPS)/SMART Aim Goal (SAG)			
Behavioral Health for Children	Measurement Set	SFY 2024 / MY 2023	SFY 2025 / MY 2024	SFY 2026 / MY 2025	SFY 2027 / MY 2026
Follow-Up After Emergency Department Visit for Mental Illness, 7-day Follow-Up, Ages 6-17	NCQA/HEDIS	MPSO	Overall Reporting Only	Reporting Only	Reporting Only
Follow-Up After Emergency Department Visit for Mental Illness, 30-day Follow-Up, Ages 6-17	NCQA/HEDIS	MPSO	Reporting Only	Reporting Only	Reporting Only
Follow-Up After Emergency Department Visit for Substance Use, 7-day Follow-Up, Ages 13-17	NCQA/HEDIS	Reporting Only	Reporting Only	Reporting Only	Reporting Only
Follow-Up After Emergency Department Visit for Substance Use, 30-day Follow-Up, Ages 13-17	NCQA/HEDIS	Reporting Only	Reporting Only	Reporting Only	Reporting Only
Follow-Up After Hospitalization for Mental Illness, 7 -day Follow-Up, Ages 6-17	NCQA/HEDIS	MPSO	Reporting Only	Reporting Only	Reporting Only
Follow-Up After Hospitalization for Mental Illness, 30 -day Follow-Up, Ages 6-17	NCQA/HEDIS	n/a	Reporting Only	Reporting Only	Reporting Only
1 - 7 Day Follow-up Visit After ED Encounter for Substance Use, Ages 10 – 17	ODM	n/a	Overall[STW] (All Children) Reporting Only	Overall[STW] (All Children) ≥ 38.17% SAG	Overall[STW] (All Children) ≥ 39.91% SAG
			Population-specific (Black Children)	Population-specific (Black Children)	Population-specific (Black Children)

Table I.1c State Fiscal Years 2024, 2025, 2026 & 2027 Performance Measures, Measurements Sets, Standards, and Measurement Years (MY)		Minimum Performance Standards (MPS)/SMART Aim Goal (SAG)			
Behavioral Health for Children	Measurement Set	SFY 2024 / MY 2023	SFY 2025 / MY 2024	SFY 2026 / MY 2025	SFY 2027 / MY 2026
			Reporting Only	≥ 30.23% SAG	≥ 31.18% SAG
1 - 7 Day Follow-up Visit After ED Encounter for Mental Illness, Ages 17 and Younger	ODM	n/a	Overall[STW] (All Children) Reporting Only	Overall[STW] (All Children) ≥ 54.05% SAG	Overall[STW] (All Children) ≥ 56.50% SAG
			Population-specific (Black Children) Reporting Only	Population-specific (Black Children) ≥ 47.18% SAG	Population-specific (Black Children) ≥ 48.65% SAG
Initiation and Engagement of Substance Use Disorder Treatment, Initiation, Ages 13-17	NCQA/HEDIS	n/a	Reporting Only	Reporting Only	TBD MPS
Initiation and Engagement of Substance Use Disorder Treatment, Engagement, Ages 13-17	NCQA/HEDIS	MPSO	Reporting Only	Reporting Only	TBD MPS
Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA/HEDIS	MPSO	Reporting Only	Reporting Only	TBD MPS
Metabolic Monitoring for Children and Adolescents on Antipsychotics, Blood Glucose and Cholesterol Testing[E]	NCQA/HEDIS	MPSO	Reporting Only	Reporting Only	TBD MPS
Antidepressant Medication Management, Effective Acute and Effective Continuation Phase Treatment, Ages 17 and younger	NCQA/HEDIS	Reporting Only	Reporting Only	n/a	n/a
Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase[E]	NCQA/HEDIS	MPSO	Reporting Only	Reporting Only	TBD MPS
Follow-Up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase[E]	NCQA/HEDIS	MPSO	Reporting Only	Reporting Only	TBD MPS
Use of Opioids at High Dosage – Ages 17 and younger	NCQA/HEDIS	Reporting Only	n/a	n/a	n/a
Use of Opioids from Multiple Providers – Ages 17 and Younger	NCQA/HEDIS	Reporting Only	n/a	n/a	n/a
Risk of Continued Opioid Use – Ages 17 and younger	NCQA/HEDIS	Reporting Only	Reporting Only	Reporting Only	Reporting Only
HE= Non-HEDIS measure methodology and performance standards & Population-Specific results and minimum performance standards methodology are calculated in accordance with the *Accelerate Children's Outcomes (ACO) Quality Measures and Minimum Performance Standards* methodology document.					

Table I.1c State Fiscal Years 2024, 2025, 2026 & 2027 Performance Measures, Measurements Sets, Standards, and Measurement Years (MY)		Minimum Performance Standards (MPS)/SMART Aim Goal (SAG)			
Behavioral Health for Children	Measurement Set	SFY 2024 / MY 2023	SFY 2025 / MY 2024	SFY 2026 / MY 2025	SFY 2027 / MY 2026
STW= Overall managed care statewide rate. SAG = SMART Aim Goal. E = ECDS reporting methodology effective MY 2024					

Table I.1d State Fiscal Year 2023, State Fiscal Year 2024, and State Fiscal Year 2025 Performance Measures, Measurements Sets, Standards, and Measurement Years

Table I.1d State Fiscal Years 2024, 2025, 2026 & 2027 Performance Measures, Measurements Sets, Standards, and Measurement Years (MY)		Minimum Performance Standards (MPS)			
Women's Health(Maternal/Infant)	Measurement Set	SFY 2024 / MY 2023	SFY 2025 / MY 2024	SFY 2026 / MY 2025	SFY 2027 / MY 2026
Prenatal and Postpartum Care – Timeliness of Prenatal Care	NCQA/HEDIS	MPSO	≥ 84.23% MPS	≥ 84.55% MPS	TBD MPS
Prenatal and Postpartum Care – Postpartum Care	NCQA/HEDIS	MPSO	≥ 78.10% MPS	≥ 80.23% MPS	TBD MPS
Percentage of Live Births Weighing Less Than 2,500 Grams	CHIPRA	≤ 9.2%	≤ 9.2% MPS	≤ 9.2% MPS	≤ 9.2% MPS
Breast Cancer Screening (BCS-E)	NCQA/HEDIS	Reporting Only	Reporting Only	Reporting Only	Reporting Only
Cervical Cancer Screening	NCQA/HEDIS	MPSO	≥ 57.11% MPS	≥ 57.18% MPS	TBD MPS
Chlamydia Screening in Women	NCQA/HEDIS	MPSO	n/a	n/a	n/a
Chlamydia Screening in Women (Chlamydia Screening, eff. MY 2025) Ages 21 to 24	NCQA/HEDIS	n/a	Reporting Only	≥ 62.63% MPS	TBD MPS
Contraceptive Care: All Women (Ages 21 – 44)	US Office of Population Affairs (OPA)	Reporting Only	Reporting Only	Reporting Only	Reporting Only
Contraceptive Care: Postpartum Women (Ages 21 – 44)	OPA	Reporting Only	Reporting Only	Reporting Only	Reporting Only
NTSV Cesarean Birth Rate	ODM	Reporting Only	Reporting Only	Reporting Only	Reporting Only
Primary Care Visits for Mother	ODM	Reporting Only	Reporting Only	Reporting Only	Reporting Only
Primary Care visits for Women of Reproductive Age	ODM	n/a	n/a	Reporting Only	Reporting Only
Prenatal Visits by 9 Weeks Gestation	ODM	n/a	n/a	Reporting Only	Reporting Only
Preterm Births (PTB)	ODM	Reporting Only	Reporting Only	Reporting Only	Reporting Only

Table I.1e State Fiscal Year 2023, State Fiscal Year 2024, and State Fiscal Year 2025 Performance Measures, Measurements Sets, Standards, and Measurement Years

Table I.1e State Fiscal Years 2024, 2025, 2026 & 2027 Performance Measures, Measurements Sets, Standards, and Measurement Years (MY)		Minimum Performance Standards (MPS)/SMART Aim Goal (SAG)			
Behavioral Health for Adults	Measurement Set	SFY 2024 / MY 2023	SFY 2025 / MY 2024	SFY 2026 / MY 2025	SFY 2027 / MY 2026
Initiation and Engagement of Substance Use Disorder Treatment, Ages 18-64	NCQA/ HEDIS	Initiation MPSO	Initiation Reporting Only	Initiation Reporting Only	Initiation Reporting Only
		Engagement MPSO	Engagement Reporting Only	Engagement Reporting Only	Engagement Reporting Only
Follow-Up After Hospitalization for Mental Illness, Ages 18-64	NCQA/ HEDIS	7-day MPSO	7-day Reporting Only	7-day Reporting Only	7-day Reporting Only
		30-day MPSO	30-day Reporting Only	30-day Reporting Only	30-day Reporting Only
Follow-Up After Hospitalization for Mental Illness, Total	NCQA/HEDIS	7-day Reporting Only	7-day & 30-day Reporting Only	7-day & 30-day Reporting Only	7-day & 30-day Reporting Only
Antidepressant Medication Management, 18 and older	NCQA/HEDIS	Acute Phase MPSO	Acute Phase ≥ 57.41%	Acute Phase n/a	Acute Phase n/a
		Continuation Phase MPSO	Continuation Phase ≥ 40.01%	Continuation Phase n/a	Continuation Phase n/a
Follow-Up After Emergency Department Visit for Mental Illness, Ages 18-64	NCQA/HEDIS	7-day MPSO	7-day Reporting Only	7-day Reporting Only	7-day Reporting Only
		30-day MPSO	30-day Reporting Only	30-day Reporting Only	30-day Reporting Only
Follow-Up After Emergency Department Visit for Substance Use, Ages 18 and older	NCQA/HEDIS	7-day Reporting Only	7-day Reporting Only	7-day Reporting Only	7-day TBD MPS
		30-day Reporting Only	30-day ≥ 42.55% MPS	30-day Reporting Only	30-day TBD MPS
Follow-Up After Emergency Department Visit for Substance Use, Ages 18 and older, 7-Day Follow-Up, Central Region	NCQA/HEDIS	n/a	Population-specific (Black Adults) Reporting Only	Population-specific (Black Adults) ≥ 39.04% SAG	Population-specific (Black Adults) ≥ 39.04% SAG

Table I.1e State Fiscal Years 2024, 2025, 2026 & 2027 Performance Measures, Measurements Sets, Standards, and Measurement Years (MY)		Minimum Performance Standards (MPS)/SMART Aim Goal (SAG)			
Behavioral Health for Adults	Measurement Set	SFY 2024 / MY 2023	SFY 2025 / MY 2024	SFY 2026 / MY 2025	SFY 2027 / MY 2026
			All Other/Non-Black Population Reporting Only	All Other/ Non-Black Population ≥ 39.04% SAG	All Other/ Non-Black Population TBD SAG
Follow-Up After Emergency Department Visit for Substance Use, Ages 18 and older, 7-Day Follow-Up, Northwest Region	NCQA/HEDIS	n/a	Population-specific (Black Adults) Reporting Only	Population-specific (Black Adults) ≥ 39.04% SAG	Population-specific (Black Adults) TBD SAG
			All Other/Non-Black Population Reporting Only	All Other/ Non-Black Population ≥ 39.04% SAG	All Other/ Non-Black Population TBD SAG
1-7 Day Follow-up After ED Encounter for Mental Illness, Ages 18 and older, Central Region	ODM	n/a	Population-specific (Black Adults) Reporting Only	Population-specific (Black Adults) ≥ 39.01% SAG	Population-specific (Black Adults) TBD SAG
			All Other/Non-Black Population Reporting Only	All Other/ Non-Black Population ≥ 39.01% SAG	All Other/ Non-Black Population TBD SAG

Table I.1e State Fiscal Years 2024, 2025, 2026 & 2027 Performance Measures, Measurements Sets, Standards, and Measurement Years (MY)		Minimum Performance Standards (MPS)/SMART Aim Goal (SAG)			
Behavioral Health for Adults	Measurement Set	SFY 2024 / MY 2023	SFY 2025 / MY 2024	SFY 2026 / MY 2025	SFY 2027 / MY 2026
1-7 Day Follow-up After ED Encounter for Mental Illness, Ages 18 and older, Northwest Region		ODM	Population-specific (Black Adults) Reporting Only	Population-specific (Black Adults) ≥ 39.01% SAG	Population-specific (Black Adults) TBD SAG
			All Other/Non-Black Population Reporting Only	All Other/ Non-Black Population ≥ 39.01% SAG	All Other/ Non-Black Population TBD SAG
Use of Opioids at High Dosage, Age 18 and older	NCQA/HEDIS	MPSO	Reporting Only	Reporting Only	TBD MPS
Use of Opioids from Multiple Providers – Age 18 and older	NCQA/HEDIS	Multiple Pharmacies Reporting Only	Multiple Pharmacies Reporting Only	Multiple Pharmacies Reporting Only	Multiple Pharmacies TBD MPS
		Multiple Prescribers Reporting Only	Multiple Prescribers Reporting Only	Multiple Prescribers Reporting Only	Multiple Prescribers TBD MPS
		Multiple Pharmacies and Prescribers Reporting Only	Multiple Pharmacies and Prescribers Reporting Only	Multiple Pharmacies and Prescribers Reporting Only	Multiple Pharmacies and Prescribers TBD MPS
Risk of Continued Opioid Use, Age 18 and older	NCQA/HEDIS	Reporting Only	Reporting Only	Reporting Only	Reporting Only
: Depression Screening and Follow-Up for Adolescents and Adults: Age 18 and older	NCQA/HEDIS	n/a	Reporting Only	Reporting Only	TBD MPS
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	NCQA/HEDIS	n/a	Reporting Only	Reporting Only	Reporting Only
Pharmacotherapy for Opioid Use Disorder	NCQA/HEDIS	n/a	Reporting Only	Reporting Only	Reporting Only
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	NCQA/HEDIS	n/a	Reporting Only	Reporting Only	Reporting Only
SAG = SMART Aim Goal					

Table I.1f State Fiscal Year 2023, State Fiscal Year 2024, and State Fiscal Year 2025 Performance Measures, Measurements Sets, Standards, and Measurement Years

Table I.1f State Fiscal Years 2024, 2025, 2026 & 2027 Performance Measures, Measurements Sets, Standards, and Measurement Years (MY)		Minimum Performance Standards (MPS)			
Chronic Conditions	Measure Set	SFY 2024 / MY 2023	SFY 2025 / MY 2024	SFY 2026 / MY 2025	SFY 2027 / MY 2026
Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (>9.0%)	NCQA/HEDIS	MPSO	n/a	n/a	n/a
Hemoglobin A1c Control for Patients With Diabetes – HbA1c Control (<8.0%)	NCQA/HEDIS	MPSO	n/a	n/a	n/a
Glycemic Status Assessment for Patients with Diabetes – Glycemic status > 9.0%	NCQA/HEDIS	n/a	Reporting Only	Reporting Only	TBD MPS
Glycemic Status Assessment for Patients with Diabetes – Glycemic status < 8.0%	NCQA/HEDIS	n/a	Reporting Only	Reporting Only	TBD MPS
Eye Exam for Patients with Diabetes	NCQA/HEDIS	MPSO	Reporting Only	Reporting Only	TBD MPS
Blood Pressure Control for Patients with Diabetes	NCQA/HEDIS	MPSO	Reporting Only	Reporting Only	TBD MPS
Kidney Health Evaluation for Patients with Diabetes, Total	NCQA/HEDIS	MPSO	Reporting Only	Reporting Only	TBD MPS
PQI 1: Diabetes Short-Term Complications Admission Rate (PQI01-AD)	AHRQ	Reporting Only	Reporting Only	Reporting Only	Reporting Only
Statin Therapy for Patients With Diabetes, Received Statin Therapy	NCQA/HEDIS	MPSO	Reporting Only	Reporting Only	TBD MPS
Controlling High Blood Pressure	NCQA/HEDIS	MPSO	≥ 61.31% MPS	≥ 67.40% MPS	TBD MPS
Statin Therapy for Patients With Cardiovascular Disease, Received Statin Therapy	NCQA/HEDIS	MPSO	≥ 80.36% MPS	≥ 83.00% MPS	TBD MPS
Cardiac Rehabilitation – Initiation, Engagement 1, Engagement 2, Achievement- 18-64, 65 and older, Total	NCQA/HEDIS	Reporting Only	Reporting Only	Reporting Only	Reporting Only
PQI 8: Heart Failure Admission Rate	AHRQ	Reporting Only	Reporting Only	Reporting Only	Reporting Only
Pharmacotherapy Management of COPD Exacerbation: Dispensed Systemic Corticosteroid Within 14 Calendar Days & Dispensed a Systemic Bronchodilator within 30 calendar days	NCQA/HEDIS	Reporting Only	Reporting Only	Reporting Only	Reporting Only
Asthma Medication Ratio – Ages 19 to 50 & 51 - 64	NCQA/HEDIS	n/a	Reporting Only	Reporting Only	Reporting Only
PQI 15: Asthma in Younger Adults Admission Rate (PQI 15 – AD)	AHRQ	Reporting Only	Reporting Only	Reporting Only	Reporting Only
PQI 5: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI 05-AD)	AHRQ	Reporting Only	Reporting Only	Reporting Only	Reporting Only

Table I.1g State Fiscal Year 2023, State Fiscal Year 2024, and State Fiscal Year 2025 Performance Measures, Measurements Sets, Standards, and Measurement Years

Table I.1g State Fiscal Years 2024, 2025, 2026 & 2027 Performance Measures, Measurements Sets, Standards, and Measurement Years (MY)		Minimum Performance Standards (MPS)			
Healthy Adults	Measure Set	SFY 2024 / MY 2023	SFY 2025 / MY 2024	SFY 2026 / MY 2025	SFY 2027 / MY 2026
Adults' Access to Preventive/Ambulatory Health Services – Total	NCQA/HEDIS	MPSO	≥ 76.57% MPS	≥ 78.35% MPS	TBD MPS
Colorectal Cancer Screening (COL-E)	NCQA/HEDIS	n/a	Reporting Only	Reporting Only	Reporting Only
Tobacco Use: Screening and Cessation, Ages 18 and Older	AMA-PCPI	≥ 12%	Reporting Only	Reporting Only	Reporting Only
Adult Rating of Health Plan (CAHPS Health Plan Survey)	NCQA/HEDIS	MPSO	≥ 79.91% MPS	≥ 79.53% MPS	TBD MPS
Adult Customer Service Composite (CAHPS Health Plan Survey)	NCQA/HEDIS	MPSO	≥ 90.38% MPS	≥ 90.20% MPS	TBD MPS
Ambulatory Care-Emergency Department (ED) Visits	NCQA/HEDIS	MPSO	n/a	n/a	n/a
Plan All-Cause Readmissions	NCQA/HEDIS	n/a	Reporting Only	Reporting Only	Reporting Only
Inpatient Utilization –General Hospital/Acute Care	NCQA/HEDIS	Reporting Only	n/a	n/a	n/a
Antibiotic Utilization for Respiratory Conditions	NCQA/HEDIS	Reporting Only	Reporting Only	Reporting Only	Reporting Only
Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis, Age 18 and older	NCQA/HEDIS	Reporting Only	Reporting Only	Reporting Only	Reporting Only

Note: No standard will be established or compliance assessed, for the measures designated 'reporting only' in the Minimum Performance Standard column for the corresponding year.
MPSO = Minimum performance standard determined in accordance with ODM MCO Minimum Performance Standards Outliers (MPSO) Methodology
MPS = Minimum performance standard

3. Data and Reporting

a. HEDIS Data

i. *Annual Submission of HEDIS Interactive Data Storage System Data*

1. The MCO must collect, report, and submit self-reported, audited Healthcare Effectiveness Data and Information Set (HEDIS) data to ODM (see *ODM Specifications for the Submission of MCO Self-Reported, Audited HEDIS Results* on ODM's website) for the full set of HEDIS measures reported by the MCO to NCQA for Ohio Medicaid members. This includes all HEDIS measures listed in this appendix. The MCO must submit its self-

reported, audited HEDIS Data to ODM as specified in Appendix P, Chart of Deliverables.

ii. *Annual Submission of HEDIS Final Audit Report*

1. The MCO must submit its HEDIS Final Audit Report that contains the audited results for the full set of HEDIS measures reported by the MCO to NCQA for Ohio Medicaid members to ODM (see *ODM Specifications for the Submission of MCO Self-Reported, Audited HEDIS Results* on ODM's website). This includes all HEDIS measures listed in this appendix. The MCO must submit its HEDIS Final Audit Report to ODM as specified in Appendix P, Chart of Deliverables.

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

1. In accordance with 42 CFR 438.604 and 42 CFR 438.606 and ODM requirements, the MCO must submit a signed data certification letter to ODM attesting to the accuracy and completeness of its audited HEDIS Interactive Data Storage System (IDSS) data and of its HEDIS Final Audit Report submitted to ODM.

2. As specified in Appendix P, Chart of Deliverables, the MCO must submit these HEDIS IDSS Data Certification Letters per the instructions and by the due dates provided in the *ODM Specifications for the Submission of MCO Self-Reported, Audited HEDIS Results.*

3. In accordance with 42 CFR 438.606 and Appendix G, Program Integrity, each data certification letter must be signed by the MCO's Chief Executive Officer (CEO), Chief Finance Officer (CFO), or an individual who reports directly to the MCO's CEO or CFO with delegated authority to sign for the CEO or CFO so that the CEO or CFO is ultimately responsible for the certification.

b. CAHPS Data

i. *Annual CAHPS Survey Administration and Data Submission*

1. The MCO must contract with an NCQA certified HEDIS survey vendor to administer an annual Consumer Assessment of Healthcare Providers System (CAHPS) survey to the MCO's members, per the survey administration requirements outlined in the *ODM CAHPS Survey Administration and Data Submission Specifications* available on ODM's website. The CAHPS Survey Data must be submitted to NCQA, the CAHPS Database, and ODM's designee consistent with the data submission requirements in the *ODM CAHPS Survey Administration and Data Submission Specifications* and as specified in Appendix P, Chart of Deliverables.

ii. *CAHPS Data Certification Requirements*

1. In accordance with 42 CFR 438.604 and 42 CFR 438.606 and ODM requirements, the MCO must submit to ODM three CAHPS data certification letters consistent with the instructions and by the due dates provided in the *ODM CAHPS Survey Administration and Data Submission Specifications.*

2. In accordance with 42 CFR 438.606 and Appendix G, Program Integrity, each data certification letter must be signed by the MCO's CEO, CFO, or an individual who reports directly to the MCO's CEO or CFO with delegated authority to sign for the CEO or CFO so that the CEO or CFO is ultimately responsible for the certification.

4. Additional Operational Considerations

a. Measures and Measurement Years

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

b. Performance Standards – Compliance Determination

i. In the event the MCO's performance cannot be evaluated for a performance measure and measurement year established in Table I.1a – I.1g of this appendix, ODM in its sole discretion will determine if the MCO has met or not met the standard or standards for that particular measure and measurement year depending on the circumstances involved. For example, if ODM assigned a “Not Report” audit result on a HEDIS measure on the MCO’s Final Audit Report and the “Not Report” designation was determined to be the result of a material bias caused by the MCO, ODM would deem the MCO to have not met the standard or standards for that measure and measurement year.

c. Termination or Non-Renewal – Compliance Determination

i. If this Agreement is terminated or not renewed, ODM will determine MCO compliance for the most recent measurement year prior to termination or non-renewal. If ODM determines that the MCO is not in compliance with a standard set forth in this appendix during that period, ODM will take compliance actions in accordance with Appendix N, Compliance Actions.

d. Performance Standards – Retrospective Adjustment

i. ODM will implement the use of a uniform methodology as needed for the retrospective adjustment of any MPS listed in Table I.1a – I.1g of this appendix, except for the CAHPS measure standards. ODM will implement this methodology at ODM's sole discretion.

APPENDIX J – QUALITY WITHHOLD

1. Quality Withhold Program

a. ODM's Quality Withhold Program will be conducted in accordance with 42 CFR 438.6(b)(3).

b. ODM will withhold a specified percentage for each applicable state fiscal year (SFY) for use in ODM's Quality Withhold Program. The amount to be withheld will be 3% of the capitation and delivery payments.

c. ODM will use the health improvement activities identified within each applicable SFY quality withhold payout determination to calculate the amount of the withhold payout.

i. Health improvement activities will be comprised of multiple quality improvement projects related to ODM's population health strategy.

ii. Health improvement activities will measure the effectiveness of the MCO's population health management strategy and quality improvement program to impact population health outcomes.

d. ODM will assess the MCO's performance according to the measurement periods described in Section 2 below for purposes of determining quality withhold payouts.

e. ODM will use the MCO's Quality Withhold QI Template and other related documentation to evaluate MCO performance related to the Quality Withhold Program.

f. ODM will determine the quality withhold payout as specified in this appendix.

g. Quality Withhold Innovation Fund

i. The MCO must collaborate with all other MCOs to establish a Quality Withhold Innovation Fund (Fund). The MCO must contribute to the Fund 75% of capitation payments it receives during the measurement period that are attributable to the 'Quality Withhold Functions' non-benefit expense category as identified in the capitation rate certification. The MCO must enter into an ODM-approved joint agreement with the other MCOs which establishes expectations for timing of MCO contributions, fund governance, and use of the funds. The MCO must work collaboratively with all other MCOs to use contributions to the Fund in a collective manner that follows the quality withhold processes designed to meet meaningful goals for the Medicaid population put forth by ODM. The MCO must not use monies in the Fund for any of the following:

1. MCO costs related to administration, management, or support of the Quality Withhold Program;

2. MCO IT System changes associated with interventions or other QI processes;

3. Paying for Medicaid-covered services under an existing context through traditional payment arrangements.

4. Projects or interventions not expressly included in the Quality Withhold Program; or

5. Activities that take place before or after the measurement period of the Quality Withhold Projects.

ii. Plans to spend monies from Fund must be presented to ODM for review and expenditures from the Fund may not be made until ODM's review has been completed. Any interest earned from monies in the Fund must remain in the Fund. Unspent funds collected in a measurement period must be carried over to the next measurement period. As specified by ODM, deposits, expenditures, including expenses related to administration and management of the Fund, and balances must be reported to ODM, as specified in Appendix P, Chart of Deliverables.

iii. In the event the Quality Withhold Innovation Fund is no longer required under this Agreement, the monies remaining the Fund will be distributed as follows:

1. Monies derived from monetary sanctions which were deposited into the Fund and monies from Quality Withhold Reinvestment amounts must be returned to ODM.

2. Monies from other sources such as interest earned on the Fund or sources attributable to the 'Quality Withhold Functions' non-benefit expense category as identified in the capitation rate certification, may be distributed to the MCOs in a manner proportional to their individual deposits or as otherwise determined by the MCOs' joint agreement.

2. CY 2024 - 2025 Quality Withhold Payout Determination

a. Quality Withhold Payout Determination

i. For the purpose of determining the return of the quality withhold, ODM will use the performance of the MCO's collective efforts to advance ODM's population health strategy using improvement tools such as the Model for Improvement[4] . This includes investing in assessing, designing, and building the necessary internal and external infrastructures for efficient collaborative quality improvement work and developing collaborative partnerships with health systems, clinics, and providers, e.g., Pediatric ACOs, school-based health centers, and academic centers. MCOs must assess the effectiveness of quality improvement collaborations, determine changes needed to enhance care efficiency and accelerate improving health outcomes, and implement these changes (e.g., enhance funding for interventions, increase staffing with appropriate knowledge and skills, improve communications, streamline documentation of work completed, develop a collaboration-wide quality improvement capacity development plan, etc.). MCOs must follow the organization,

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

policies, and procedures specified in the *Quality Withhold Program Governance for 2024 – 2025* document.

b. Quality Improvement Projects

i. The MCOs must work collaboratively with other managed care entities and apply ODM-established quality improvement processes to implement activities to:

1. Improve adult health outcomes; and

2. Improve pediatric health outcomes.

ii. CY 2024 and CY 2025 SMART Aims, including quality improvement goals for each adult-focused and pediatric-focused quality withhold project, are listed in ODM's payout methodology document, i.e., *Medicaid Managed Care Quality Withhold: Payout Methodology for Measurement Period January 1, 2024 – December 31, 2025.*

c. Performance Evaluation

i. ODM's performance evaluation of the MCO will include the following:

1. The MCO's Population Health Management and Quality Improvement activities, which include:

a. An organizational structure and sufficient staffing that supports common data and quality improvement processes to advance each collective team's interventions at an accelerated pace. For each quality improvement activity, this includes having:

i. An engaged executive sponsor (i.e., MCO's Administrator/Chief Executive Officer);

ii. Active involvement of the MCO's Medical Director/Chief Medical Officer;

iii. Participating staff with knowledge and experience using the Model for Improvement methods to ensure fidelity to the Model;

iv. Dedicated data collection and analytical staff who are experienced with interpreting data for learning; and

v. Sufficient staff necessary to meet intervention implementation needs (i.e., staff with the subject matter expertise necessary to quickly bring up new structures and processes as required by for intervention testing, implementation, sustainability, and spread).

b. An updated Population Health Management Strategy as described in Appendix C, Population Health and Quality, that addresses the

needs of the MCO's members and the communities the members live in that is aligned with ODM priorities.

c. Adherence to the Model for Improvement, as applicable, including:

i. Actively and continually assessing member and provider perspectives to inform intervention selection, design, and modifications, paying particular attention to disparities and high-risk populations;

ii. Conducting active primary and secondary research to develop changes to the MCO's normal processes (e.g., care coordination, vendor agreements, data tracking and analysis, coverage of services, addressing health-related social needs) to better serve members experiencing disparities;

iii. Using quality improvement tools (e.g., key driver diagrams, process mapping, failure mode and effects analysis, PDSA testing, run charts) to depict the theory of change, rationale for chosen interventions, intervention testing, and intervention impact;

iv. Monitoring of interventions implementation, sustainability, and spread (e.g., measuring the effectiveness and degree of intervention impact, and adjusting or refining to increase effectiveness); and

v. Documenting intervention impact on the SMART Aim, using annotated run charts as applicable.

d. Maintaining or surpassing performance for each Quality Withhold 2022-2023 SMART Aim at the level achieved at the end of the Quality Withhold 2022 – 2023 measurement period for 24 months after the measurement year.

1. *Collaboration*

a. Evidence of the MCO's collaboration with community entities, providers, and other stakeholders as appropriate for the SMART Aim topic; and

b. Evidence of the MCO's collaboration with other health plans as appropriate for collective impact.

2. *Results*

a. Achieving a decrease in the gap between the baseline and the goal by shifting the median, i.e., eight consecutive points between the median and goal, in the desired direction for each SMART Aim or another method specified by ODM;

b. Demonstrating that the interventions have broad impact on the targeted populations by providing data showing the number and percentage of members affected as applicable; and

c. Demonstrating a significant impact on disparate populations (e.g., members with geographic or racial disparities and members with a gap in access to and usage of information and communication technology [the digital divide population]), as applicable.

3. Measurement Year

a. The measurement years for the performance evaluation are CY 2024 and CY 2025.

4. Potential Payout

a. Methods to determine the Quality Withhold payout are described in *Medicaid Managed Care Quality Withhold: Payout Methodology for Measurement Period January 1, 2024 – December 31, 2025*.

3. Quality Withhold 2026 – 2027 (QW26-27)

a. Quality Withhold Payout Determination

i. For the purpose of determining the return of the quality withhold, ODM will use the performance of the MCO's collective efforts to advance ODM's population health strategy using improvement tools such as the Model for Improvement. This includes investing in assessing, designing, and building the necessary internal and external infrastructures for efficient collaborative quality improvement work and developing collaborative partnerships with health systems, clinics, and providers, e.g., Pediatric ACOs, school-based health centers, and academic centers. MCOs must assess the effectiveness of quality improvement collaborations, determine changes needed to enhance care efficiency and accelerate improving health outcomes, and implement these changes (e.g., enhance funding for interventions, increase staffing with appropriate knowledge and skills, improve communications, streamline documentation of work completed, develop a collaboration-wide quality improvement capacity development plan, etc.). MCOs must follow the organization, policies, and procedures specified in the Quality Withhold Governance for 2024 – 2025 document.

b. Quality Improvement Projects

i. In 2025, MCOs must participate and contribute to the development of the QW26-27 Program. This includes conducting foundational research and analysis, staffing appropriately to initiate QW26-27 Projects while QW24-25 Projects are ongoing, establishing needed partnerships in the community, and building appropriate infrastructure to launch the QW26-27 Program on 1/1/2026.

4. Additional Considerations

a. Quality Withhold Payout

i. The Quality Withhold payout is comprised of two components, i.e., the Quality Withhold Retention amount and Quality Withhold Reinvestment amount. The sum of both amounts will equal the total amount withheld for the measurement period.

ii. The Quality Withhold Retention amount will be based on the MCO's collective performance for the measurement period as specified in this appendix and may be retained by the MCO. ODM will pay the Quality Withhold Retention amount to the MCO regardless of the balance of the Quality Withhold Innovation Fund balance.

iii. At ODM's discretion, ODM may pay the Quality Withhold Reinvestment amount to the MCOS. If ODM pays the MCO the Quality Withhold Reinvestment amount to the MCO, the MCO must reinvest the Quality Withhold Reinvestment amount into the Quality Withhold Reinvest Innovation Fund within 30 days of receipt from ODM. Upon request from ODM proof of deposit must be sent to ODM to demonstrate timely payment. If the balance of the Quality Withhold Innovation Fund is greater than $100 million, ODM may not pay the Quality Withhold Reinvestment amount to the MCO.

b. Timing of Quality Withhold Program Determinations

i. ODM will issue results for each Quality Withhold Program determination to the MCO within 12 months of the end of each established report period.

ii. ODM reserves the right to revise the timeframe in which the Quality Withhold Program determination is issued (i.e., the determination may be made more than 12 months after the end of the contract period).

c. Agreement Termination or Non-Renewal

i. Upon termination or non-renewal of this Agreement, the incentive or withhold amount will be retained or awarded by ODM in accordance with Appendix O, MCO Termination and Non-Renewal.

d. Quality Withhold Measures, Requirements, and Measurement Years

i. ODM reserves the right to revise quality withhold measures, standards, benchmarks, requirements, and measurement years, as needed.

ii. Unless otherwise noted, the most recent report or study finalized prior to the end of the contract period will be used in determining the MCO's overall performance level for that contract period.

APPENDIX K – INFORMATION SYSTEMS, CLAIMS, AND DATA

1. Health Information System Requirements

a. Federal Requirements

i. As required by 42 CFR 438.242:

1. The MCO 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 MCO membership terminations for reasons other than loss of Medicaid eligibility.

2. The MCO must comply with section 6504(a) of the Affordable Care Act, which requires that state claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the state to meet the requirements of Section 1903(r)(1)(F) of the Social Security Act.

3. The MCO must collect data on member and provider characteristics and on all services furnished to its members.

4. The MCO must ensure data received from providers is accurate and complete by verifying the accuracy and timeliness of reported data, screening the data for completeness, logic, and consistency, and collecting service information in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies used for ODM's quality improvement and care coordination efforts.

5. The MCO must make all collected data available upon request by ODM or the Centers for Medicare and Medicaid Services (CMS).

b. ODM Access to MCO's Systems and Data

i. The MCO must provide ODM with table level access (remote connectivity) to all data relevant to care provided to members, including but not limited to encounter, care management, and utilization management (UM) information. The MCO must provide ODM the schematic, data dictionary, and other systems documentation necessary for ODM to interpret and use the data.

ii. The MCO (including subcontractors) must provide ODM staff query access to real-time operational data and information relevant to members.

iii. The MCO's system must have the ability to exchange files through secure file transfer protocol (SFTP) with other systems through the state's file transfer protocol (FTP)/SFTP service.

c. MCO Access to ODM Systems and Data

i. MCOs may be provided access to ODM systems and data only after following the processes established pursuant to Appendix A, Paragraph 3, Subparagraph f.

ii. ODM may establish a centralized point of access for all member and provider data. Both aggregate and member-level data may be accessible to all MCEs. This data may only be accessed, used, or disclosed to support collaborative work across the MCEs for population health management and quality improvement efforts.

iii. MCOs use or disclosure of data obtained from ODM is subject to compliance with State and Federal law, and all required administrative, technical, and physical safeguards. See Appendix A, Paragraph 3.

d. Data and Systems Integration

i. The MCO must have an integrated system that allows the different MCO functions to work seamlessly within the MCO.

ii. If the MCO has separate claims processing systems for physical and behavioral health, the MCO must have appropriate front-end routing logic to ensure the provider's claim is seamlessly routed to the correct claims system based upon the provider type, services, and diagnoses. If the MCO receives claims containing both physical and behavioral health services, the MCO must adjudicate both service types without requiring resubmission.

iii. The MCO must collect data from all subcontractors relevant to care of its members and integrate that data into the MCO's systems.

iv. The MCO's system must capture and maintain all ODM-identified data necessary to support business functions.

v. The MCO's system must integrate data with all Ohio Medicaid Enterprise System (OMES) modules (e.g., member module, provider module, fiscal intermediary module), through the systems integrator in real-time and batch (based on data currency needs), to support Ohio Medicaid managed care program.

vi. The MCO's system must integrate with Ohio's Identity and Access Management System, the Innovate Ohio Platform, to provide single sign on services for all authorized users identified by the MCO or ODM.

vii. The MCO's system must use role-based authorization and access to ensure minimal necessary access to data and screens.

viii. The MCO must have the ability to submit, accept, and integrate all data transmission protocols necessary to support the Ohio Medicaid managed care program, including internal and external entities.

ix. The MCO must comply with the population health information system and data requirements in Appendix C, Population Health and Quality.

x. The MCO must comply with the care coordination information system and data requirements in Appendix D, Care Coordination.

xi. The MCO must accept, maintain, and use data received from ODM or the OhioRISE Plan related to behavioral health services provided to members who are enrolled in the OhioRISE Plan. This includes but is not limited to care coordination data, including the name of the member's care coordinator(s) and contact information, assessments, care plans, critical incidents, and admission, discharge, and transfer (ADT) data; prior authorization data; and claims adjudication data. The MCO must use this data to support its responsibilities under this Agreement, including but not limited to ensuring members are receiving necessary services, informing the MCO's population health activities, risk stratification, supporting care coordination activities, and informing quality improvement (QI) activities.

xii. The MCO must provide data to the OhioRISE Plan and/or ODM as directed by ODM. This data may include but is not limited to health risk assessment (HRA) data, other assessment data, risk stratification data, population health data, care coordination data, prior authorization data, admission, discharge, and transfer (ADT) data, and claims data.

xiii. The MCO must accept, maintain, and use pharmacy data received from ODM or the single pharmacy benefit manager (SPBM). This includes but is not limited to real-time access to view targeted member pharmacy data, including claims adjudication and prior authorization data; daily pharmacy claims data; and daily prior authorization data. The MCO must use this data to support its responsibilities under this Agreement, including but not limited to ensuring members are receiving necessary pharmacy services, developing and monitoring medication therapy management (MTM) activities, informing the MCO's population health activities, risk stratification, identifying members in need of care coordination, supporting care coordination activities, and informing QI activities.

xiv. The MCO must provide data to the SPBM and/or ODM as directed by ODM. This data may include but is not limited to HRA data, risk stratification data, population health data, care coordination data, MTM data, claims data, diagnosis codes on claims, medical outpatient drug data, and prior authorization data.

e. General

i. If the MCO has systems and information technology staff and operations supported at the enterprise-level, the MCO must ensure that required information technology changes, fixes, and enhancements are prioritized and resolved in a manner that meets ODM's contractual and performance expectations.

ii. The MCO must conduct thorough end-to-end testing for all new program implementations, system upgrades, software updates, and new or revised data requirements. The MCO must provide a description of system changes and a summary of testing results, including any corresponding mitigation plans to ODM for review and approval prior to implementation.

iii. The MCO's technical security standards must include permission and role-based access mechanisms to monitor for unauthorized access, two-factor authentication, virus protection software, up-to-date security patch installation, encryption protection at the operating system level, and virtual private networks (VPNs) for remote users.

iv. The MCO's systems and user environment must comply with National Institute of Standards and Technology (NIST) 800-53 R4 (or current release) moderate baseline and Minimum Acceptable Risk Standards for Exchanges (MARS-e) 2.0 (or current release) or a similar standard that demonstrates comparable controls by mapping a crosswalk to NIST 800-53 and MARS-e.

v. The MCO's application systems foundation must employ a relational data model in its architecture (RDBMS). The MCO's application systems must support query access using Structure Query Language. The MCO's application systems must support open database connectivity (ODBC) and/or Object Linking and Embedding (OLE).

vi. The MCO must implement updates to national standard code sets as of their effective date. The MCO must implement any other ODM specified updates within 30 calendar days unless otherwise specified by ODM.

vii. The MCO must comply with all relevant federal and state information technology standards, information security standards, and privacy standards.

2. Information Systems Review

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

b. The MCO must support the needs of reviewers.

c. The review will assess the extent to which the MCO is capable of maintaining a health information system, including producing valid encounter data, performance measures, and other data necessary to support quality assessment and improvement, as well as managing the care delivered to its members.

d. The following activities, at a minimum, will be carried out during the review. ODM or its designee will:

i. Review the Information Systems Capabilities Assessment (ISCA) forms, as developed by CMS, which the MCO must complete;

ii. Review the completed ISCA and accompanying documents;

iii. Conduct interviews with MCO staff responsible for completing the ISCA, as well as staff responsible for the MCO's information systems;

iv. Analyze the information obtained through the ISCA, conduct follow-up interviews with MCO staff, and write a statement of findings about the MCO's information system;

v. Assess the ability of the MCO to link data from multiple sources;

vi. Examine MCO processes for data transfers;

vii. If the MCO has a data warehouse, evaluate its structure and reporting capabilities;

viii. Review MCO processes, documentation, and data files to ensure they comply with state and federal specifications for encounter data submissions; and

ix. Assess the claims adjudication process and capabilities of the MCO.

3. Business Continuity and Disaster Recovery

a. The MCO must develop and be continually ready to invoke a comprehensive business continuity and disaster recovery (BC-DR) plan that addresses operations, staff, and systems that support this Agreement.

b. The BC-DR plan must comply with NIST 800-34. https://nvlpubs.nist.gov/nistpubs/Legacy/SP/nistspecialpublication800-34r1.pdf

c. The MCO's BC-DR plan, and any significant updates to the plan, must be submitted to ODM for review 60 calendar days prior to its effective date.

d. The MCO must periodically, but not less than annually, test its BC-DR plan through simulated disasters and lower level failures.

i. As specified in Appendix P, Chart of Deliverables, the MCO must provide a summary of its BC-DR test results (Summary of BC-DR Plan Test Results), including any corrective actions, to ODM within 30 calendar days of receiving the results.

4. Acceptance Testing

a. General

i. Before the MCO may submit production files to ODM, the MCO must conduct acceptance testing of any data electronically submitted to ODM as follows:

1. Whenever the MCO changes the method, preparer, or file layout of the electronic data; and/or

2. When ODM determines that the MCO's data submissions have an error or failure rate of 2% or higher.

b. New or Modified Information System

i. The MCO must include ODM in user acceptance testing and end-to-end integration testing when significant system changes are made that impact the user experience and/or end-to-end data flow. System changes include any of the following:

1. Existing system updates;

2. New system implementations (replacing system or component with another);

3. New infrastructure support systems (replacing an infrastructure component [e.g., SFTP or EDI system]);

4. File format changes; and

5. File transmission protocol changes.

ii. User acceptance testing must include training if there is a perceivable change to workflows or user screens.

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

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

5. Claims Adjudication and Payment Processing Requirements

a. Timely Filing

i. The MCO must accept claims for 365 calendar days from the date of service, as described in OAC rule 5160-1-19. In addition, the MCO must follow the overpaid claims and timely filing exceptions described in the rule.

b. Claims Adjudication

i. The MCO must integrate with the OMES for claims, third party liability (TPL), authorizations, and any other types of data or processes as directed by ODM.

ii. The MCO must electronically accept claims from the OMES and adjudicate all claims to final status (payment or denial) within the timeframes specified in Appendix L, Payment and Financial Performance. The diagram in Exhibit K.1 provides a high-level overview of the claims flow.

iii. All claims forwarded from the OMES to the MCO for processing are to be considered clean as these claims meet the threshold edits applied at the submission of the claim through the EDI and meet the X12/TR3 standard. If the claim forwarded from the OMES to the MCO does not have the necessary documentation to adjudicate the claim, the MCO may suspend the claim until documentation is provided. If system changes are required to properly adjudicate claims, the MCO must notify ODM of the intent to suspend claims for programmatic and/or systems concerns via their compliance mailbox and follow the Claims Payment Systemic Errors requirements to report any potential impact to providers as outlined in this appendix.

iv. If there is information on the provider network management (PNM) system generated provider master file (PMF) or any other supplemental file generated by an ODM system to support claims payment, the MCO must use the PMF or other ODM system generated supplemental file information to adjudicate the claim(s).

v. The MCO must utilize the ODM PNM as the system of record and reconcile claims against the ODM PNM PMF data points as directed by ODM.

vi. The MCO must provide updated claim status demonstrating all claims activity daily to ODM.

vii. The MCO must provide its network providers detailed instructions on claims submission procedures, including information provided by ODM about the role of ODM's OMES.

viii. The MCO must provide out-of-network providers detailed instructions on claims submission procedures, including information provided by ODM about the role of ODM's OMES, within one business day of the earlier of receiving a request from an out-of-network provider or becoming aware that an out-of-network provider has rendered services to a member.

ix. The MCO must notify providers via ODM's OMES, who have submitted claims of claim status (paid, denied, and all claims not in a final paid or denied adjudicated status [hereinafter referred to as "suspended"]) within 30 calendar days of receipt by the MCO or its designee. Such notification may be in the form of a claim payment/remittance advice produced on a routine monthly or more frequent basis.

x. If a provider and/or a provider's clearinghouse submits a Health Insurance Portability and Accountability Act (HIPAA) compliant 276 electronic data interchange (EDI) transaction to the MCO and/or the MCO's clearinghouse via ODM's OMES, the MCO/clearinghouse must respond with a complete HIPAA compliant 277 EDI transaction within the required Council for Affordable Quality Healthcare, Inc. (CAQH) Committee on Operating Rules for Information Exchange (CORE) timeframes with the HIPAA compliant claim status category code(s) and claim status code(s) that will provide information on all denied, paid, or suspended claims to the submitter.

xi. The MCO must accept and use, and must require its providers to use, third party liability (TPL) data maintained by ODM's OMES for the MCO's and provider's TPL activities.

c. Edits

i. The MCO must implement claims edits (e.g., Strategic National Implementation Process [SNIP], National Correct Coding Initiative [NCCI]) at the direction of ODM.

d. Grouping Methodology

i. When the MCO uses a grouping methodology to pay inpatient and/or outpatient hospital claims, or ambulatory surgery center claims, the MCO is expected to use the same grouper software and inpatient only procedure listing (determined by Medicare, 3M, or other grouping product) that ODM uses to process fee-for-service (FFS) claims.

e. Electronic Visit Verification (EVV)

i. The MCO must have foundational knowledge of the Ohio EVV system and processes to issue resolve as needed. The MCO must direct providers, individuals receiving services, and direct care workers to appropriate resources either at the health plan, ODM EVV vendor, or ODM to address provider questions/concerns. The MCO must inform providers of the use of the EVV data collection system and how the data will be utilized by the MCO.

ii. *Applicable Services Subject to EVV Requirements*

1. The MCO must use data collected from the EVV data collection system to validate all claim lines subject to EVV against EVV data (100% review) during the claim adjudication process. EVV validation must be the last step in claims adjudication for the MCO. The MCO must determine which claims lines are to be sent for EVV validation based on Provider Type/Provider Specialty, and service code (and modifier as applicable). The following list of services are subject to EVV validation:

    a. Home Health (HH) Aide;

    b. Nursing RN;

    c. Nursing LPN;

    d. PDN/Independent Nursing;

    e. RN Assessment;

    f. HH Physical Therapy;

    g. HH Occupational Therapy; and

    h. HH Speech Language Pathology.

iii. *EVV Claims Validation*

1. The MCO must inform providers of the outcome of the claim validation review for each claim line. The MCO claim adjudication system shall be flexible to allow the ability to deny payment, as directed by ODM, for EVV claim lines during validation. The MCO Remittance Advice (RA) and/or the 835 transaction (via the Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) are to be used to communicate success or no success of claim line validations.

2. For services that ODM directs as only requiring an informational warn edit:

    a. The MCO must code their claims adjudication system to post ODM directed RARC on a claim line that does not have an EVV visit match. The RARC will be reported on the 835 transaction to inform

providers that the claim has been paid, but future claim payments may be impacted if the provider does not make changes.

3. For services that ODM directs as requiring a denial based on no EVV validation:

    a. The MCO must code their claims adjudication system to post ODM directed denials, and RARC and CARC codes on the claim line that does not have an EVV visit match. The RARC and CARC codes will be reported on the 835 transaction to inform providers of the denial.

iv. *EVV Reporting*

1. The MCO must submit a monthly report of all EVV-related claim lines to ODM in a format specified by ODM, as specified in Appendix P, Chart of Deliverables.

2. The MCO must review the monthly visit report provided by ODM to identify trends, provide outreach and education to providers, and identify potential fraud, waste, or abuse. The MCO must report fraud, waste, and abuse to ODM in accordance with Appendix G, Program Integrity.

3. The MCO must work collaboratively with the EVV vendor to establish connectivity, to conduct system testing, and to adhere to technical specifications until all scenarios are passed and the system is production ready. The MCO must also collaborate with the EVV vendor to implement any system updates or changes as necessary.

4. MCOs must show a 3% monthly average increase in EVV claims matching by June 30, 2025. ODM will use the July 1, 2023 – April 30, 2024 time period as the baseline for meeting this requirement.

f. Systems Audit

i. The MCO and any subcontractor systems must undergo an annual third party audit that confirms that the MCO's systems and environment comply with the NIST 800-53 Rev 4 (or current release) moderate baseline.

ii. The MCO and any subcontractor systems must also utilize a third party to determine compliance with MARS-E 2.0 (or current release) standards.

iii. If the MCO or any subcontractor systems utilizes a cloud hosting provider, the cloud provider must be Fed-RAMP certified or undergo an annual third party audit that certifies compliance with NIST 800-53 Rev 4 (or current version) moderate baseline.

iv. The MCO, and any subcontractors that adjudicate claims, must undergo a System and Organizational Control (SOC) 2 Type II or an alternative privacy and security systems audit that is prior approved by ODM. This audit must be completed prior to implementation and at least annually thereafter.

v. As specified in Appendix P, Chart of Deliverables, the MCO must submit the results of the systems audit (Systems Audit Results), including any corrective action, to ODM within two weeks of receiving the final report.

g. Claims Payment Systemic Errors

i. For the purpose of this appendix, a claims payment systemic error (CPSE) is defined as the MCO's claims adjudication incorrectly underpaying, overpaying, denying, or suspending claims that impact five or more providers.

ii. The MCO must submit the MCO's CPSE report (CPSE Report) to ODM as specified in Appendix P, Chart of Deliverables.

iii. The MCO must submit all communications regarding CPSEs to MedicaidCPSE@medicaid.ohio.gov, unless otherwise directed by ODM.

iv. The MCO must follow all CPSE instructions as directed by ODM, including the CPSE reporting template instructions and guidelines.

v. The MCO must ensure each identified error has a unique error ID to tie each reported line to a specific error the MCO is addressing. For each error, the MCO must provide a specified begin date, and when resolved, a definitive end date. For each CPSE, the following information is required:

1. A detailed description and scope of all active CPSEs;
2. The date the CPSE was first identified;
3. The type(s) of provider(s) impacted;
4. The number of providers impacted;
5. The timeline for fixing the CPSE;
6. The number of claims impacted; and
7. The date of claims adjustments or required provider action.

vi. The MCO must report all CPSEs on a monthly CPSE report posted on the MCO's Ohio Medicaid website.

1. The CPSE report must be public facing for anyone to view.
2. The MCO must post the online CPSE report as specified in Appendix P, Chart of Deliverables, and must label the report to reflect the updated date.
3. The MCO's CPSE online report must include, at a minimum, the following information:
    a. A detailed description and scope of all CPSEs;
    b. The date of first identification;

c. The type(s) of provider(s) impacted;

d. The timeline for fixing the CPSE; and

e. The date of claims adjustments or required provider action.

vii. The MCO must have policies and procedures to identify, communicate, and correct CPSEs. The MCO must keep its CPSE policies and procedures current to reflect the CPSE requirements. Upon request, the MCO must submit its CPSE policies and procedures to ODM for review.

viii. The MCO's CPSE policies and procedures must include, at a minimum:

1. The use of input from internal and/or external sources to identify a CPSE, including but not limited to:

a. User acceptance testing activities;

b. Claims processing activities;

c. Provider complaints/inquiries; and

d. ODM inquiries.

2. The identification of issues impacting smaller provider types (e.g., independent providers);

3. A description of the process, including timelines, to escalate from initial identification to definition of the error;

4. A full description of the root cause analysis conducted when issues or defects are found, and the software development life cycle (SDLC) processes followed, including timelines;

5. The timeframe to re-adjudicate claims, if applicable, or notify providers of an overpayment and the process for providers to dispute those actions in accordance with the requirements of this Agreement; and

6. A description of the process to complete and submit a completed CPSE report monthly to ODM.

h. Non-CPSE Errors

i. The MCO must correct errors in provider payments that do not meet the definition of claims payment systematic errors per this appendix within 30 calendar days from the date of identification of the error.

i. Software Updates

i. The MCO's claims adjudication systems must apply software updates based on a validated risk analysis and no less frequently than quarterly. The MCO must implement major software version releases based on a validated risk analysis and not

more than 180 calendar days from release date. If the MCO maintains its own software, the schedule and description of changes for future updates must be provided to ODM for review.

j. Implementing ODM Rate Changes

i. The MCO must load ODM rate changes into applicable systems by either the rate change implementation date or within 20 calendar days of being notified by ODM of the change, whichever date is later. The effective date of the rate change must be the date specified by ODM, regardless of when the MCO's system(s) are updated. If necessary, the MCO must back date the effective date and reprocess claims to ensure any claim received after the specified date of the rate change is adjudicated accurately. If the MCO is unable to load rate changes timely, the MCO must report the issue on the CPSE report. Reporting the inability to load rate changes timely on the CPSE report does not limit ODM from taking compliance actions against the MCO in accordance with Appendix N, Compliance Actions, for the MCO's failure to load rate changes on a timely basis.

k. Processing Delays

i. The MCO must not engage in any practice that unfairly or unnecessarily delays the processing or payment of any claim for services to a member.

l. Notice to Providers

i. The MCO must provide a 30 calendar day advance notice to providers of any new edits or system changes related to claims adjudication or payments processing.

ii. The MCO must provide a notice of intent to recover an overpayment in accordance with Appendix G, Program Integrity.

6. Electronic Data Interchange

a. The MCO's technology strategy and systems must have the capability to accept and transmit real-time transactions as directed by ODM.

b. The MCO must comply with all applicable provisions of HIPAA, including EDI standards for code sets and the following electronic transactions:

i. ASC X12 837 – Health care claims (institutional, professional, and dental);

ii. ASC X12 837 Post-adjudicated claims data reporting (PACDR) – Health care claims (institutional, professional, and dental);

iii. ASC X12 270/271 – Eligibility and benefit verification and response;

iv. ASC X12 276/277 – Health care claim status request and response;

v. ASC X12 Unsolicited 277 Claim Status transaction and/or the 277 Claim Acknowledgement (CA);

vi. ASC X12 269 – Health care benefit coordination verification;

vii. ASC X12 274 – Health care provider information/directory;

viii. ASC X12 275 – Patient information;

ix. ASC X12 278 – Authorization/referral request and response;

x. ASC X12 824 – Application advice; and

xi. ASC X12 835 – Health care payment and remittance status (or electronic funds transfer).

c. The MCO must implement EDI transactions in conformance with the appropriate version of the transaction implementation guide, as specified by applicable federal requirements.

d. The MCO must be able to accept, send, and process multiple versions of X12 transactions concurrently.

e. The MCO 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 Companion Guides issued by ODM:

i. ASC X12 837 – Health care claims (institutional, professional, and dental);

ii. SC X12 270/271 – Eligibility and benefit verification and response;

iii. ASC X12 276/277 – Health care claim status request and response;

iv. ASC X12 278 – Authorization/referral request and response;

v. ASC X12 275 – Patient information;

vi. ASC X12 820 – Payroll deducted and other group premium payment for insurance products; and

vii. ASC X12 834 – Benefit enrollment and maintenance.

f. The MCO must comply with the HIPAA-mandated EDI transaction standards and code sets as set forth in federal requirements. The MCO must keep codes up to date and meet all implementation dates as directed by ODM.

g. The capacity of the MCO and/or applicable trading partners and business associates to electronically conduct claims processing and related transactions must be demonstrated to the satisfaction of ODM.

h. The MCO must complete and submit to ODM an EDI trading partner agreement by the timeframe and in a format specified by ODM.

i. If the MCO fails to identify an error on its behalf with EDI transactions within two business days and/or correct it within three months, it may be liable for the cost incurred by ODM for additional transaction fees if it must correct and retransmit EDI transactions due to the error at any time thereafter.

j. The MCO must connect a production mirror to the EDI CERT Region by March 1, 2024. The EDI CERT region will be used to add new trading partners and to allow trading partners to test in accordance with OAC rule 5160-1-20 requirements before they are authorized for production (PROD). The MCO must collaborate with ODM for adequate testing and validation for new transactions, policy changes, and other changes before running in PROD.

7. Encounter Data Submission Requirements

a. The MCO must collect data on services furnished to members through a claims system and must report encounter data to ODM. The MCO must submit encounter electronically to ODM as specified in this appendix.

b. Information concerning the proper submission of electronic data interchange (EDI) encounter transactions is available on ODM's website. ODM's website contains Encounter Data Companion Guides for the Managed Care 837 dental, professional, and institutional transactions. Additional Companion Guides for transactions that should be used in conjunction with encounters, including the U277 Unsolicited Claim/Encounter Status Notifications, the 824 Application Advice, and the TA1 Transmission Acknowledgement are also available on ODM's website. The MCO must use the Encounter Data Companion Guides in conjunction with the X12 Implementation Guides for EDI transactions.

c. The MCO must submit a test file in the ODM-specified medium in the required formats as directed by ODM. Test files must be submitted, reviewed, and approved by ODM prior to the MCO submitting production encounter data files.

d. For subcontracted payment arrangements in which the subcontractor directly pays particular claims (i.e., delegated arrangements in which the delegate is responsible for paying claims on behalf of the MCO to providers), the MCO must submit encounters that include the amounts paid by the subcontractor to the provider and include claim-level detailed information.

e. For subcapitated payment arrangements (i.e., the vendor/provider is paid a fixed amount regardless of whether or what services are rendered), the MCO must shadow price the encounter and submit encounters that include the amount that would have been paid if the vendor/provider was not capitated and include claim-level detailed information.

f. The MCO must submit encounters no later than seven calendar days from completion of the claim (i.e., remittance advice generated). The MCO must submit encounters for capitated providers within seven calendar days of receipt of the encounter.

g. As specified in Appendix G, Program Integrity, in accordance with 42 CFR 438.604 and 42 CFR 438.606, the MCO must submit a certification letter with the submission of an encounter data file.

h. The MCO must submit valid encounter submissions that include the application of specific edits, including checking for member eligibility, MCO enrollment, valid current procedural terminology (CPT) codes, cross field editing, and include valid line-level detail with meaningful claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) accurately reflecting the data submitted to the provider indicating final status of adjudication. ODM reserves the right to direct the MCO's editing and payment.

i. The MCO must submit valid claim and line-level denials that reflect the data submitted on the claim and accurately reflect the adjudication results.

j. The MCO must submit encounters for all claim activities, including instances when the MCO applies adjustments at the individual line level or in a mass adjustment update. Encounter submissions must reflect all claims activity.

k. The MCO must have software edits that check for and prevent duplicates on encounter data submissions.

l. The MCO must follow the 837 PACDR standards for dental, professional, and institutional encounter data submissions, including allowed amount and paid amount in accordance with 42 CFR 438.242(c)(3).

m. The MCO must have processes and staffing to ensure that if ODM discovers errors or a conflict with a previously adjudicated encounter or claim, the MCO is able to adjust or void the encounter within the specified number of days as directed by ODM.

n. The MCO must comply with the encounter data quality measures as calculated by ODM. Information concerning ODM's encounter data quality measures, including the methodology, is available in the Methodology for Encounter Data Quality Measures document located on the ODM website. ODM reserves the right to revise this document as needed.

o. Exceptions to any of the requirements in this section must be prior approved by ODM.

8. Non-Claims Data Submission Requirements

a. All data on any services provided to members that are not reflected as claims or encounters will be submitted through the Managed Care Entity Non-Claims Reporting Template as specified in Appendix P, Chart of Deliverables. This includes but is not limited to non-emergency transportation and other value -added or additional services.

9. Electronic Health Records

a. The MCO must encourage, support, and facilitate its network providers' adoption and effective use of electronic health records (EHRs), including for population health and quality improvement.

b. The MCO must identify and track internally which network providers have or have not adopted EHRs and how effectively they use EHRs, including for population health and quality improvement.

10. Health Information Exchanges

a. The MCO must participate with both of Ohio's health information exchanges (HIEs) and be capable of exchanging protected health information, connecting to inpatient and ambulatory electronic health records, connecting to care coordination information technology system records, and supporting secure messaging or electronic querying between providers, patients, and the MCO. This must include but is not limited to using the

HIEs for admission, discharge, and transfer (ADT) data and closing referral loops for social determinants of health (SDOH).

b. The MCO must support and facilitate its network providers' exchange of data with Ohio's two HIEs.

c. The MCO must require its network hospitals to provide admission, discharge, and transfer (ADT) data to both HIEs.

d. As specified in Appendix P, Chart of Deliverables, the MCO must submit an annual report (Network Provider HIE Participation Report) to ODM providing the number and percentage of network providers, by provider type, connected to one or both HIEs and the type of participation.

e. As specified in Appendix P, Chart of Deliverables, the MCO must submit to ODM an annual plan to support use of HIEs (HIE Provider Support Plan), including, but not limited to, collaborative MCO efforts that facilitate and support consistent and accurate data submission from health care providers to the HIEs.

11. Interoperability

a. In accordance with 42 CFR 438.242, the MCO must implement and maintain an application programming interface (API) that permits third party applications to retrieve, with the approval and at the direction of a member, member health information and data maintained by the MCO.

b. In accordance with 42 CFR 438.62, the MCO must implement a process for the electronic exchange of the United States core data for interoperability (USCDI) data classes and elements with other MCOs, the SPBM, the OhioRISE Plan, ODM, and any other payer designated by the member.

c. The MCO must implement a process for the electronic exchange of the USCDI data classes and elements with care coordination entities and providers serving the member.

12. Artificial Intelligence and Machine Learning

a. All systems using Artificial Intelligence or Machine Learning technology must incorporate core principles of fairness, accountability, security and privacy, transparency, and human centeredness.

i. *Fairness*

1. Performance of systems and tools must be assessed for potential bias or disparate impact prior to implementation.

ii. *Accountability*

1. Systems and tools must be subject to governance, including a human in the loop or human on the loop, as appropriate.

iii. *Security and Privacy*

1. Systems and tools must comply with all legal, regulatory, and other relevant portions of this agreement as it relates to information security and privacy. Member PHI and PII shall not be provided to unconstrained tools or systems, publicly accessible service or training models.

iv. *Transparency*

1. Systems and tools must be explainable in their operation and output.

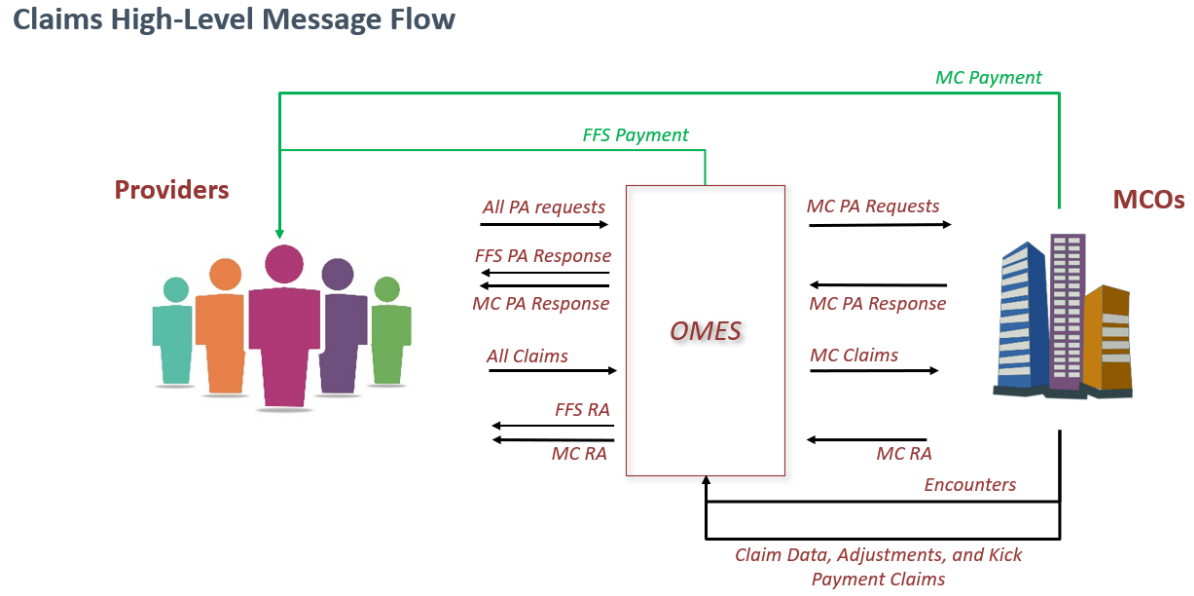
v. *Human Centeredness*

1. Systems and tools must prioritize member needs, values, and capabilities.

b. An up-to-date inventory of Artificial Intelligence or Machine Learning models and tools must be maintained by the plan and provided to ODM upon request.

c. ODM may provide additional requirements regarding specific uses of AI tools or software.

Exhibit K.1 Claims High-Level Message Flow



APPENDIX L – PAYMENT AND FINANCIAL PERFORMANCE

1. Monthly Premium Payment

a. ODM will remit payment to the MCO via an electronic funds transfer (EFT), or at the discretion of ODM, by paper warrant.

b. ODM will confirm all premium payments paid to the MCO during the month via a monthly remittance advice (RA).

c. ODM will provide a record of each recipient detail level payment via Health Insurance Portability and Accountability Act (HIPAA) compliant 820 transactions.

2. Delivery (Childbirth) Payments for Modified Adjusted Gross Income Members

a. ODM will reimburse the MCO for Modified Adjusted Gross Income (MAGI) member childbirth deliveries using the methodology outlined in the *MAGI Delivery Payment Reporting Procedures and Specifications for ODM Managed Care Organizations* document.

b. The delivery payment represents the facility and professional service costs associated with the delivery event, postpartum care rendered in the hospital immediately following the delivery event, and the additional costs associated with multiple birth events; no prenatal or neonatal experience is included in the delivery payment.

3. Institution for Mental Disease Stays

a. If a member age 21 through 64 has an Institution for Mental Disease (IMD) stay exceeding 15 calendar days per calendar month, ODM will recover a percentage of the MCO's monthly capitation payment based on the total number of calendar days the member was in the IMD.

4. Submission of Financial Statements

a. National Association of Insurance Commissioners Financial Statements

i. As specified in Appendix P, Chart of Deliverables, the MCO must submit quarterly and annual National Association of Insurance Commissioners (NAIC) financial statements (NAIC Quarterly Financial Statement and NAIC Annual Financial Statement) to ODM.

ii. The NAIC financial statements must include all required filings, schedules, exhibits, and components as stated in the NAIC health statement instructions.

iii. The MCO must provide ODM with an electronic copy of the NAIC statements in the NAIC-approved format.

iv. The MCO must submit NAIC financial statements to ODM even if the Ohio Department of Insurance (ODI) does not require the MCO to submit these statements to ODI.

b. Annual Audit Report

i. As specified in Appendix P, Chart of Deliverables, the MCO must submit a copy of its annual audit report (Annual Audit Report) required by ODI in accordance with ORC section 1751.321.

c. NAIC/Cost Report Reconciliation

i. As specified in Appendix P, Chart of Deliverables, the MCO must submit an annual NAIC/Cost Report Reconciliation.

d. Health Insuring Corporation Tax

i. As specified in Appendix P, Chart of Deliverables, the MCO must submit quarterly Health Insuring Corporation (HIC) tax reports (HIC Tax Report) to ODM.

e. Other Financial Reports and Information

i. The MCO must maintain a system to evaluate and monitor the financial viability of all risk bearing subcontractors, FDRs, or network providers, including but not limited to accountable care organizations (ACOs), health maintenance organizations (HMOs), independent physician/provider associations (IPAs), medical groups, and federally qualified health centers (FQHCs).

ii. The MCO must provide any financial reports and information as deemed necessary by ODM, in a format determined by ODM, to properly monitor the financial condition of the MCO, its subcontractors, FDRs, and network providers.

5. Financial Performance Measures and Standards

a. The MCO must comply with the following financial performance measures and standards.

i. *Current Ratio*

1. The MCO's current ratio, calculated in accordance with the *ODM Methods for Financial Performance Measures*, must not fall below 1.00.

ii. *Medical Loss Ratio*

1. As specified in Appendix P, Chart of Deliverables, the MCO must submit an annual medical loss ratio (MLR) reporting tool and documentation (MLR Reporting Tool and Documentation).

2. The MCO's MLR, calculated in accordance with 42 CFR 438.8 and ODM directives, must not fall below 86%.

iii. *Administrative Expense Ratio*

1. The MCO's administrative expense ratio, calculated in accordance with the *ODM Methods for Financial Performance Measures*, must not exceed 15%.

iv. *Defensive Interval*

1. The MCO's defensive interval, calculated in accordance with the *ODM Methods for Financial Performance Measures*, must not fall below 30 calendar days.

6. Insurance Requirements

a. General

i. The MCO must procure and maintain, for the duration of this Agreement, insurance against claims for injuries to persons or damages to property that may arise from or in connection with the MCO's performance under this Agreement.

ii. The MCO must procure and maintain, for the duration of this Agreement, insurance for claims arising out of its performance under this Agreement, including but not limited to loss, damage, theft, or other misuse of data, infringement of intellectual property, invasion of privacy, and breach of data.

b. Minimum Scope and Limit of Insurance

i. The MCO's coverage must be at least as broad as:

1. Commercial General Liability (CGL): written on an "occurrence" basis, including products, completed operations, property damage, bodily injury, and personal and advertising injury with limits no less than $1,000,000 per occurrence. If a general aggregate limit applies, either the general aggregate limit must apply separately to this Agreement or the general aggregate limit must be twice the required occurrence limit. Defense costs must be outside the policy limit.

2. Automobile Liability: covering Code 1 (any auto), or if the MCO has no owned autos, Code 8 (hired) and 9 (non-owned), with a limit no less than $1,000,000 per accident for bodily injury and property damage.

3. Workers' Compensation insurance: as required by the state of Ohio, or the state in which the work will be performed, that meets statutory limits, and employer's liability insurance with a limit of no less than $1,000,000 per accident for bodily injury or disease. If the MCO is a sole proprietor, partnership, or has no statutory requirement for workers' compensation, the MCO must provide a letter stating that it is exempt and agreeing to hold the state of Ohio harmless from loss or liability for such.

4. Professional Liability insurance: covering all staff with a minimum limit of $1,000,000 per incident and a minimum aggregate of $3,000,000. If the MCO's policy is written on a "claims made" basis, the MCO must provide ODM with proof of continuous coverage at the time the policy is renewed. If for any reason the policy expires, or coverage is terminated, the MCO must purchase and maintain "tail" coverage through the applicable statute of limitations.

5. Technology Professional Liability (Errors and Omissions) insurance: appropriate to the MCO's professional services provided under this Agreement, with limits not less than $2,000,000 per occurrence or claim, $2,000,000 aggregate. Coverage must be sufficiently broad to respond to the duties and obligations as is undertaken by the MCO in this Agreement and must cover all applicable MCO personnel who perform professional services under this Agreement.

6. Cyber Liability (first and third party): coverage, with limits not less than $5,000,000 per claim, $10,000,000 aggregate, must be sufficiently broad to respond to the duties and obligations as is undertaken by the MCO in this Agreement and must include but not be limited to claims involving infringement of intellectual property, including but not limited to infringement of copyright, trademark, trade dress, invasion of privacy violations, information theft, damage to or destruction of electronic information, release of private information, alteration of electronic information, extortion, and network security. The coverage must provide for breach response costs, as well as regulatory fines and penalties and credit monitoring expenses, with limits sufficient to respond to these obligations.

ii. The insurance obligations under this Agreement are the minimum insurance coverage requirements and/or limits for this Agreement. Any insurance proceeds in excess of or broader than the minimum required coverage and/or minimum required limits, which are applicable to a given loss, must be available to ODM.

iii. No representation is made that the minimum insurance requirements of this Agreement are sufficient to cover the obligations of the MCO under this Agreement.

c. Required Provisions

i. The MCO's insurance policies must contain, or be endorsed to contain, the following provisions:

1. *Additional Insured Status*

a. Except for Workers' Compensation and Professional Liability insurance, the state of Ohio, its officers, officials, and employees must be covered as additional insureds with respect to liability arising out of work or operations performed by or on behalf of the MCO under this Agreement, including materials, parts, or equipment furnished in connection with such work or operations.

b. Coverage can be provided in the form of an endorsement to the MCO's insurance.

7. Primary Coverage

a. For any claims related to this Agreement, the MCO's insurance coverage must be primary insurance. Any insurance or self-insurance maintained by the state of Ohio, its officers,

officials, and employees must be in excess of the MCO's insurance and must not contribute with it.

8. Umbrella or Excess Insurance Policies

a. The MCO may use umbrella or excess commercial liability policies in combination with primary policies to satisfy the limit requirements above. Such umbrella or excess commercial liability policies must apply without any gaps in the limits of coverage and be at least as broad as and follow the form of the underlying primary coverage required above.

a. Notice of Cancellation

i. The MCO must provide ODM with a written notice of cancellation or material change to any insurance policy required above 30 calendar days in advance, except for non-payment cancellation.

ii. Material change is defined as any change to the insurance limits, terms, or conditions that would limit or alter ODM's available recovery under any of the policies required above.

iii. A lapse in any required insurance coverage during this Agreement will be a breach of this Agreement.

b. Waiver of Subrogation

i. The MCO must grant to the state of Ohio a waiver of any right to subrogation which any insurer of the MCO may acquire against the state of Ohio by virtue of the payment of any loss under such insurance.

ii. The MCO must obtain any endorsement necessary to affect this waiver of subrogation; however, the waiver of subrogation provision applies regardless of whether or not the state of Ohio has received a waiver of subrogation endorsement from the insurer.

c. Deductibles and Self-Insured Retentions

i. Deductibles and self-insured retentions must be declared to and approved by ODM. ODM may require the MCO to provide proof of ability to pay losses and related investigations, claims administration, and defense expenses within the retention. The policy language must provide, or be endorsed to provide, that the deductible or self-insured retention may be satisfied by either the named insured or ODM.

d. Claims Made Policies

i. If any of the required policies provide coverage on a claims-made basis:

1. The retroactive date must be shown and must be before the date of this Agreement or the beginning of performance under this Agreement.

2. Insurance must be maintained, and evidence of insurance must be provided for at least five years after completion of this Agreement.

3. If coverage is canceled or non-renewed, and not replaced with another claims-made policy form with a retroactive date prior to effective date of this Agreement, the MCO must purchase "extended reporting'' coverage for a minimum of five years after completion of performance under this Agreement. The discovery period must be active during the extended reporting period.

e. Verification of Coverage

i. The MCO must furnish ODM with original certificates and amendatory endorsements or copies of the applicable policy language effecting coverage required by this section.

ii. All certificates and endorsements must be received and approved by ODM before work commences under this Agreement. However, failure to obtain the required documents prior to the work beginning will not waive the MCO's obligation to provide them.

iii. ODM reserves the right to require complete, certified copies of all required insurance policies, including endorsements required by this section, at any time.

f. Subcontractors

i. The MCO must require and verify that all subcontractors maintain insurance meeting all the requirements stated herein, and the MCO must ensure that ODM is an additional insured on insurance required from subcontractors.

g. Special Risks or Circumstances

i. ODM reserves the right to modify these requirements, including limits, based on the nature of the risk, prior experience, insurer, coverage, or other special circumstances.

9. Reinsurance Requirements

a. General

i. The MCO must carry reinsurance coverage from a licensed commercial carrier to protect against catastrophic inpatient-related medical expenses incurred by members.

ii. To the extent that the risk for inpatient-related medical expenses is transferred to a subcontractor, the MCO must provide proof of reinsurance coverage for that subcontractor or FDR.

iii. The MCO's reinsurance coverage must remain in force during the term of this Agreement and must contain adequate provisions for contract extensions.

iv. In the event of termination of the reinsurance agreement due to insolvency of the MCO or the reinsurance carrier, the MCO must be fully responsible for all pending or unpaid claims, and any reinsurance agreements that cover expenses to be paid for

continued benefits in the event of insolvency must include Medicaid members as a covered class.

b. Deductible and Coverage

i. The MCO's annual deductible or retention amount for such insurance must be specified in the reinsurance agreement and must not exceed $100,000, unless ODM has provided the MCO with prior approval in writing for a higher deductible amount or alternate reinsurance arrangement. Except for transplant services, the MCO's reinsurance must cover, at a minimum, 80% of inpatient costs incurred by one member in one year in excess of $100,000, unless ODM has provided the MCO with prior approval in writing for a higher deductible amount or alternate reinsurance arrangement. The MCO may request a higher deductible amount and/or that the reinsurance cover less than 80% of inpatient costs in excess of the deductible amount. If the MCO has less than one year of Ohio Medicaid managed care contracting experience, the MCO must demonstrate sufficient capital resources, as determined by ODM.

c. Transplant Services

i. For transplant services, the MCO's reinsurance must cover, at a minimum, 50% of inpatient transplant related costs incurred by one member in one year, in excess of $100,000, unless ODM has provided the MCO with prior approval in writing for a higher deductible amount or alternate reinsurance arrangement. The MCO may request a higher deductible amount and/or that the reinsurance cover less than 50% of inpatient costs in excess of the deductible amount. If the MCO has less than one year of Ohio Medicaid managed care contracting experience, the MCO must demonstrate sufficient capital resources, as determined by ODM.

d. Reinsurance Documentation Requirements

i. In determining whether or not a change in reinsurance is required or a request for alternate reinsurance requirements will be approved, ODM may consider:

1. Whether the MCO has sufficient reserves available to pay unexpected claims;

2. The MCO's history in complying with financial indicators as specified in this appendix;

3. The number of members covered by the MCO;

4. The length of time the MCO has been covering Medicaid or other members on a full risk basis;

5. A risk-based capital ratio greater than 2.5 or higher calculated from the last annual ODI financial statement; and/or

6. A scatter diagram or bar graph from the last calendar year that shows the number of reinsurance claims that exceeded the current reinsurance

deductible graph/chart showing the claims history for reinsurance above the previously approved deductible from the last calendar year.

e. ODM Notification of Claims

i. If directed by ODM, the MCO must provide documentation specifying the dates of admission, diagnoses, and estimates of the total claims incurred for all Medicaid members for which reinsurance claims have been submitted.

f. Submission of Reinsurance Agreements to ODM

i. The MCO must submit fully executed reinsurance agreements to ODM prior to the effective date of this Agreement.

ii. The MCO must submit any proposed changes or modifications to a reinsurance agreement to ODM in writing for review and approval 30 calendar days prior to the intended effective date and must include the complete and exact text of the proposed change. The MCO must provide copies of new or modified reinsurance agreements to ODM within 30 calendar days of execution.

10. Prompt Pay Requirements

a. Standard

i. In accordance with 42 CFR 447.46 and this Agreement, except if the MCO and its network provider has established an alternative payment schedule mutually agreed upon and described in the provider contract, the MCO must:

1. Pay or deny 90% of all submitted clean claims within 21 calendar days of the date of receipt of the claim;

2. Pay or deny 99% of clean claims within 60 calendar days of the date of receipt of the claim; and

3. Pay or deny 100% of all claims within 90 calendar days of receipt of the claim.

b. Separate Measurement

i. The MCO must measure and comply with the prompt payment standards by the claim types specified below:

1. Nursing facility claims;

2. Behavioral health claims; and

3. All other claim types (excluding nursing facility and behavioral health claims).

c. Application

i. The MCO must comply with the prompt pay requirement for all claims, including both network and out-of-network providers.

d. Reporting

i. As specified in Appendix P, Chart of Deliverables, the MCO must submit quarterly prompt pay reports (Prompt Pay Report) to ODM.

11. Physician Incentive Plan Requirements

a. If the MCO operates a physician incentive plan, it must operate the plan in accordance with 42 CFR 438.3(i), 42 CFR 422.208, and 42 CFR 422.210.

b. In accordance with 42 CFR 422.208, if the MCO operates a physician incentive plan, no specific payment must be made directly or indirectly under the physician incentive plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

c. In accordance with 42 CFR 422.208, if the MCO's physician incentive plan places a physician or physician group at substantial financial risk for services that the physician or physician group does not furnish itself, the MCO must ensure all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection.

d. In accordance with 42 CFR 422.210, the MCO must provide assurance satisfactory to ODM that the requirements of 42 CFR 422.208 are met. In addition, the MCO must provide additional documentation and information about its physician incentive plans to ODM upon request.

e. In accordance with 42 CFR 428.10 and 42 CFR 422.210, and as specified by this Agreement, upon request by a member, and no later than 14 calendar days after the request, the MCO must provide the following information to the member:

i. Whether the MCO uses a physician incentive plan that affects the use of referral services;

ii. The type of incentive arrangement; and

iii. Whether stop-loss protection is provided.

f. Beginning with the rating period of January 1, 2026, in accordance with 42 CFR 438.3(i), the MCO’s incentive payment contract with network providers must include the following elements:

i. Have a defined performance period that can be tied to the applicable MLR reporting periods;

ii. Be signed and dated by all appropriate parties before the commencement of the applicable performance period;

iii. Include clearly defined, objectively measurable and well-documented clinical or quality improvement standards that the provider must meet to receive the incentive payment; and

iv. Specify a dollar amount or a percentage of a verifiable dollar amount that can be linked to successful completion of the metrics defined in the incentive payment contract, including date of payment.

v. The MCO must, on an annual basis, maintain a list of all incentive payments arrangements reported in the MLR numerator for each performance period. Upon request, the MCO must make this annual list and incentive payment contracts available to ODM.

12. Third Party Liability Requirements

a. The MCO must comply with OAC rule 5160-26-09.1 related to tort recovery, coordination of benefits, and reporting to ODM.

b. Pursuant to OAC rule 5160-26-09.1, the MCO must notify ODM of requests for information and provide ODM copies of information released pursuant to a tort action.

c. In performing its third party liability (TPL) responsibilities, the MCO must accept and use ODM's TPL information as specified in Appendix K, Information Systems, Claims, and Data, of this Agreement.

d. If a member has third party insurance through a commercial payer (third party payer), the MCO must help the member find a provider that is a network provider for both the MCO and the third party payer or cover the coordination of benefits (COB) portion of the claim as if the provider were an MCO network provider. If the member uses an MCO network provider that is out-of-network with the third party payer, the MCO must follow COB procedures outlined in OAC rule 5160-26-09.1 and pay the claim if there is a valid reason for non-payment by the third party payer.

e. The MCO must coordinate with its coordination of benefits (COB)/third party liability (TPL) vendor to ensure provider recoupments are not taken back by both the MCO and its COB/TPL vendor resulting in a loss for the provider.

f. As specified in Appendix P, Chart of Deliverables, the MCO must provide ODM with TPL information, including a change file based on reconciliation with ODM's data (Third Party Liability Data File).

13. Submission of Cost Reports

a. As specified in Appendix P, Chart of Deliverables, the MCO must submit quarterly and annual cost reports (Quarterly Cost Report and Annual Cost Report) using the cost report template provided by ODM. ODM may make modifications to the cost report template that the MCO must use at any time.

b. The MCO must complete the cost reports in accordance with this Agreement and the cost report instructions provided by ODM.

c. The MCO must submit the cost reports in accordance with the timeframes specified by ODM in the cost report instructions.

d. The MCO must revise its cost reports in accordance with the observation log prepared by ODM's actuary and/or ODM instructions. The MCO must address and submit responses to all comments from either ODM or ODM's actuary within the timeframe specified by ODM.

14. Sharing Data with ODM's Actuary

a. Upon ODM's request, the MCO must share data with ODM's actuary. ODM represents and warrants that a Business Associate Agreement that complies with HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH), and the implementing federal regulations under both Acts, has been executed by ODM's actuary, is currently in effect, and will remain in effect for the term of this Agreement.

15. Notification of Regulatory Action

a. If the MCO is notified by ODI of proposed or implemented regulatory action, the MCO must report such notification and the nature of the action to ODM no later than one business day after receipt from ODI. Upon ODM's request, the MCO must provide any additional information as necessary to ensure continued satisfaction of the requirements of this Agreement. The MCO may request that information related to such actions be considered proprietary in accordance with Article VII of the Baseline Provider Agreement.

APPENDIX M – RATE METHODOLOGY

MILLIMAN REPORT

Calendar Year 2025 Medicaid Managed Care Provider Agreement Rate Summary

January 1, 2025 through December 31, 2025

Ohio Department of Medicaid

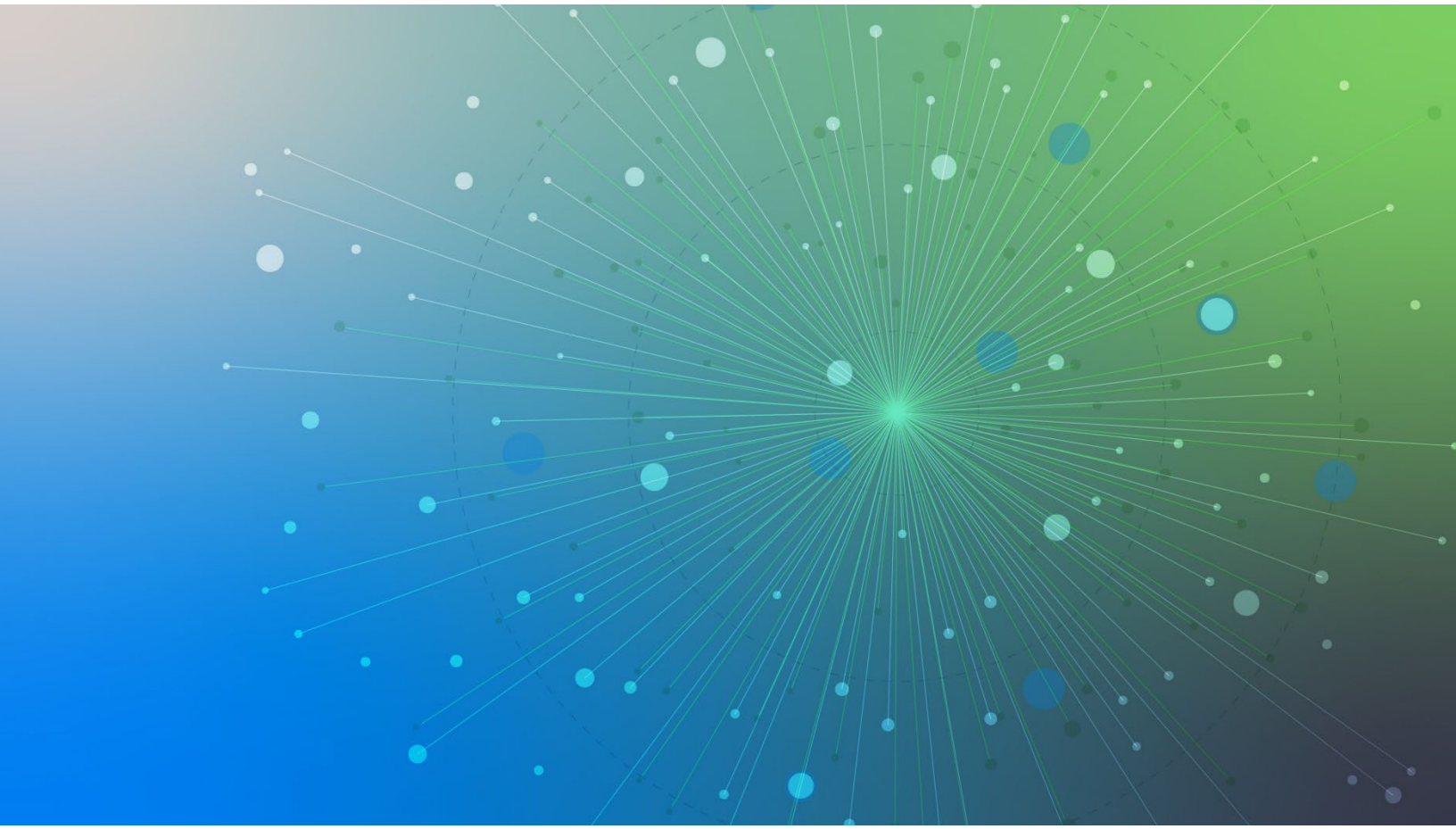
December 20, 2024

Jason A. Clarkson, FSA, MAAA, Principal and Consulting Actuary

Tyler J. Schulze, FSA, MAAA, Senior Consulting Actuary

Suraj M. Datta, FSA, MAAA, Consulting Actuary

Seth D. Kruse, ASA, MAAA, Consulting Actuary



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APPENDIX 1: RATE CHANGE SUMMARIES

Introduction & Executive Summary

This document is an abridged version of the file titled "CY 2025 Medicaid Managed Care Rate Certification" dated December 18, 2024. Please refer to the certification report for a complete version of the January 2025 Medicaid Managed Care capitation rate development documentation.

BACKGROUND

Milliman, Inc. (Milliman) has been retained by the Ohio Department of Medicaid (ODM) to provide actuarial and consulting services related to the development of capitation rates for its Medicaid Managed Care Program (MMC) effective January 1, 2025 through December 31, 2025.

This report provides documentation of the development of the actuarially sound capitation rates.

Section I. Medicaid managed care rates

1. GENERAL INFORMATION

This section provides information listed under the General Information section of CMS guide, Section I.

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

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

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

- Actuarial standards of practice (ASOPs) applicable to Medicaid managed care rate setting which have been enacted as of the capitation rate certification date, including: ASOP 1 (Introductory Actuarial Standard of Practice); ASOP 5 (Incurred Health and Disability Claims); ASOP 12 (Risk Classification (for All Practice Areas)); ASOP 23 (Data Quality); ASOP 25 (Credibility Procedures); ASOP 41 (Actuarial Communications); ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies); ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification); and ASOP 56 (Modeling).
- Actuarial soundness and rate development requirements in the Medicaid and CHIP Managed Care Final Rule (CMS 2439-F).
- The 2024-2025 Medicaid Managed Care Rate Development Guide published by CMS.
- Throughout this document and consistent with the requirements under 42 CFR 438.4(a), the term "actuarially sound" will be defined as in ASOP 49:

  "Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes."[1]

[1] http://www.actuarialstandardsboard.org/asops/medicaid-managed-care-capitation-rate-development-and-certification/

A. RATE DEVELOPMENT STANDARDS

I. RATING PERIOD

The capitation rates are effective for a 12-month rating period from January 1, 2025 through December 31, 2025.

II. REQUIRED ELEMENTS

(a) Program information

(i) Managed Care program

These rates were developed for the State of Ohio's MMC program.

Under this program, comprehensive services are provided on a statewide basis. The program includes seven rating regions, with each MCO expected to operate in each region. ODM began enrolling the Modified Adjusted Gross Income (MAGI, formerly Covered Families and Children) and Adult Aged, Blind, and Disabled (ABD 21+) populations into mandatory managed care beginning in July 2006. The Disabled Children (ABD <21) population began mandatory enrollment into managed care on July 1, 2013. The ABD <21 and ABD 21+ populations include beneficiaries receiving Supplemental Security Income (SSI) and the Breast and Cervical Cancer Project (BCCP) population that are non-dual and non-institutional. The Expansion population, also known as the 'Group 8', 'Extension', or 'MAGI Expansion Adult' population, began mandatory enrollment into managed care in January 2014, coinciding with the Affordable Care Act (ACA) Medicaid expansion. Effective January 1, 2017, the Adoption and Foster Kids (AFK) population (i.e., children in custody) began enrolling in mandatory managed care.

Benefits covered under the MMC program are comprehensive in nature, except for pharmacy services and OhioRISE-covered behavioral health services for a subset of children. A large portion of pharmacy services are covered under the single pharmacy benefit manager (SPBM). This includes both retail pharmacy and professional claims dispensed via a pharmacy provider (provider type 70), except for medical and surgical supplies, equipment, home health / infusion services, durable medical equipment, and nursing services. Many long-term care services are covered on a fee-for-service basis for the MAGI, ABD, and AFK populations.

III. DIFFERENCES AMONG CAPITATION RATES

Any proposed differences among capitation rates according to covered populations are based on valid rate development standards and are not based on the rate of federal financial participation (FFP) associated with the covered populations.

IV. CROSS-SUBSIDIZATION OF RATE CELL PAYMENT

The capitation rates were developed at the rate cell level and neither cross-subsidized nor are cross-subsidized by payments from any other rate cell.

V. EFFECTIVE DATES

To the best of our knowledge, the effective dates of changes to the MMC program are consistent with the assumptions used in the development of the certified CY 2025 capitation rates.

VI. MINIMUM MEDICAL LOSS RATIO

The capitation rates were developed such that the MCOs are reasonably expected to achieve a medical loss ratio greater than 85 percent, which includes provisions for non-benefit costs that are appropriate and attainable. ODM's provider agreement indicates that ODM will perform medical loss ratio (MLR) calculations for the MMC program. ODM has implemented a minimum MLR requirement of 86% for the MMC program. ODM will require remittance in the event an MCO reports a MLR below 86%.

VII. COVID-19 PUBLIC HEALTH EMERGENCY

As part of the public health emergency (PHE) unwinding process, in February 2023 ODM began reviewing members' eligibility information for potential dis-enrollment, and the first set of members were dis-enrolled effective May 2023. A future section provides details on associated rate adjustments.

B. APPROPRIATE DOCUMENTATION

I. DOCUMENTATION OF REQUIRED ELEMENTS

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.

II. COVID-19 PUBLIC HEALTH EMERGENCY AND RELATED UNWINDING

As part of the Consolidated Appropriations Act, 2023, continuous enrollment requirements were decoupled from the PHE on March 31, 2023, allowing eligibility reviews to begin prior to the expiration of the PHE. As such, the first disenrollments from the COVID-19 unwinding period began prior May 2023 and the unwinding period is estimated to have been completed prior to CY 2025.

(a) Available data and information

In developing rate assumptions related to the impact of COVID-19, our primary data source consisted of monthly MMC enrollment experience through August 2024, plus claims experience through August 2024, to understand caseload and utilization patterns pre-, during- and post-PHE for the purpose of projecting future cost levels. We also reviewed information available from the Centers for Disease Control (CDC).

(b) Direct and indirect impacts in capitation rates

The base data used to develop the capitation rates consists of January 1, 2023 through December 31, 2023 (CY 2023) data, which inherently reflects some impact of COVID-19 on population acuity and service utilization. A later section provides descriptions of direct adjustments made to the rates to reflect projected acuity differences between the CY 2023 period and the CY 2025 rating period in instances where the CY 2023 period was impacted by COVID-19 and associated PHE unwinding. The impact of other COVID-19 related items that may contribute to differences between CY 2023 and CY 2025 service cost, such as the prevalence of telehealth utilization, COVID-19-related care, or systemic changes to healthcare utilization, are inherently encompassed in the CY 2023 base data and prospective utilization and cost per unit trend assumptions included in the rates.

(c) Non-risk arrangements

The MMC program does not include non-risk arrangements for COVID-19 related services covered by the MCOs.

(d) Risk mitigation strategies

The certified rates reflect consideration of a minimum MLR requirement of 86% for the MMC program, which is consistent with the prior rating period.

2. DATA

This section provides information regarding the base data used to develop the capitation rates.

A. APPROPRIATE DOCUMENTATION

I. REQUESTED DATA

As the actuary contracted by ODM to provide consulting services and associated financial analyses for many aspects of the MMC program (and not limited to capitation rate development), Milliman intakes and summarizes eligibility and expenditure data monthly using vendor files provided by ODM. As such, there is no separate data request from Milliman to the state specifically related to the base data for the capitation rate development. The remainder of this section details the base data and validation processes utilized in the CY 2025 capitation rate development.

II. DATA USED TO DEVELOP THE CAPITATION RATES

(a) Description of the data

(i) Types of data

The primary data sources used in the development of the MMC rates are the following:

- Historical enrollment and eligibility files provided by ODM;
- Encounter data submitted by the MCOs;
- CY 2023 ad-hoc encounter data submitted by select MCOs;
- Annual and quarterly cost report data submitted by the MCOs;
- Re-priced inpatient and outpatient hospital claims experience provided by ODM;
- CY 2025 MCO Survey completed by each MCO; and,
- ODM fee schedules applicable to services affected by reimbursement changes due to legislative budget appropriations.

(ii) Age of the data

The data serving as the base experience in the capitation rate development process reflects the CY 2023 incurred period. The annual cost report and encounter data used in developing data quality adjustments as part of the base data process reflected claims incurred in CY 2023, paid through March 31, 2024. For the purposes of data adjustments, trend development, and analysis of emerging population enrollment patterns and claims experience, we reviewed cost report and encounter experience incurred through June 2024. Cost report data was provided by the MCOs and encounter data was provided by ODM.

To analyze inpatient and outpatient hospital reimbursement changes, we received encounter data for inpatient and outpatient hospital services that was re-priced to ODM's fee schedule in place at various points in time.

(iii) Data sources

The historical encounter data used for the rate certification is submitted by the MCOs on an ongoing basis. This data is stored in ODM's data warehouse. Medicaid enrollment and encounter data stored in ODM's data warehouse was provided to us for the purpose of developing the CY 2025 capitation rates.

We also received CY 2023 and Q3 2024 cost report data. The cost report data is contained in Microsoft Excel files that the MCOs submit to ODM.

(iv) Sub-capitation

Sub-capitated data is identified separately in both the encounter and cost report experience.

Encounter Data: MCOs indicated whether an encounter is sub-capitated and "shadow priced" at the detail and header level, depending on how the encounter was paid. In the payment arrangement field ('CDE_PAY_ARR'), code '05' indicates sub-capitated arrangements. This field was used to separate sub-capitated encounter data from the non-sub-capitated encounter data. The MCOs provided additional information related to sub-capitated services through their MCO Survey submissions. These submissions provide insight into areas where a sub-capitated arrangement is present, yet the claims are not "shadow priced" in the submitted encounter data. We relied on this information for the purpose of properly identifying sub-capitated MCO encounter data.

Cost Report: We relied on the separate reporting of non-sub-capitated and sub-capitated experience by the MCOs in the medical cube worksheets of the cost reports. In the MCO cost reports, total sub-capitated expenditures represent the amounts paid by MCOs for sub-capitated services, rather than "shadow priced" claims as illustrated in the encounter data. MCOs are required to separate total sub-capitated expenditures into FFS amounts (i.e., chargebacks), encounterable expenditures, and non-encounterable expenditures.

(b) Availability and quality of the data

(i) Steps taken to validate the data

The base experience used in the capitation rates relies on cost report and encounter data submitted to ODM by participating MCOs. Managed care eligibility is maintained by ODM. The actuary, the MCOs, and ODM all play a role in validating the quality of encounter and cost report data used in the development of the capitation rates. The MCOs play the initial role, collecting and summarizing data sent to the state. ODM's Bureau of Health Research and Quality Improvement, Data Analytics section focuses on encounter data quality and MCO performance measurement, with measures focused on completeness, accuracy, and comparison between data sources. ODM's contract with the MCOs stipulates encounter data specific submission and quality standards. Additionally, we perform independent analysis of encounter data and cost report data to evaluate the quality of the data being used in the rate development process. Below is a summary of measures specific to each quality area that are applied by either Milliman or ODM.

Completeness

Encounter Data

ODM applies several measures to the MCO-submitted encounter data to evaluate the completeness of the data. A sample of measures focused on the completeness of the data include:

- Encounter data volume measures by population and service category;
- Incomplete rendering provider data;
- NPI provider number usage without Medicaid / reporting provider numbers;
- Percentage of encounters in an MCO's fully adjudicated claims file not present in the ODM encounter data files; and,
- Percentage of encounters in the ODM encounter data files not present in the MCO's fully adjudicated claims file.

We also summarize the encounter data to assess month to month completeness of the encounter data. These measures include:

- Encounter claims PMPM by MCO and high-level service categories;
- MCO distribution of members by annual encounter-reported expenditures; and,
- MCO distribution of members by monthly encounter-reported expenditures.

These measures are applied to identify any months where encounter data volume is unusually large or small, indicating a potential issue with the submitted encounter data. The CY 2023 encounter data used in the development of the rates was paid through March 31, 2024.

Cost Report Data

MCOs submit quarterly and year-end annual cost report data to ODM. We reviewed each MCO's quarterly and annual cost reports to identify large data variances, incomplete data, and other reporting issues. These issues are provided to each MCO by ODM and the cost reports are re-submitted to ODM as necessary.

The year-end cost report data must be certified by two officers of each MCO and reconciled to the MCO's audited NAIC financial statement information. The year-end annual cost report is completed by the MCOs using claims incurred and paid through March 31st of the following calendar year. The three months of claims run-out limits the impact of the incurred but not paid (IBNP) estimate on the incurred expenditure estimates.

Accuracy

Encounter Data

We review the accuracy of the encounter data by comparing expenditures to outside data sources including MCO Cost Report and MCO Survey submissions. We also review the encounter data to ensure each claim is related to a covered individual and a covered service. Annual base period data summaries are created to ensure that the data for each service is consistent across the MCOs and with prior historical periods. Stratification by rate cell facilitates this review, as it minimizes the impact of changes in population mix. This process identifies MCO and service category combinations that may have unreasonable reported data.

Cost Report Data

As stated in the Completeness section, MCOs submit quarterly and annual cost report data to ODM. In terms of accuracy measures, the process of submitting both quarterly and annual reports identifies unreasonable or inconsistent values in the data among cost report submissions. In addition to utilization and cost metrics, financial measures such as medical loss ratio, underwriting margin, and administrative loss ratio are tracked across MCOs and rate cells. These metrics enable us to quickly identify potential cost allocation issues. We also evaluate the cost report expenditures in relation to statutory financial statements for each MCO to ensure expenditure differences are reasonable.

Consistency of data across data sources

We performed a detailed review of the encounter data used in the development of the CY 2025 capitation rates. Assessing the encounter data for consistency with the MCO cost reports was a vital part of the rate development process. We reviewed utilization and cost metrics by rate cell and region for CY 2023 encounter data and CY 2023 cost report data. Experience was reviewed for non-sub-capitated services, sub-capitated services, and in aggregate. Composite PMPM expenditures in the encounter data were slightly less than composite PMPM expenditures in the cost report data (prior to any data quality adjustment). Differences between the encounter data and cost report expenditures were generally greater in rate cells where a large portion of the expenditures were sub-capitated, due to differences in the reporting of sub-capitated expenditures between the two data sources (shadow-priced versus ceded premium).

We also reviewed the consistency of other data sources used to inform assumptions in the rate setting process:

- **Eligibility.** Monthly enrollment in eligibility files received by ODM was reconciled with publicly available values on ODM's publicly available Enrollment and Expenditures Dashboard[2].
- **Re-priced inpatient claims experience.** To support our analysis of the impact of the All Patients Refined Diagnosis Related Groups (APR-DRG) and cost-to-charge ratio changes during the historical experience period and rate period, we received re-priced inpatient encounter records from ODM. The claims experience included the actual MCO paid amount, along with claims re-priced to ODM's fee schedule. We confirmed the MCO paid amount is consistent with the encounter experience we had previously received and confirmed the re-priced amounts are consistent with ODM's published inpatient hospital fee schedule.

[2] https://data.ohio.gov/wps/portal/gov/data/projects/demographic-expenditure-dashboard

- **Re-priced outpatient claims experience.** To support our analysis of the impact of Enhanced Ambulatory Patient Grouping System (EAPG) implementation, we received re-priced outpatient encounter records from ODM. The claims experience included the actual MCO paid amount, along with claims re-priced to ODM's fee schedule. We confirmed the MCO paid amount is consistent with the encounter experience we had previously received and confirmed the re-priced amounts are consistent with ODM's published outpatient hospital fee schedule.

(ii) Actuary's assessment

As required by Actuarial Standard of Practice (ASOP) No. 23, Data Quality, we disclose that Milliman has relied upon certain data and information provided by the Ohio Department of Medicaid and their vendors, primarily the MCOs. The values presented in this report are dependent upon this reliance.

While there are areas for data improvement, as detailed in the Data concerns section below, we found the encounter data to be of appropriate quality for developing the CY 2025 capitation rates.

(iii) Data concerns

Through discussions with ODM and various data analyses, we were made aware of and confirmed encounter data quality concerns, as follows:

- Remove delegated admin from cost report sub-capitated expenditures, apply data quality adjustment to encounter data as warranted.
- Remove non-state plan services from cost report and encounter expenditures.
- State both cost report and encounter expenditures on a net basis.
- Apply missing encounter data adjustments as provided by the MCOs in the CY 2025 MCO Survey.
- Reallocate negative cost report amounts and substitute adjusted cost report PMPM amounts.
- Remove monthly eligibility associated with members who have death dates prior to the start of the month.
- Remove monthly claims and eligibility associated with members that were incarcerated at the time.
- Remove monthly eligibility associated with member months that were duplicated in the vendor file eligibility information.
- Remove monthly claims and eligibility associated with members that were in an IMD for greater than 15 days in a calendar month.
- Adjust claims and utilization for OhioRISE covered services that were paid by MMC MCOs.

We have not identified any material concerns with the quality or availability of the cost report data, other than those listed above.

(c) Appropriate data

(i) Use of encounter and fee-for-service data

Managed care encounter data was used in the development of the capitation rates for all populations. The base data reflects the historical experience and covered services used by the covered populations.

(ii) Use of managed care encounter data

Managed care encounter data was the primary data source used in the development of the capitation rates.

(d) Reliance on a data book

Development of the capitation rates did not rely on a data book or other summarized data source. We were provided with detailed claims data for all covered services and populations. We created data books summarizing CY 2023 encounter data, which were shared with ODM and participating MCOs.

III. DATA ADJUSTMENTS

Capitation rates were developed primarily from CY 2023 encounter data. Adjustments that were made to the base data are described in this section.

(a) Credibility adjustment

The MMC program, as represented in the base experience, was fully credible. No adjustments were made for credibility.

(b) Completion adjustment

The encounter data, cost reports, and CY 2025 MCO surveys submitted by the MCOs used in developing the capitation rates were each analyzed separately to estimate claim completion factors. The base period encounter and cost report data reflects claims incurred during CY 2023 and paid through March 31, 2024. Separate sets of completion factors for the three data sources were developed and compared by summarizing the claims data and applying traditional actuarial techniques to develop estimates of incurred but not paid (IBNP) liability, using Milliman's Robust Time-Series Analysis System (RTS)[3].

First, we stratified the data by category of service in the population groupings. Claims for each of these population-service category stratifications were analyzed and formed into lag triangles by paid and incurred month. Claim completion factors were developed for each month of the base experience period, based on historical completion patterns. Completion factors developed using encounter data were compared to MCO-reported IBNP liability estimates in the MCO cost report data for reasonableness.

The monthly completion factors were applied to unadjusted CY 2023 experience to estimate the remaining claims liability for the period.

(c) Errors found in the data

Through discussions with ODM and our independent review of the data, we were made aware of and confirmed data quality concerns.

(d) Program change adjustments

The subsections below include details related to the program and reimbursement changes that have occurred in the MMC program.

Retrospective IMD as an "In Lieu of" Service Update. Effective July 1, 2017, ODM began permitting the use of IMDs as an "in lieu of" service for the 21 to 64-year-old population for up to 15 days per month. This program change was implemented in compliance with the conditions outlined in the final Medicaid managed care regulations. Consistent with the rate-setting guidance published by CMS, in reviewing the impact of this program adjustment we did not use the unit cost of the IMD. The unit cost for IMD services was developed based on the cost per admit of Inpatient Psychiatric/SA services for non-teaching hospitals.

Retrospective Semi-annual Nursing Facility Cost Per Diem Updates. ODM updates nursing facility (NF) payment rates and acuity scores on a semi-annual basis. We applied retrospective adjustments to reflect the impact of the per diem update that occurred on July 1, 2023. In developing this adjustment, we considered the impact of provider mix and hospice services where reimbursement is often derived from the NF fee schedule.

[3] The Robust Time Series Reserve Analysis System (RTS) is a model designed to assist an actuary in performing an Incurred But Not Paid (IBNP) reserving analysis. The RTS is unique because it contains functionality that: provides reasonable best estimates in spite of contaminated data, provides reasonable margins for the total reserve, independently models shock claims, and provides forecasts of future cash flows. This methodology forecasts future claim runout using time series forecasting which employs the interrelationship between claim payments during the first three months of claim payments for each incurred month.

Adjustments were applied to the nursing facility and hospice categories of service and vary based on differences in base nursing facility experience by rate cell and region.

Treatment Transfer / Transitional Control Population. Effective November 1, 2023, individuals classified as treatment transfer (TT) and transition control (TC) who transition from Department of Rehabilitation and Correction (DRC) prisons to DRC-licensed facilities to complete their sentencing were eligible for the MMC program. Benefits for these members are consistent with those covered via state plan services.

To develop this adjustment, we utilized data provided by ODM, which included a list of members who were released from the TT / TC population between the months of January 2023 and July 2024 and subsequently enrolled in the MMC program. We utilized this member list to estimate the level of enrollment of TT / TC members in the MMC program during CY 2025, the distribution of these members by region and rate cell, and the estimated cost of these members.

OhioRISE Enrollment Changes. We evaluated the impact of changes in the OhioRISE program that could serve to impact the level of enrollment for MMC members in the OhioRISE program.

- **OhioRISE Incremental Enrollment.** To develop the CY 2023 base data that serves as the foundation of the capitation rates, we excluded expenditures for MMC members that were attributable to the OhioRISE program. Based on projected OhioRISE enrollment into the CY 2025 rating period, we estimate that the level of MMC-member OhioRISE enrollment in the CY 2023 base period is understated relative to projected CY 2025 levels. We included an adjustment to the projected benefit expense to account for additional MMC members covered by the OhioRISE program in the rating period relative to the base period, effectively moving claims out of the MMC program and into the OhioRISE program.
- **OhioRISE Eligibility and Enrollment Policy.** Effective July 1, 2024, Section 5160-59-02 (OhioRISE: Eligibility and Enrollment) of the Ohio Administrative Code (OAC) was amended to indicate that OhioRISE individuals that meet the following criteria are subject to disenrollment:
    - Two years have passed since the youth's enrollment in OhioRISE and the youth subsequently:
        - Has not had a Child and Adolescent Needs and Strengths (CANS) assessment; and
        - Does not meet the criteria for intensive home-based treatment (IHBT) services in the last 365 days; and
        - Has not experienced an inpatient condition (including PRTF) with primary diagnosis of mental illness or substance use disorder in the last 365 days.

  Members that meet the criteria above will be disenrolled on the last day of the following month in which they meet the criteria, beginning with August 31, 2024. In developing the CY 2025 MMC capitation rates, we considered the impact of this policy change on MMC/OhioRISE enrollment. We included an acuity adjustment to reflect additional behavioral health service utilization in the MMC program incurred by members who were enrolled in both the MMC and OhioRISE programs and are now projected to disenroll from the OhioRISE program. To determine the impact of this acuity adjustment, we analyzed historical and emerging data for members subject to disenroll, based on the CANS data extract from ODM and historical claims experience.

OhioRISE Mixed Service Protocol. Effective January 1, 2024, updates were made to the OhioRISE Mixed Services Protocol which identifies the responsible payer for services that may feasibly be covered either by MMC MCOs or the OhioRISE plan. Effective January 1, 2024, ODM discontinued use of the Outpatient Hospital Behavioral Health Services (OPHBH) fee schedule and instead uses the existing EAPG payment methodology to determine the responsible payer. We included an adjustment to reflect changes in the projected distribution of expenditures between the two programs.

Child and Adolescent Needs and Strengths (CANS) Comprehensive Assessments. CANS assessments are designed to establish eligibility for OhioRISE and subsequently determine the level of care coordination necessary for individuals who are determined to be eligible for OhioRISE. CANS assessments performed for potentially eligible members on an ongoing basis are covered by the MMC or FFS programs, until the day after OhioRISE enrollment.

The CY 2025 MMC capitation rates include adjustments for the portion of projected CANS assessment benefit expense anticipated to be covered by the MMC program during the rating period relative to the base period. We utilized monthly OhioRISE CANS enrollment information from ODM to project the utilization of future CANS assessments covered under the MMC program.

The average unit cost was developed based on the CANS assessment rates in the *Community Behavioral Health Services Medicaid Fee Schedule*[4], inclusive of reimbursement rate changes, and assumptions for the distribution of practitioner types expected to perform the assessments.

Expansion of Mental Health Peer Support Services. Effective September 1, 2024, ODM expanded the coverage of peer support services to those with mental health (MH) needs. Previously, peer support services were only available to individuals with substance use disorder (SUD) needs. We developed an adjustment to the capitation rates for the expanded coverage of MH peer support based on the observed ramp up of the SUD service, higher assumed utilization of mental health services relative to SUD services, and the proposed fee schedule for MH peer support.

Maternal and Infant Support Program (MISP). Beginning in 2021, ODM implemented a Maternal and Infant Support Program (MISP) that focuses on providing services and strategies that are designed to address disparities in birth outcomes. We evaluated the impact to the capitation rates for the following MISP policy and payment rate changes.

- **Increased PRAF Reimbursement.** Effective July 1, 2024, ODM began covering up to 6 pregnancy risk assessment forms (PRAFs) per pregnancy for expectant mothers, where reimbursement rates are lower for PRAFs after the first one. We analyzed the number of professional visits for pregnant individuals prior to and after delivery to develop assumptions for projected increases in PRAF utilization. We included adjustments to account for the difference in expected PRAF expenditures due to this policy change relative to the level of expenditures contained in the base period.
- **Nurse Home Visiting.** Effective January 1, 2022, ODM outlined coverage and payment for nurse home visiting services for women at risk for pre-term birth complications due to asthma, diabetes, cardiovascular disease, substance use disorder or previous history of pre-term birth. These in-home services can be provided by a registered nurse or advanced practice registered nurse as ordered by a physician. Following recent ODM rule modifications that expanded the provider types able to bill for these services, we expect utilization of these services to be materially higher in CY 2025 than the CY 2023 base period.
- **Multiple-User Lactation Supplies.** Effective January 1, 2022, ODM amended its lactation supply coverage rules to remove specific medical necessity requirements, under the assumption that the desire for a mother to breastfeed establishes medical necessity in and of itself, due to its nutritional benefits and impact on mother and infant health outcomes. Based on conversations with ODM and greater provider and member awareness of these services moving forward, we expect utilization of these services to be materially higher in CY 2025 than the CY 2023 base period.
- **Group Pregnancy Education.** Effective January 1, 2022, ODM enhanced coverage of group pregnancy education. Medicaid enrolled providers who offer group prenatal care using evidence-based models of pregnancy education and who administer evidence-informed curriculums are able to render these services. Limitations requiring individuals to be considered “high-risk” have been removed and additional health equity language has been added to include use of culturally sensitive communication and facilitation of family-centered collaboration and support. In addition, the fee-for-service reimbursement rate for the group sessions increased. Therefore, we expect utilization of these services to be materially higher in CY 2025 than the CY 2023 base period.
- **Lactation Consultant Rates.** Effective July 1, 2024, lactation consulting services were added to the covered service list in accordance with OAC 5160-8-42. We included an adjustment to account for lactation consultant claims projected in the rating period.

[4] https://medicaid.ohio.gov/static/Stakeholders%2C+Partners/LegalandContracts/Rules/DR-NonBIA/ERF199554.pdf

- **Increased Doula Coverage.** Effective October 1, 2024, ODM expanded the types of providers eligible to receive reimbursement for doula services that meet certain qualifications. We included an adjustment to reflect additional doula services in the rating period.
- **Pediatric Recovery Center Rates.** Effective during the CY 2025 rating period, ODM will expand coverage for newborns and infants with neonatal abstinence syndrome (NAS) that are placed in a pediatric recovery center for treatment. ODM-approved and medically necessary PRC services may be reimbursed on a bundled per diem rate basis. While the PRC coverage parameters and per diem rates are not yet finalized, the capitation rates include an estimate for the level of reimbursement anticipated in the rating period.

Quality Withhold Goals. For the CY 2025 rating period, ODM will administer a quality withhold arrangement for the MMC program where return of withhold will be calculated based on MCO performance on four separate measures:

- Utilization of PRAFs for expectant mothers;
- Utilization of diabetic self-management education (DSME) and continuous glucose monitors (CGMs);
- Utilization of follow-up visits for adults experiencing an emergency department visit due to substance use; and,
- Achievement of various pediatric SMART aims.

Based on a review of the measures for the PRAF and diabetic quality withhold goals, we estimate the composite level of utilization for these services observed in the base period is sufficient for the MCOs to attain these two goals. In developing the CY 2025 capitation rates, we included additional benefit expense to reflect the estimated increase in needed follow-up visits for adults with a substance use-related emergency department visit. We also included additional projected benefit expense for services that would be needed to achieve the pediatric SMART aims.

Inpatient Reimbursement. ODM rebased its inpatient hospital base rates and relative weights through the continued use of APR-DRG and for APR-DRG exempt hospitals, cost to charge ratios. In addition, ODM continues to include an enhanced reimbursement methodology to ensure adequate and continued access to inpatient hospital services via the Cost Coverage Add-On (CCA).

Outpatient Reimbursement. ODM rebased its outpatient hospital base rates and EAPG relative weights. Outpatient EAPG payments continued to reflect an enhanced reimbursement methodology to ensure adequate and continued access to outpatient hospital services via the CCA. We also considered the impact of reimbursement changes for outpatient facility services not paid based on EAPG.

Long Term Care Supports and Services Reimbursement. ODM implemented material fee schedule updates related to several long-term care services including nursing facility per diem rates, ventilator dependent services, home health, and other services. We estimated the impact of the fee schedule changes on the MMC program, and applied rating adjustments to impacted categories of services.

Ohio Administrative Code (OAC) Rule 5160-56-06 indicates that hospice room and board is reimbursable at 95% of the rate established for the long-term-care facility. We applied adjustments to the Hospice & Home Health category of service such that the capitation rates include projected hospice room and board benefit expense consistent with nursing facility minimum fee schedule per diem rates.

Effective December 18, 2024, ODM will begin reimbursing approved nursing facilities for private room accommodations for Medicaid eligible residents if the resident requires a private room due to medical necessity, or if semi-private or ward accommodations are not available. We reflected the anticipated impact of this program change.

Behavioral Health Reimbursement. Effective January 1, 2024, ODM implemented fee schedule updates for community behavioral health services incurred at billing provider types 84 and 95. Using fee schedules provided by ODM, we estimated the impact of the changes and applied rating adjustments to impacted categories of service.

Other Non-Institutional Reimbursement Changes. We reviewed other known fee schedule changes for changes effective between the start of CY 2023 and the end of the CY 2025 rating period. Updates include but are not limited to the following service types: Transportation, Dental, Vision, Opioid Treatment Program, Durable Medical Equipment, Lab Services, and Physician-Administered Drugs. Using fee schedules provided by ODM, as well as 5160-1-60 Appendix DD, we estimated the impact of these and other fee schedule changes, and applied rating adjustments to impacted categories of service.

Population Acuity Changes – PHE Unwinding. Due to the COVID-19 pandemic, the federal government declared a public health emergency (PHE) beginning in March 2020. During the PHE, ODM received enhanced federal funding by meeting maintenance of eligibility (MOE) requirements. One aspect of the MOE required continuous Medicaid eligibility during the PHE, which materially decreased member movement out of the MMC program. In addition, we also observed an increase in the rate at which members newly enrolled in the MMC program, particularly in the early months of the PHE. With the PHE ending effective May 11, 2023, MMC member dis-enrollment resumed as part of "unwinding", with the first set of members having been dis-enrolled effective May 2023. Through discussions with ODM and review of emerging level MMC enrollment, we anticipate that dis-enrollment due to the PHE unwinding process will be complete prior to the CY 2025 rating period and incorporated acuity adjustments in recognition.

Population Acuity Changes – HST 19-64 F Rate Cell. The HST 19-64 F rate cell includes pregnant women who fall between 138-200% of the federal poverty level (FPL). In the CY 2023 base period, members were subject to eligibility during their pregnancy and up to 3 months postpartum. However, given the PHE MOE requirements, a material portion of members were able to remain in the program after being enrolled during their pregnancy. For CY 2025, recent ODM changes to the eligibility policy allow for these women to remain the program for up to 12 months postpartum. We included an adjustment to reflect estimated CY 2025 acuity levels for this rate cell as a result of the PHE unwinding process.

Prospective program changes deemed immaterial to benefit expenses in the rate period

Adjustment factors were developed for policy and program changes estimated to ***materially*** affect the managed care program during the CY 2025 rating period that are not fully reflected in the CY 2023 data. Program adjustments were made in the rate development process to the extent a policy or reimbursement change is deemed to have a material cost impact to the MCOs. *We defined a program adjustment to be 'material' if the total benefit expense for any individual rate cell is impacted by more than 0.1%.* In addition, program adjustments that were determined to be material in prior rate setting activities, or are material to the MyCare Ohio or OhioRISE programs, are considered material. Program adjustments deemed immaterial include:

- **Quality withhold measures.** Based on a review of the measures for the PRAF and diabetic quality withhold goals, we estimate the composite level of utilization for these services observed in the base period is sufficient for the MCOs to attain these two goals. Adjustments were made for the two new quality withhold measure categories for CY 2025 (adult SUD ER follow-up visits and pediatric SMART aims).

(e) Exclusion of payments or services from the data

The following adjustments were made to the base experience data to reflect non-state plan services, uncollected co-pays, pharmacy rebates, third party liability recoveries, and non-encounter claims payments.

Services excluded from initial base data summaries

Non-State Plan Services

We excluded all services included in the base data that do not reflect approved state plan services (nor are an approved in-lieu-of service).

Institution for Mental Disease (IMD) Stays Greater than 15 Days

We excluded all costs and member months for enrollees aged 21 to 64 associated with a non-substance use disorder IMD stay of more than 15 days in a calendar month. This exclusion included any other costs outside of the IMD for any services delivered during the time an enrollee was in the IMD for more than 15 days.

Adjustments made to base data

Uncollected Co-pays

Adjustments were made to reflect fee-for-service co-pay amounts that were not collected by the MCOs in CY 2023. Co-pay amounts were estimated by applying ODM's co-pay policies to the MCO encounter data. Separate adjustments were made for emergency room, dental, and vision categories of service based on the uncollected co-pay amounts as a percentage of CY 2023 expenditures. Co-pay adjustments were not applied to children or pregnant women populations, except for co-pays for vision services for pregnant women.

Pharmacy Rebates

We reviewed the supplemental pharmacy rebate amounts reported by the MCOs in both the annual cost report submissions as well as the CY 2025 MCO Surveys. Due in large part to the presence of ODM's single PBM, we estimate that the impact of supplemental pharmacy rebates will be immaterial to projected benefit expense incorporated in the MMC program. As a result, no adjustments were applied for consideration of supplemental pharmacy rebates.

Third Party Liability/Fraud and Abuse

In addition to cost avoidance inherently reflected in the encounter data, we estimated additional third-party liability (TPL) and fraud recoveries based on data available in cost reports and CY 2025 MCO surveys.

We adjusted encounter baseline data by region to reflect an estimated amount of TPL and fraud recoveries using data reported by the MCOs.

Non-encounter Claims Payment

We adjusted the encounter data base experience period to reflect non-claim payments made to providers for items such as plan directed shared savings payments, quality incentives, and other similar provider incentive payments that are not reflected in the base data or in other components of the capitation rate.

Net Reinsurance

The MCO provider agreement requires MCOs contracted with ODM for the MMC program to carry reinsurance for high-cost inpatient claims. We adjusted inpatient expenses as part of the base data development using the net cost of reinsurance (reinsurance premiums less reinsurance recoveries) reported in the CY 2025 MCO surveys.

Reinsurance recoveries and premiums were provided by the MCOs in the CY 2025 MCO Survey.

The statewide rate cell reinsurance premium estimates were further adjusted based on estimated regional reinsurance loss ratios. Reinsurance recoveries were based on amounts reported in MCO cost report data. While we have not changed the aggregate amount of MMC reinsurance premiums reported, we believe these adjustments allocate the reinsurance premium on a more actuarially sound basis at the rate cell level.

3. PROJECTED BENEFIT COST AND TRENDS

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

A. RATE DEVELOPMENT STANDARDS

I. FINAL CAPITATION RATE COMPLIANCE

The final capitation rates are in compliance with 42 CFR 438.4(b)(6) and are only based on services outlined in 42 CFR 438.3(c)(1)(ii) and 438.3(e). Non-state plan services provided by the MCOs have been excluded from the capitation rate development process. Effective July 1, 2017, ODM began permitting the use of IMDs as an in-lieu-of service for the 21 to 64-year-old population for up to 15 days per month.

II. BENEFIT COST TREND ASSUMPTIONS

Projected benefit cost trend assumptions are developed in accordance with generally accepted actuarial principles and practices. The primary data used to develop benefit cost trends is historical claims and enrollment from the covered populations.

III. IN LIEU OF SERVICES

As noted earlier, ODM began permitting the use of IMDs as an in-lieu-of service (ILOS) effective July 1, 2017. Consistent with the rate-setting guidance published by CMS, in reviewing the impact of this program adjustment we did not use the unit cost of the IMD, and instead utilized the unit cost for that of existing state plan providers.

IV. ILOS COST PERCENTAGES

In accordance with the State Medicaid Directors Letter published on January 4, 2023, when a managed care program includes ILOSs, with the exception of short term stays in an IMD, states must provide documentation of the projected ILOS of the projected ILOS Cost Percentage and the final ILOS Cost Percentage, as well as summary of actuarial managed care plan costs for delivering ILOSs. The projected ILOS Cost Percentage is the portion of the total capitation payments attributable to all ILOSs, excluding short term stays in an IMD, for the specific managed care program (numerator) divided by the total projected dollar amount of capitation payments specific to the MMC program that includes the ILOS (denominator), which must include all state directed payments in accordance with 42 CFR § 438.6(c) and pass-through payments in accordance with 42 CFR § 438.6(d).

ODM has indicated that there are no ILOSs anticipated for CY 2025, except for short term stays in an IMD. As a result, there is no projected ILOS Cost Percentage for the MMC program.

V. BENEFIT EXPENSES ASSOCIATED WITH MEMBERS RESIDING IN AN IMD

Effective July 1, 2017, ODM began permitting the use of IMDs as an in-lieu-of service for the 21 to 64-year-old population for up to 15 days per month. We reviewed benefit costs for enrollees aged 21 to 64 during the base experience period to identify costs associated with a non-substance use disorder (SUD) Institution for Mental Diseases (IMD) stay of more than 15 days in a month and any other MCO costs for services delivered in a month when an enrollee had a non-SUD IMD stay of more than 15 days. The enrollment and costs for these enrollees were identified and removed from the encounter data. We included costs and associated member months for members aged 21 to 64 with an SUD primary diagnosis who incurred IMD stays of more than 15 days, due to the presence of ODM's 1115 SUD IMD waiver. In addition, as noted above we did not use the unit cost of the IMD as an in-lieu-of service, and instead utilized the unit cost for that of existing state plan providers.

B. APPROPRIATE DOCUMENTATION

I. PROJECTED BENEFIT COSTS

This section provides documentation of the methodology utilized to develop the benefit cost component of the capitation rates at the rate cell level.

II. DEVELOPMENT OF PROJECTED BENEFIT COSTS

(a) Description of the data, assumptions, and methodologies

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

Step 1: Create calendar year (CY) 2023 per member per month (PMPM) cost summaries

The capitation rates were developed from historical claims and enrollment data for the MMC-enrolled populations. The foundation of the capitation rates consists of CY 2023 incurred encounter data that has been submitted by the MCOs operating in the program during the period. We utilized the CY 2023 MCO annual cost reports where appropriate, along with information provided by the MCOs via an additional survey of CY 2023 experience, which included updated medical and eligibility data formatted consistent with the MCO cost reports. In addition, we received and reviewed ad-hoc member-level encounter data summaries from select MCOs.

Step 2: Apply data quality adjustments

We applied data quality adjustments to the CY 2023 incurred encounter data submitted by the MCOs. This process included adjustments for known reporting discrepancies between the encounter data and what was reported in the CY 2025 MCO survey, among other items. In situations where there are known discrepancies with MCO encounter data, we applied adjustments using the updated CY 2023 cost report data.

Step 3: Apply historical and other adjustments to cost summaries

Utilization and cost per service rates from the CY 2023 experience period were adjusted for items such as incurred but not paid amounts, uncollected copays, pharmacy rebates, program adjustments, and fee schedule changes that occurred during CY 2023.

Step 4: Adjust for prospective program and policy changes and trend to the rating period

The CY 2023 data was adjusted for known policy and program changes that have occurred or are expected to be implemented between January 1, 2024 and December 31, 2025. Adjustments were applied to the per member per month (PMPM) values to reflect changes in the program between the base period and effective rate period. The adjusted PMPM values from the base experience period are trended forward to the midpoint of the contract period (July 1, 2025).

As described later in this section, further adjustments were applied to reflect targeted improvements in managed care efficiency for specific rate cells and service categories that are estimated to impact projected benefit expense. The resulting PMPM amounts established the adjusted claim cost by population rate cell for the contract period.

Other material adjustments - managed care efficiency

We calculated percentage adjustments to reflect the utilization and cost per unit differential between the base experience and the levels targeted for the projection period managed care environment. We developed the targeted managed care efficiency adjustments through a review and analysis of the following:

- Potentially avoidable emergency room utilization
- Agency for Healthcare Research and Quality (AHRQ) prevention quality indicators (PQI) for inpatient admissions
- Mix of vaginal and cesarean section deliveries in the CY 2023 base period utilization

Emergency Room

For the emergency room service category, multiple potentially avoidable diagnosis groups were clinically developed using the primary diagnosis of each claim. The potentially avoidable diagnosis groups were stratified by severity to target potentially avoidable emergency room visits in the three lowest severity groups. In addition, potentially avoidable outpatient hospital emergency room visits were summarized by rate cell.

When applying these adjustments, reductions were taken from level 1 emergency room claims first, followed by level 2 and level 3 claims if applicable. No adjustments were made to level 4 or level 5 emergency room claims. We reviewed historical data, along with data from other Medicaid states, to develop assumptions for additional services that may also be included with an office visit. Based on this review, additional services related to pathology/lab and radiology were included with the replacement office visit.

Inpatient Hospital

We applied managed care efficiency adjustments to reflect higher levels of care management relative to the CY 2023 experience period. We identified potentially avoidable admissions using the AHRQ prevention quality indicators (PQI). We also analyzed the frequency of re-admissions. Inpatient hospital managed care adjustments were developed by applying assumed reductions to potentially avoidable inpatient admissions as well as readmissions.

Our analysis was completed at the regional level by first reducing readmissions within 30 days, and then reducing non-readmissions for select PQIs. No adjustments were made to corresponding inpatient physician charges to account for the potential shift of these services to an ambulatory setting. Nursing facility claims were excluded from this analysis.

Maternity Delivery Kick Payment

We reviewed the mix of vaginal and cesarean section deliveries by MCO and region to determine appropriate efficiency adjustments for the maternity delivery kick payment. Delivery managed care efficiency adjustments were developed by analyzing the percent of cesarean and vaginal deliveries by MCO and region. Managed care savings were estimated by evaluating the cost per delivery difference between cesarean and vaginal deliveries. No adjustments were made to the total number of deliveries.

(b) Material changes to the data, assumptions, and methodologies

All material assumptions are documented in the rate certification report and the overall methodology utilized to develop the capitation rates is consistent with the prior rate-setting analysis.

(c) Overpayments to providers

As outlined previously, we estimated TPL and fraud recoveries based on data available in CY 2025 MCO surveys. No additional adjustments were applied related to overpayments to providers.

III. PROJECTED BENEFIT COST TRENDS

This section discusses the data, assumptions, and methodologies used to develop the benefit cost trends, i.e., the annualized projected change in benefit costs from the CY 2023 encounter data to the CY 2025 rating period. We evaluated prospective trend rates using historical experience for the MMC program, as well as external data sources.

(a) Required elements

(i) Data

The primary data used to develop benefit cost trends is historical claims and encounters from the covered populations. Data used for trend development included cost and utilization experience, from January 2021 through June 2024.

External data sources that were referenced for evaluating trend rates developed from ODM data include:

- *National Health Expenditure (NHE) projections* developed by the CMS office of the actuary[5], specifically those related to Medicaid. Please note that as these are expenditure projections, projected growth reflects not only unit cost and utilization, but also aggregate enrollment growth and enrollment mix changes such as aging. For trends used in these rates, we are displaying unit cost and utilization trends, net of acuity and fee schedule changes, so in general our combined unit cost and utilization trends may differ from NHE trends.
- *Other sources*: We also reviewed internal sources that are not publicly available, such as historical experience from other programs and trends used by other Milliman actuaries.

(ii) Methodology

For internal ODM data, historical utilization and per member per month cost data was stratified by month, rate cell, and category of service. The data was adjusted for completion and normalized for historical population acuity changes and fee schedule changes. We used linear regression to project experience during the contract period. Contract period projections were compared to base period experience and emerging experience through June 2024 to determine an appropriate annualized trend. Additional details related to key aspects of the trend development process are outlined below.

(iii) Comparisons

Historical trends should not be used in a simple formulaic manner to determine future trends; actuarial judgment is also needed. We did not explicitly rely on the historical MCO encounter data trend experience due to anomalies observed in the historical trend data.

[5] https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsprojected.html

We referred to the sources listed in the prior section as well as considered changing practice patterns, the impact of reimbursement changes on utilization in the MMC population and shifting population mix due to unwinding or post-unwinding dynamics.

Note that explicit adjustments were made outside of trend to reflect all recent or planned changes in reimbursement from the base period to the rating period, as well as applicable program changes.

(b) Any other adjustments

(i) Impact of managed care

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

(ii) Trend changes other than utilization and cost

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

IV. MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT SERVICE ADJUSTMENTS

We have reviewed ODM's final report regarding compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) as required by 42 CFR 438.3(c)(1)(ii). Results of the analysis indicate full compliance with MHPAEA for both quantitative and non-quantitative treatment limits with no remediation needed that would constitute a program adjustment. Based on the results, we have not made any rating adjustments to accommodate parity compliance.

V. IN LIEU OF SERVICES

(a) Description of ILOSs

Effective July 1, 2017, ODM began permitting the use of IMDs as an in-lieu-of service for the 21 to 64-year-old population for up to 15 days per month. This program change was implemented in compliance with the conditions outlined in the final Medicaid managed care regulations. Consistent with the rate-setting guidance published by CMS, in reviewing the impact of this program adjustment we did not use the unit cost of the IMD, and instead utilized the unit cost for that of existing state plan providers.

(b) ILOS Cost Percentages

ODM has indicated that there are no other ILOSs anticipated for CY 2025 apart from short term stays in an IMD; therefore, we have assumed no ILOS cost percentage.

(c) Incorporation into rate development

Consistent with the rate-setting guidance published by CMS, in reviewing the impact of this program adjustment we did not use the unit cost of the IMD, and instead utilized the unit cost for that of existing state plan providers.

(d) Inclusion of IMD services

The rate development complies with the requirements of 42 CFR 438.6(e). In reviewing the impact of this program adjustment, we did not use the unit cost of the IMD, and instead utilized the unit cost for that of existing state plan providers.

VI. RETROSPECTIVE ELIGIBILITY PERIODS

(a) MCO responsibility

In many situations, MCOs are responsible for retrospective eligibility periods when the beneficiary was previously enrolled with an MCO in the MMC program less than 90 days prior to re-enrolling with an MCO.

(b) Claims treatment

Claims for retrospective eligibility periods are reflected in the base data.

(c) Enrollment treatment

Enrollment for retrospective eligibility periods are included in the base data.

(d) Adjustments

No explicit adjustment was applied for the CY 2025 capitation rates.

4. SPECIAL CONTRACT PROVISIONS RELATED TO PAYMENT

A. INCENTIVE ARRANGEMENTS

I. RATE DEVELOPMENT STANDARDS

There will be no incentive payments in the MMC program during the rating period.

II. APPROPRIATE DOCUMENTATION

There will be no incentive payments in the MMC program during the rating period.

B. WITHHOLD ARRANGEMENTS

I. RATE DEVELOPMENT STANDARDS

This section provides documentation of the withhold arrangement in the MMC program.

II. APPROPRIATE DOCUMENTATION

(a) Description of the Withhold Arrangement

(i) Time period

ODM is utilizing a quality withhold arrangement for the MMC program. The return of the withhold will be measured based on MCO performance during the CY 2025 period.

(ii) Coverage

All enrollees, services, and providers that are part of the MMC program are covered by the withhold arrangement.

(iii) Withhold purpose

The withhold measures are in place for the purpose of incentivizing higher quality of care provided.

(iv) Description of total percentage withheld

For the CY 2025 rating period, ODM will establish a quality withhold of 3.0% of the capitation and will determine the return of the withhold based on review of all MCOs' data relative to applicable benchmarks.

The capitation rates shown in this report are illustrated before offset for the withhold amount; however, the CY 2025 capitation rates documented in this report are actuarially sound while considering the amount of the withhold not expected to be earned.

(v) Estimate of percent to be returned

Based on discussions with ODM, return of the CY 2025 quality withhold will be determined based on MCO utilization in multiple areas. These include MCO performance related to:

- Utilization of PRAFs for expectant mothers;
- Utilization of diabetic self-management education (DSME) and continuous glucose monitors (CGMs);
- Utilization of follow-up visits for adults experiencing an emergency department visit due to substance use; and
- Various pediatric SMART aims.

The capitation rates include projected benefit expense and non-benefit expense associated with achieving the milestones put forth by ODM for full withhold return.

(vi) Reasonableness of withhold arrangement

Our review of the total withhold percentage of 3.0% of capitation revenue indicates that it is reasonable within the context of the capitation rate development and the magnitude of the withhold does not have a detrimental impact on the MCOs' financial operating needs and capital reserves. Our interpretation of financial operating needs relates to cash flow needs for the MCO to pay claims and administer benefits for its covered population.

We evaluated the reasonableness of the withhold within this context by reviewing the MCOs' cash available to cover operating expenses, as well as the capitation rate payment mechanism utilized by ODM.

C. RISK SHARING MECHANISMS

I. RATE DEVELOPMENT STANDARDS

This section provides documentation of the risk-sharing mechanisms in the MMC program.

II. APPROPRIATE DOCUMENTATION

(a) Description of Risk-sharing Mechanism

There are no risk-sharing mechanisms in the MMC program. The program includes a minimum MLR requirement.

(b) Medical Loss Ratio

Description

ODM's provider agreement indicates that ODM will perform MLR calculations for the MMC program. This includes the ABD, MAGI, AFK, and Expansion populations. The capitation rates were developed such that the MCOs are reasonably expected to achieve a medical loss ratio greater than 85 percent, which includes provisions for non-benefit costs that are appropriate and attainable. ODM's provider agreement indicates that ODM will perform MLR calculations for the MMC program.

Financial consequences

ODM has implemented a minimum MLR requirement of 86% for the MMC program. ODM will require remittance in the event a MCO reports a MLR below 86%.

(c) Reinsurance Requirements and Effect on Capitation Rates

The MCO provider agreement requires MCOs contracted with ODM for the MMC program to carry reinsurance for high-cost inpatient claims. We adjusted inpatient expenses in the historical period by the net cost of reinsurance (reinsurance premiums less reinsurance recoveries) as reported in the CY 2023 cost report data. Reinsurance recoveries were based on amounts reported in MCO cost report data.

D. STATE DIRECTED PAYMENTS

I. RATE DEVELOPMENT STANDARDS

Consistent with guidance in 42 CFR §438.6(c), CY 2025 rates reflect consideration of the following delivery system and provider payment initiatives:

- Nursing facility minimum fee schedule;
- COVID-19 testing minimum fee schedule;
- Care Innovation and Community Improvement Program (CICIP);
- Premier Health (PH) physician payments;
- University Hospital (UH) physician payments;
- Hospital Additional Payment (HAP);
- University of Cincinnati Health Hospital (UCHth-HAP) hospital payments;

- University of Toledo Medical Center (UTMC-HAP) hospital payments; and,
- Mobile Response and Stabilization Services (MRSS) Firehouse Model.

(a) Description of managed care plan requirement

ODM stipulates that MCOs adhere to a state-established minimum fee schedule for nursing facility reimbursement.

For COVID-19 diagnostic testing services, the MCOs must reimburse at least 100% of the Medicare rate.

MCOs participate in CICIP through enhanced reimbursement to hospital agencies based on value added through the agencies' quality improvement efforts. The MCOs are responsible for allocating PMPM payments to these agencies. MCOs are also required to provide enhanced reimbursement for physician services as part of the PH and UH directed payment arrangements submitted via 438.6(c) preprints. The MCOs are responsible for allocating PMPM payments to these providers attributable to the CY 2025 incurred period.

ODM requires that MCOs provide enhanced reimbursement to hospitals for inpatient and outpatient facility services as part of the HAP, UCHth-HAP, and UTMC-HAP directed payment arrangements submitted via 438.6(c) preprints. The MCOs are responsible for allocating PMPM payments to these providers attributable to the CY 2025 incurred period.

ODM requires that the MCOs adhere to a state-established minimum fee schedule for MRSS services as part of the MRSS directed payment arrangements submitted via 438.6(c) preprint. The MCOs are responsible for allocating PMPM payments to these providers attributable to the CY 2025 incurred period.

(b) Prior written approval

At the time of writing, ODM has submitted but not yet received approval for all directed payment preprints. It is our understanding that the nursing facility and COVID-19 minimum fee schedules will not require a preprint since they are based on rates established in Ohio's approved state plan. For CICIP, PH, UH, HAP, UCHth-HAP, and UTMC-HAP preprints were submitted and approved for the prior rating period. We have reviewed the submitted preprints and the state directed payment arrangements reflected are consistent with what was submitted to CMS.

(c) Accordance with standards

The contract arrangements that direct MCO expenditures were developed in accordance with guidance in 42 CFR §438.4, the standards in §438.5, and generally accepted actuarial principles and practices.

(d) How payment arrangement is reflected in managed care rates

The nursing facility and COVID-19 testing minimum fee schedules, CICIP, PH, and UH are considered as part of the monthly capitation rates paid to the MCOs except for the portion of CICIP, PH, and UH which are reflected via a separate payment term. HAP, UCHth-HAP, UTMC-HAP, and MRSS are reflected via a separate payment term.

(e) Directed payments not documented in the certification

We acknowledge the state may not use *de minimis* flexibility for changes to state directed payments and must submit a rate amendment for updates to state directed payments not included in the rate certification.

II. APPROPRIATE DOCUMENTATION

(a) Description of state directed payments

(i) Description of state directed payments included in the capitation rates

Nursing facility minimum fee schedule. ODM updates provider-specific nursing facility (NF) payment rates and acuity scores on a semi-annual basis.

COVID-19 testing minimum fee schedule. The state is requiring MCOs to pay CLIA-certified laboratories for the COVID-19 diagnostic testing codes at 100% of the Medicare rate during the CY 2025 rating period. Use of the Medicare fee schedule is implemented to ensure access to care for MMC enrollees. This is a minimum fee schedule directed payment arrangement.

CICIP. Effective July 1, 2018, CICIP was developed to increase alignment of quality improvement strategies and goals between ODM, MCOs, and both public and nonprofit hospital agencies.

CICIP is a quality payment program in which hospital agencies are paid based on the value of their quality improvement efforts. In recognition of implementing and executing quality improvement initiatives, monthly CICIP PMPM payments are made to eligible hospital agencies from the MCOs. These payments are allocated to hospital agencies based on historical utilization data.

In addition, participating hospital agencies will be eligible to receive annual quality improvement payments if they adhere to data reporting requirements and achieve performance improvements based on criteria established by ODM. The sum of CICIP PMPM amounts and annual quality improvement payments will not exceed average commercial reimbursement for physician services.

The goals of CICIP align with the ODM goals: improve healthcare for Medicaid beneficiaries at risk for or currently with an opioid or other substance abuse disorder, along with improving care coordination. Each participating hospital will receive supplemental payments under the Medicaid program for physician and other professional services that are covered by the Medicaid program and provided to Medicaid recipients.

Premier Health. In accordance with House Bill 33 as passed by the 135th General Assembly, the MCOs shall pay Premier Health an added payment amount for members receiving physician and other covered professional services. Payment amounts are based on an increase to target a percentage of average commercial reimbursement amounts. These payments are allocated monthly to participating health systems based on historical utilization. Upon completion of the rating period, an annual reconciliation will be performed against actual utilization for participating health systems. The total monthly payments will not exceed average commercial reimbursement for physician services. ODM estimates these payments will increase CY 2025 rating period aggregate Medicaid expenditures for physician services. The payment increases will apply to professional services provided to MMC enrollees.

University Hospital. In accordance with House Bill 33 as passed by the 135th General Assembly, the MCOs shall pay University Hospital an added payment amount for members receiving physician and other covered professional services. These payments are allocated monthly to participating health systems based on historical utilization. The total monthly payments will not exceed average commercial reimbursement for physician services. The payment increases will apply to professional services provided to MMC enrollees.

HAP. Effective January 1, 2021, ODM required that MCOs provide enhanced reimbursement to hospitals for inpatient and outpatient facility services as part of the Hospital Additional Payment (HAP) directed payment arrangement approved via a 438.6(c) preprint. The HAP arrangement is intended to increase hospital reimbursement above historical levels. Under the preprint, in-state hospitals will receive a quarterly payment initially calculated based on utilization from a prior period and ultimately reconciled based on utilization from the incurred period. Enhanced payment amounts will be determined separately for inpatient and outpatient services as outlined in the preprint. To determine payment amounts by hospital, ODM will apply a per discharge amount for inpatient services and a percentage of base payments for outpatient services. The payment increases will apply to in-state inpatient and outpatient services provided to MMC enrollees.

UCHth-HAP. In accordance with House Bill 33 as passed by the 135th General Assembly, effective January 1, 2024, ODM will require the MCOs to pay UCHth an added payment amount for MMC members receiving inpatient and outpatient hospital services. The MCOs shall pay a uniform percentage increase for inpatient and outpatient claims. Under the preprint, UCHth will receive a quarterly payment calculated based on historical utilization from a prior period and ultimately reconciled based on utilization from the incurred period. Enhanced payment amounts will be determined separately for inpatient and outpatient services and after accounting for HAP. In subsequent quarters, inpatient and outpatient service utilization underlying the interim payment will be reconciled to actual service utilization. The payment increases will apply to inpatient and outpatient services provided to MMC enrollees.

UTMC-HAP. In accordance with House Bill 110 as passed by the 134th General Assembly, the MCOs shall pay UTMC an added payment amount for members receiving inpatient and outpatient hospital services. The MCOs shall pay a uniform percentage increase for inpatient and outpatient claims. UTMC will receive an interim quarterly payment calculated based on inpatient and outpatient utilization from a previous period. Enhanced payment amounts will be determined separately for inpatient and outpatient services and after accounting for HAP. In subsequent quarters, inpatient and outpatient service utilization underlying the interim payment will be reconciled to actual service utilization. The payment increases will apply to inpatient and outpatient services provided to MMC enrollees.

MRSS. The MCOs shall pay the Regional MRSS Providers (RMPs) according to the state-defined minimum fee schedule amount for MRSS services. Each RMP will receive a monthly payment based on estimated utilization for that time period. A reconciliation is anticipated to occur following the end of the rating period. The minimum fee schedule will apply to MRSS services provided to MMC-enrolled children.

(ii) Payments incorporated as a rate adjustment

The section below illustrates the effect on the capitation rates of payments incorporated as a rate adjustment.

(A) Affected rate cells

The nursing facility minimum fee schedule, COVID-19 minimum fee schedule, CICIP, PH, and UH affect all rate cells (MAGI, EXP, ABD <21, ABD 21+, AFK) except the delivery kick payment.

(B) Reflection of payment arrangement in the certified capitation rates

Nursing facility minimum fee schedule. A previous section describes the adjustments made to the capitation rates in recognition of ODM's updated nursing facility fee schedule effective January 1, 2025.

COVID-19 testing minimum fee schedule. Amounts associated with the COVID-19 testing payment arrangement are reflected in the certified capitation rates through the base data. We do not anticipate that COVID-19 testing expenditures from the base period will be materially impacted by items such as program changes, acuity, trend, or non-benefit expenses.

Physician-directed payments

The calculation of the incentive pools for physician-directed payments will be completed after the rate year using actual utilization of professional services from eligible hospital agencies and will ensure that total payments do not exceed average commercial reimbursement for physician services.

CICIP. We estimated total payments for CICIP using historical utilization and cost data provided by ODM for CY 2023.

The total CICIP payment amounts were converted to a PMPM basis for application in the capitation rates.

The difference between CICIP payments and the ACR will be used to form an annual incentive pool, which will be provided to CICIP providers based on achievement of performance measures.

The CY 2025 capitation rates include PMPM amounts for CICIP, which vary by region and rate cell. The four hospitals participating in the program are the MetroHealth System, UC Health, University of Toledo Medical Center, and The Ohio State University Wexner Medical Center. Participating hospitals are categorized as:

> "Nonprofit hospital agency" as defined in Section 140.01 of the Revised Code, which is affiliated with a State university as defined in section 3345.011 of the Revised Code.
>
> "Public hospital agency" as defined in Section 140.01 of the Revised Code.

PH. We estimated total payments for PH using historical utilization and cost data provided by ODM for CY 2023. The total PH payment amounts were converted to a PMPM basis for application in the capitation rates. PH payment amounts were identified by provider NPI as provided by ODM.

UH. We estimated total payments for UH using historical utilization and cost data provided by ODM for CY 2023. State directed payments are established at levels below ACR. The total PH payment amounts were converted to a PMPM basis for application in the capitation rates. UH payment amounts were identified by provider NPI as provided by ODM.

(C) Description of consistency with 438.6(c) preprint

We confirm that each directed payment incorporated via rate adjustments as described in the rate certification is consistent with the submitted 438.6(c) preprints. We received and reviewed each state directed payment preprint as of the time of certification.

(D) Maximum fee schedule

The MMC rates do not include arrangements that have been implemented via a maximum fee schedule.

(iii) Payment incorporated as a separate payment term

The section below illustrates the effect on the capitation rates of payments incorporated as a separate payment term.

(A) Estimated PMPM by rate cell

Actual PMPM payments will be calculated on a retrospective basis and provided to CMS.

(B) Consistency with 438.6(c) preprint

We confirm that each directed payment incorporated via separate payment term as described in the rate certification is consistent with the approved 438.6(c) preprints. We received and reviewed each state directed payment preprint as of the time of certification.

(C) Statement that certification will be amended if rates vary

If the final state directed PMPM payments by rate cell for HAP, UCHth-HAP, UTMC-HAP, MRSS, CICIP, PH, and UH vary from the initial estimates presented in the rate certification, an amendment will be completed to reflect the final payments.

(b) Additional Directed Payments

There are no additional directed payment arrangements.

(c) Other Reimbursement Rate Requirements

There are no requirements regarding reimbursement rates the plans must pay to providers unless specified in the certification as a directed payment, pass-through payment, or authorized under applicable law, regulation, or waiver.

E. PASS-THROUGH PAYMENTS

I. RATE DEVELOPMENT STANDARDS

There are no pass-through payments reflected in the CY 2025 capitation rates.

II. APPROPRIATE DOCUMENTATION

There are no pass-through payments reflected in the CY 2025 capitation rates.

5. PROJECTED NON-BENEFIT COSTS

A. RATE DEVELOPMENT STANDARDS

I. OVERVIEW

In accordance with 42 CFR §438.5(e), the non-benefit component of the capitation rate includes reasonable, appropriate, and attainable expenses related to MCO operation of the MMC program.

The remainder of this section provides documentation of the data, assumptions, and methodology that we utilized to develop the non-benefit cost component of the capitation rate.

II. PMPM VERSUS PERCENTAGE

The non-benefit cost was developed as a percentage of the capitation rate.

B. APPROPRIATE DOCUMENTATION

I. DEVELOPMENT OF NON-BENEFIT COSTS

(a) Description of the data, assumptions, and methodologies

Data

The primary data sources used in the development of the CY 2025 non-benefit costs are listed below:

- Q2 2024 cost report data submitted by the MCOs, which includes experience through June 2024;
- CY 2022 and CY 2023 cost report data submitted by the MCOs;
- CY 2025 MCO Surveys completed by each MCO; and,
- Average costs from the financial statements of Medicaid health plans nationally, as summarized by Palmer, Pettit, and McCulla. These reports date from 2012 through 2024, analyzing financial results from 2011 through 2024.[6]

Assumptions and methodology

In developing the administrative costs, we reviewed historical administrative expenses for the MMC program along with national Medicaid health plan administrative expenses. We considered the size of participating health plans and the resulting economies of scale that could be achieved, along with the benefits covered and the demographics of the MMC population.

Historically reported administrative expenses were reconciled between the available data sources for the purpose of evaluating the quality of the data provided. CY 2023 and Q2 2024 cost report administrative expenses were analyzed by MCO for reasonableness and completeness of the data provided. This data formed the baseline for projected CY 2025 administrative expense amounts. There is a material amount of variation in the reporting of administrative expenses between MCOs, both in the magnitude of administrative expenses and in the rate cell allocation methodology utilized.

We summarized historical reported values for each MCO and reallocated these values using a percent of revenue before taxes allocation methodology. Separate administrative expense amounts were developed for MAGI Children, ABD <21, ABD 21+, Delivery, AFK, and the adult MAGI/EXP populations.

Non-benefit expense amounts were developed with consideration for sub capitated administrative expense amounts included in MCO cost report submissions.

(b) Material changes

To identify areas of material administrative cost changes, we completed a review of CY 2025 MCO Survey submissions, cost report data, the managed care provider agreement and considered anticipated changes impacting the rating period. Key areas of focus in terms of identifying administrative cost impacts included, but were not limited to:

- The impact of Ohio's Next Generation of Managed Care, including interfacing with ODM's newly implemented fiscal intermediary and EDI certification testing environment requirements;
- The impact of new MCOs providing benefits in the MMC program;

[6] The 2024 report analyzing administrative costs for 2023 can be found at: https://www.milliman.com/-/media/milliman/pdfs/2024-articles/7-31-24_medicaid-managed-care-financial-results-2023.ashx

- The impact of member disenrollments and economies of scale on fixed and variable costs;
- Administrative expenses associated with sub-capitated arrangements;
- Efforts associated with achieving quality withhold measures and minimum performance standards;
- Migration of member services to the OhioRISE program; and,
- MCO staffing requirements.

There are no other material changes to the data, assumptions, or methodology used to develop the projected non-benefit cost since the last rate certification.

(c) Other material adjustments

There are no other material adjustments applicable to the non-benefit cost component of the capitation rate.

II. NON-BENEFIT COSTS, BY COST CATEGORY

Administrative expenses have not been developed from the ground up (based on individual components). However, individual components were reviewed within MCO cost reports and financial statement data, in part to determine a distribution between administrative expenses and care management activities. In developing non-benefit amounts by cost category, we also attributed care management amounts to Healthcare Quality Improvement (HCQI). We anticipate a subset of HCQI expenses will reflect activities undertaken by the MCOs to achieve the quality withhold targets.

In addition, the CY 2025 capitation rates include amounts for the following projected non-benefit expenses:

Enhanced Maternal Program: ODM has implemented an enhanced maternal health program to target geographic areas with high infant mortality rates. ODM will provide guidelines to the MCOs for the purpose of developing strategies and systems that will provide enhanced maternal case management and reduce infant mortality rates. Funding to support MCO initiatives for the program is included in the applicable regions and female rate cells.

The aggregate funding was added to four female MAGI rate cells, before fees and taxes, for the enhanced maternal program. The rate cells assumed to be included in the program are HF/HST 14-18 F, HF 19-44 F, HF 45+ M+F, and HST 19-64 F. The total amount of available funding for the enhanced maternal program was allocated based on the assumed percent of targeted membership in each region and rate cell.

Quality Withhold Functions: This is incorporated via a PMPM amount attributable to each non-delivery rate cell. ODM requires the MCOs to enter into a joint agreement that establishes a Quality Withhold Innovation Fund ("Fund") with expectations for timing of MCO contributions, governance of funds, and use of funds.

MRSS State Directed Payment: For CY 2025, the MCOs will be required to contract with the state-identified Single Funding Source Manager for the MRSS state directed payment described in a previous section. The Single Funding Source Manager will collect the MRSS separate payment term amount from the MCOs on a monthly basis. The contract will be an administrative services subcontract directly between the MCOs and the Single Funding Source Manager. We included additional projected administrative expenses associated with this arrangement in the capitation rates. As this is a delegation of an MCO administrative services function, we expect the MCOs to delegate this additional administrative expense to the Single Funding Source Manager.

HUB Contracting Requirements: We included care management amounts under the delivery kick payment in six regions to account for the Pathways Community HUB (HUB) contracting requirements (North Central, Northwest, South Central, Southwest, Northeast Central, and Northeast).

Fees and Taxes are loaded to the capitation rates after the application of non-benefit expenses. This includes the Health Insuring Corporation (HIC) Franchise Fee along with the HIC tax. The HIC Franchise Fee consists of a PMPM amount that varies based on an entity's Medicaid member months. The development of the actuarially sound capitation rates includes HIC Franchise Fee (collected by ODM) and HIC tax (collected by the Ohio Department of Insurance) components.

HIC Franchise Fee amounts were developed by MCO based on estimated Medicaid member months for January through June 2025, and then weighted based on regional enrollment by MCO. As the HIC Franchise Fee is assessed on a state fiscal year basis, we anticipate amending the CY 2025 capitation rates to reflect HIC Franchise Fee amounts applicable to July through December 2025. The HIC tax will remain at 1% of total capitation.

6. RISK ADJUSTMENT

This section provides information on the risk adjustment included in the contract.

A. RATE DEVELOPMENT STANDARDS

I. OVERVIEW

In accordance with 42 CFR §438.5(g), we will follow the rate development standards related to budget-neutral risk adjustment for the MMC program. The composite rates for the MAGI, ABD, Expansion, and AFK populations will initially be prospectively risk adjusted by MCO on a regional basis to reflect estimated prospective acuity differences in the underlying population enrolling with each MCO. The initially risk-adjusted rates will be updated using the results of a concurrent risk adjustment process.

II. RISK ADJUSTMENT MODEL

Risk adjustment will be performed using CDPS-Rx risk scoring models. Risk adjustment will be performed on a budget neutral basis at the region and rate cell level. Select rate cells may be excluded from the risk adjustment process.

B. APPROPRIATE DOCUMENTATION

I. PROSPECTIVE RISK ADJUSTMENT

(a) Data and adjustments

The January 1, 2025 through June 30, 2025 period will initially be risk adjusted based on a methodology that utilizes the most recent available data and concurrent disease weights. The risk adjustment diagnosis base data will exclude diagnosis codes associated with diagnostic testing and certain medical supply codes. The July 1, 2025 through December 31, 2025 period will be risk adjusted using a process similar to the January 1, 2025 through June 30, 2025 period.

The risk adjustment process will account for the variation in HIC Franchise Fee payments by MCO. Risk scores will be applied to the CY 2025 capitation rates less CICIP, PH, UH, HIC Franchise Fee, and HIC tax amounts. We will then apply CICIP, PH, and UH amounts along with MCO-specific HIC Franchise Fee and HIC tax amounts to the normalized rates on a budget neutral basis. For rate cells excluded from risk adjustment yet subject to the HIC Franchise fee, we will apply adjustments to account for variation in projected HIC Franchise Fee amounts by MCO.

(b) Risk adjustment model

Populations will be risk-adjusted using CDPS-Rx risk scoring models as the basis for assigning members to condition categories.

(c) Risk adjustment methodology

The risk adjustment is designed to be cost neutral for each population. Relative risk scores will be normalized to result in a composite risk score of 1.000 for each population group, across all MCOs. The risk adjustment methodology uses generally accepted actuarial principles and practices.

II. RETROSPECTIVE RISK ADJUSTMENT

Following the completion of the rating period, we anticipate revising the preliminary CY 2025 risk adjusted rates to utilize relative risk scores derived from an updated concurrent risk adjustment analysis. This methodology is being implemented because of enrollment changes in the MMC program which have the potential to produce discrepancies in the risk profile by MCO for members not scored under the initial prospective risk adjustment methodology.

7. ACUITY ADJUSTMENTS

A. RATE DEVELOPMENT STANDARDS

This section provides documentation of the acuity adjustments in the MMC program.

B. APPROPRIATE DOCUMENTATION

There are no acuity adjustments included in the CY 2025 MMC capitation rate development.

Section II. New adult group capitation rates

ODM implemented the Affordable Care Act's Medicaid expansion on January 1, 2014. As of August 2024, approximately 727,000 individuals receive Medicaid benefits through MCOs under ODM's Expansion population[7].

1. DATA

A. DATA USED IN CERTIFICATION

The source of data used to develop the Expansion capitation rates for CY 2025 is consistent with the source of data used in the development of rates for the ABD, MAGI, and AFK populations: encounter data submitted by the contracted MCOs.

B. EXPERIENCE VS. ASSUMPTIONS

ODM has monitored enrollment and costs in the Expansion population on an ongoing basis. Internal reports are shared with ODM personnel and its vendors, tracking eligibility changes by rate cell and county. Encounter and cost report data is used to track financial experience from the MCOs on a quarterly basis.

2. PROJECTED BENEFIT COSTS

A. DESCRIPTION OF PROJECTED BENEFIT COST ISSUES

CY 2023 encounter data was used as the underlying data source for the development of the CY 2025 capitation rates. This process is consistent with the methodology used in developing the January 1, 2024 through December 31, 2024 capitation rates for the Expansion population.

The data sources, assumptions, and methodologies are generally consistent with the January 1, 2024 through December 31, 2024 certification.

Discussion of other assumption changes is provided in the next section.

B. DESCRIPTION OF KEY ASSUMPTIONS

I. ACUITY OR HEALTH STATUS ADJUSTMENTS

We observed material enrollment increases in the Expansion population due to ODM's pause in member disenrollment as well as economic impacts of the COVID-19 pandemic. With member dis-enrollments resuming as part of PHE unwinding, the CY 2025 capitation rates include adjustments to reflect the fact that the Expansion population is anticipated to be more acute in composite as a result. Our methodology for developing these adjustments is detailed further in preceding sections.

II. ADJUSTMENTS FOR PENT-UP DEMAND

Consistent with the CY 2024 capitation rates, it was assumed that the baseline experience data did not require these adjustments.

[7] *Medicaid Demographic and Expenditure, Ohio.* (Accessed October 31, 2024). https://analytics.das.ohio.gov/t/ODMPUB/views/MedicaidDemographicandExpenditure/WhoWeServe?%3AisGuestRedirectFromVizportal=y&%3Aembed=y

III. ADJUSTMENT FOR ADVERSE SELECTION

Consistent with the CY 2024 capitation rates, it was assumed that the baseline experience data did not require these adjustments.

IV. ADJUSTMENT FOR DEMOGRAPHICS OF THE NEW ADULT GROUP

The current rate cell structure of the Expansion population appropriately adjusts capitation payments to the MCOs to the extent the demographic mix of the Expansion population changes materially during the CY 2025 rate period.

V. DIFFERENCES IN PROVIDER REIMBURSEMENT RATES OR PROVIDER NETWORKS

MCOs were required to report provider reimbursement relative to ODM's reimbursement schedule by population group (MAGI, ABD <21, ABD 21+, Expansion, and AFK) and major service category in the 2025 MCO Survey. In addition, we received re-priced inpatient and outpatient claims experience from ODM that allowed us to evaluate MCO hospital reimbursement relative to ODM's reimbursement schedule. We are not aware of any provider network differences between the Expansion population and other Medicaid populations. Variations in assumptions by covered population were not based on the rate of Federal financial participation associated with the population.

VI. OTHER MATERIAL ADJUSTMENTS TO THE NEW ADULT GROUP PROJECTED BENEFIT COSTS

No other material adjustments were applied exclusively to the new adult group projected benefit costs.

C. CHANGES TO BENEFIT PLAN

No benefit changes have been made to the Expansion benefit plan, other than items discussed previously in this report.

D. OTHER MATERIAL CHANGES OR ADJUSTMENTS TO BENEFIT COSTS

We did not make any other adjustments in the Expansion rate development process other than those previously outlined in this report.

3. PROJECTED NON-BENEFIT COSTS

A. CHANGES IN DATA SOURCES, ASSUMPTIONS, OR METHODOLOGIES SINCE LAST CERTIFICATION

Cost report data, including non-benefit costs, was available for CY 2022, CY 2023, and through Q2 2024. We used this information to evaluate the reasonableness of our non-benefit expense assumptions for the Expansion population. The non-benefit expense percentage loads are the same for the MAGI 19+ and Expansion populations in the development of the CY 2024 rates, consistent with the prior certification.

Non-benefit expense amounts were developed with consideration for sub capitated administrative expense amounts included in MCO cost report submissions.

To identify areas of material administrative cost changes, we completed a review of CY 2025 MCO Survey submissions, cost report data, the managed care provider agreement and considered anticipated changes impacting the rating period. Key areas of focus in terms of identifying administrative cost impacts included, but were not limited to:

- The impact of Ohio's Next Generation of Managed Care, including interfacing with ODM's newly implemented fiscal intermediary and EDI certification testing environment requirements;
- The impact of new MCOs providing benefits in the MMC program;
- The impact of member disenrollments and economies of scale on fixed and variable costs;
- Administrative expenses associated with sub-capitated arrangements;
- Efforts associated with achieving quality withhold measures;

- Migration of member services to the OhioRISE program and SPBM; and,
- MCO staffing requirements.

B. ASSUMPTION DIFFERENCES RELATIVE TO OTHER MEDICAID POPULATIONS

As stated previously, these assumptions for the Expansion population are equivalent to the MAGI 19+ population.

4. FINAL CERTIFIED RATES

A. COMPARISON TO PREVIOUS CERTIFICATION

On an aggregate basis, the CY 2025 Expansion rates are estimated to increase materially. Details regarding program changes representing key drivers of the rate increase can be found in preceding sections.

B. DESCRIPTION OF OTHER MATERIAL CHANGES TO THE CAPITATION RATES

We have addressed all material changes to the Expansion rate development methodology.

5. RISK MITIGATION STRATEGIES

A. DESCRIPTION OF RISK MITIGATION STRATEGY

The capitation rates were developed such that the MCOs are reasonably expected to achieve a medical loss ratio greater than 85 percent, which includes provisions for non-benefit costs that are appropriate and attainable. ODM's provider agreement indicates that ODM will perform medical loss ratio (MLR) calculations for the MMC program. ODM has implemented a minimum MLR requirement of 86% for the MMC program. ODM will require remittance in the event an MCO reports a MLR below 86%.

B. CHANGES TO RISK MITIGATION STRATEGY RELATIVE TO PRIOR YEARS

The CY 2025 rating period includes an 86% minimum MLR requirement, which is consistent with the requirements for the Expansion program in the January 2024 through December 2024 rating period.

Limitations and Data Reliance

The information contained in this report has been prepared for the Ohio Department of Medicaid (ODM) to provide documentation of the development of the capitation rates for the Medicaid Managed Care (MMC) program for the period of January 1, 2025 through December 31, 2025. The data and information presented may not be appropriate for any other purpose.

The information contained in this report, including the appendices, has been prepared for ODM and their consultants and advisors. It is our understanding that the information contained in this report may be shared with managed care organizations (MCO) participating in the MMC program and the Centers for Medicare and Medicaid Services (CMS). Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this report to third parties. Likewise, third parties are instructed that they are to place no reliance upon this report prepared for ODM by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this report must rely upon their own experts in drawing conclusions about the capitation rates, assumptions, and trends.

Milliman has developed certain models to estimate the values included in this report. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP). The models rely on data and information as input to the models. We have relied upon certain data and information provided by ODM and the participating Medicaid MCOs for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete. The models, including all input, calculations, and output may not be appropriate for any other purpose.

It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

We acknowledge the unique nature of the COVID-19 Public Health Emergency and the resumption of redeterminations and terminations of coverage occurred between the base period and the rating period. The assumptions documented in this report reflect information known to us at the time of this report. We acknowledge that the resumption of redeterminations and enrollment unwinding period could have a material impact on utilization, acuity, Medicaid enrollment, service delivery, and other factors related to the capitation rates.

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

Appendix 1: Rate Change Summaries

Ohio Department of Medicaid
Medicaid Managed Care Program
Capitation Rates Effective January 1, 2025
Rate Change Summary

Region: North Central

Rate Cell	Avg Monthly Enrollment / Deliveries	July 2024 Capitation Rate	CY 2025 Capitation Rate	% Change
MAGI				
HF/HST <1 M+F	3,855	$ 1,173.14	$ 1,096.89	(6.5%)
HF/HST 1 M+F	3,549	194.68	198.62	2.0%
HF/HST 2-13 M+F	45,077	190.44	210.09	10.3%
HF/HST 14-18 M	8,683	200.38	188.70	(5.8%)
HF/HST 14-18 F	8,643	241.94	247.57	2.3%
HF 19-44 M	4,409	284.00	315.24	11.0%
HF 19-44 F	18,982	468.79	476.80	1.7%
HF 45+ M+F	3,034	569.16	624.92	9.8%
HST 19-64 F	1,950	448.47	480.72	7.2%
Subtotal MAGI	**98,182**	**$ 309.43**	**$ 320.38**	**3.5%**
EXP				
EXP 19-34 M	10,293	$ 483.17	$ 507.06	4.9%
EXP 19-34 F	8,934	439.58	470.37	7.0%
EXP 35-44 M	5,504	734.79	821.78	11.8%
EXP 35-44 F	4,368	692.17	764.29	10.4%
EXP 45-54 M	4,218	809.45	943.17	16.5%
EXP 45-54 F	4,218	793.99	869.55	9.5%
EXP 55-64 M	3,423	1,007.39	1,123.89	11.6%
EXP 55-64 F	3,583	838.00	857.00	2.3%
Subtotal EXP	**44,541**	**$ 655.18**	**$ 715.00**	**9.1%**
ABD				
ABD <21	3,717	$ 730.07	$ 708.88	(2.9%)
ABD 21+	9,855	1,297.29	1,328.88	2.4%
Subtotal ABD	**13,572**	**$ 1,141.94**	**$ 1,159.08**	**1.5%**
AFK	**2,171**	**$ 467.40**	**$ 402.30**	**(13.9%)**
MAGI & EXP Delivery	**242**	**$ 6,477.52**	**$ 6,682.29**	**3.2%**
Total	**158,466**	**$ 489.97**	**$ 514.46**	**5.0%**

Ohio Department of Medicaid
Medicaid Managed Care Program
Capitation Rates Effective January 1, 2025
Rate Change Summary

Region: Northwest

Rate Cell	Avg Monthly Enrollment / Deliveries	July 2024 Capitation Rate	CY 2025 Capitation Rate	% Change
MAGI				
HF/HST <1 M+F	2,904	$ 1,143.18	$ 930.96	(18.6%)
HF/HST 1 M+F	2,598	194.76	217.33	11.6%
HF/HST 2-13 M+F	30,825	160.08	172.99	8.1%
HF/HST 14-18 M	6,032	207.19	169.99	(18.0%)
HF/HST 14-18 F	5,820	240.27	225.41	(6.2%)
HF 19-44 M	2,926	319.92	352.28	10.1%
HF 19-44 F	11,250	423.37	443.97	4.9%
HF 45+ M+F	1,763	584.29	704.34	20.5%
HST 19-64 F	1,656	382.94	396.78	3.6%
Subtotal MAGI	**65,774**	**$ 285.40**	**$ 286.77**	**0.5%**
EXP				
EXP 19-34 M	5,048	$ 413.12	$ 424.93	2.9%
EXP 19-34 F	4,994	412.56	411.33	(0.3%)
EXP 35-44 M	2,756	649.12	695.75	7.2%
EXP 35-44 F	2,707	586.14	656.85	12.1%
EXP 45-54 M	2,192	757.51	842.76	11.3%
EXP 45-54 F	2,592	827.80	916.75	10.7%
EXP 55-64 M	2,027	1,048.22	1,113.47	6.2%
EXP 55-64 F	2,283	945.91	949.23	0.4%
Subtotal EXP	**24,599**	**$ 634.65**	**$ 672.48**	**6.0%**
ABD				
ABD <21	1,744	$ 724.62	$ 764.67	5.5%
ABD 21+	4,425	1,128.17	1,157.49	2.6%
Subtotal ABD	**6,169**	**$ 1,014.08**	**$ 1,046.44**	**3.2%**
AFK	**1,554**	**$ 371.69**	**$ 272.55**	**(26.7%)**
MAGI & EXP Delivery	**179**	**$ 5,733.10**	**$ 6,381.48**	**11.3%**
Total	**98,096**	**$ 430.63**	**$ 442.69**	**2.8%**

Ohio Department of Medicaid
Medicaid Managed Care Program
Capitation Rates Effective January 1, 2025
Rate Change Summary

Region: Southwest

Rate Cell	Avg Monthly Enrollment / Deliveries	July 2024 Capitation Rate	CY 2025 Capitation Rate	% Change
MAGI				
HF/HST <1 M+F	16,648	$ 1,217.60	$ 1,268.16	4.2%
HF/HST 1 M+F	14,738	269.93	276.22	2.3%
HF/HST 2-13 M+F	179,133	198.12	201.25	1.6%
HF/HST 14-18 M	35,193	207.09	192.19	(7.2%)
HF/HST 14-18 F	35,475	284.16	248.99	(12.4%)
HF 19-44 M	18,358	302.71	309.49	2.2%
HF 19-44 F	70,812	445.16	454.08	2.0%
HF 45+ M+F	12,269	557.41	587.20	5.3%
HST 19-64 F	7,831	445.96	504.99	13.2%
Subtotal MAGI	**390,457**	**$ 318.90**	**$ 322.25**	**1.0%**
EXP				
EXP 19-34 M	41,213	$ 436.49	$ 430.03	(1.5%)
EXP 19-34 F	34,119	436.51	436.64	0.0%
EXP 35-44 M	23,281	686.92	709.56	3.3%
EXP 35-44 F	17,994	700.40	731.13	4.4%
EXP 45-54 M	17,787	827.81	855.73	3.4%
EXP 45-54 F	17,083	811.99	811.73	(0.0%)
EXP 55-64 M	14,443	989.60	1,069.23	8.0%
EXP 55-64 F	14,946	849.21	927.06	9.2%
Subtotal EXP	**180,866**	**$ 647.21**	**$ 667.25**	**3.1%**
ABD				
ABD <21	12,279	$ 866.11	$ 953.29	10.1%
ABD 21+	32,469	1,235.61	1,260.86	2.0%
Subtotal ABD	**44,748**	**$ 1,134.22**	**$ 1,176.46**	**3.7%**
AFK	**9,415**	**$ 448.37**	**$ 492.08**	**9.7%**
MAGI & EXP Delivery	**984**	**$ 6,244.03**	**$ 6,521.76**	**4.4%**
Total	**625,486**	**$ 483.94**	**$ 495.94**	**2.5%**

Ohio Department of Medicaid
Medicaid Managed Care Program
Capitation Rates Effective January 1, 2025
Rate Change Summary

Region: South Central

Rate Cell	Avg Monthly Enrollment / Deliveries	July 2024 Capitation Rate	CY 2025 Capitation Rate	% Change
MAGI				
HF/HST <1 M+F	14,587	$ 1,479.15	$ 1,320.34	(10.7%)
HF/HST 1 M+F	12,459	296.34	329.06	11.0%
HF/HST 2-13 M+F	155,582	197.35	215.09	9.0%
HF/HST 14-18 M	29,609	231.96	232.02	0.0%
HF/HST 14-18 F	29,794	276.91	294.34	6.3%
HF 19-44 M	16,506	329.81	350.86	6.4%
HF 19-44 F	57,230	491.30	512.57	4.3%
HF 45+ M+F	12,181	593.78	658.05	10.8%
HST 19-64 F	6,935	505.78	543.27	7.4%
Subtotal MAGI	**334,883**	**$ 344.57**	**$ 356.46**	**3.4%**
EXP				
EXP 19-34 M	34,225	$ 576.41	$ 577.01	0.1%
EXP 19-34 F	28,542	523.88	556.16	6.2%
EXP 35-44 M	18,462	833.32	919.28	10.3%
EXP 35-44 F	14,732	800.13	886.04	10.7%
EXP 45-54 M	14,524	960.56	1,034.69	7.7%
EXP 45-54 F	13,636	898.44	961.51	7.0%
EXP 55-64 M	10,755	1,112.36	1,223.44	10.0%
EXP 55-64 F	11,543	932.77	1,077.19	15.5%
Subtotal EXP	**146,419**	**$ 756.63**	**$ 815.32**	**7.8%**
ABD				
ABD <21	10,424	$ 1,024.80	$ 1,112.68	8.6%
ABD 21+	28,857	1,294.31	1,388.36	7.3%
Subtotal ABD	**39,281**	**$ 1,222.79**	**$ 1,315.20**	**7.6%**
AFK	**5,952**	**$ 589.86**	**$ 517.89**	**(12.2%)**
MAGI & EXP Delivery	**816**	**$ 6,080.66**	**$ 6,405.71**	**5.3%**
Total	**526,535**	**$ 536.87**	**$ 567.34**	**5.7%**

Ohio Department of Medicaid
Medicaid Managed Care Program
Capitation Rates Effective January 1, 2025
Rate Change Summary

Region: Southeast

Rate Cell	Avg Monthly Enrollment / Deliveries	July 2024 Capitation Rate	CY 2025 Capitation Rate	% Change
MAGI				
HF/HST <1 M+F	4,308	$ 1,071.19	$ 1,019.53	(4.8%)
HF/HST 1 M+F	3,878	241.80	222.04	(8.2%)
HF/HST 2-13 M+F	48,966	173.56	177.13	2.1%
HF/HST 14-18 M	9,683	190.88	189.20	(0.9%)
HF/HST 14-18 F	9,719	239.37	241.12	0.7%
HF 19-44 M	5,905	310.92	329.74	6.1%
HF 19-44 F	19,201	461.21	471.53	2.2%
HF 45+ M+F	3,581	602.32	637.73	5.9%
HST 19-64 F	2,439	486.39	502.98	3.4%
Subtotal MAGI	**107,680**	**$ 299.60**	**$ 302.87**	**1.1%**
EXP				
EXP 19-34 M	10,256	$ 424.59	$ 456.06	7.4%
EXP 19-34 F	9,137	452.59	483.17	6.8%
EXP 35-44 M	5,808	601.16	691.06	15.0%
EXP 35-44 F	5,231	665.95	721.84	8.4%
EXP 45-54 M	4,843	753.17	795.03	5.6%
EXP 45-54 F	5,418	763.40	901.18	18.0%
EXP 55-64 M	4,359	928.68	939.05	1.1%
EXP 55-64 F	4,830	843.23	975.11	15.6%
Subtotal EXP	**49,882**	**$ 628.88**	**$ 689.98**	**9.7%**
ABD				
ABD <21	3,178	$ 750.47	$ 903.21	20.4%
ABD 21+	11,254	1,133.31	1,205.25	6.3%
Subtotal ABD	**14,432**	**$ 1,049.01**	**$ 1,138.74**	**8.6%**
AFK	**3,064**	**$ 428.78**	**$ 357.79**	**(16.6%)**
MAGI & EXP Delivery	**258**	**$ 5,538.83**	**$ 5,957.08**	**7.6%**
Total	**175,058**	**$ 465.63**	**$ 491.83**	**5.6%**

Ohio Department of Medicaid
Medicaid Managed Care Program
Capitation Rates Effective January 1, 2025
Rate Change Summary

Region: Northeast

Rate Cell	Avg Monthly Enrollment / Deliveries	July 2024 Capitation Rate	CY 2025 Capitation Rate	% Change
MAGI				
HF/HST <1 M+F	16,579	$ 1,386.18	$ 1,523.77	9.9%
HF/HST 1 M+F	15,439	267.24	298.00	11.5%
HF/HST 2-13 M+F	203,671	214.43	220.56	2.9%
HF/HST 14-18 M	40,444	229.47	230.22	0.3%
HF/HST 14-18 F	40,545	285.95	268.24	(6.2%)
HF 19-44 M	21,230	290.07	292.63	0.9%
HF 19-44 F	85,974	449.02	465.79	3.7%
HF 45+ M+F	16,369	541.60	590.82	9.1%
HST 19-64 F	9,432	569.39	626.08	10.0%
Subtotal MAGI	**449,683**	**$ 335.02**	**$ 348.70**	**4.1%**
EXP				
EXP 19-34 M	53,407	$ 385.83	$ 397.39	3.0%
EXP 19-34 F	44,456	414.04	451.32	9.0%
EXP 35-44 M	28,169	574.45	600.98	4.6%
EXP 35-44 F	21,490	590.09	650.71	10.3%
EXP 45-54 M	22,955	734.77	741.82	1.0%
EXP 45-54 F	22,095	734.51	771.73	5.1%
EXP 55-64 M	19,892	913.34	1,028.70	12.6%
EXP 55-64 F	21,124	769.05	870.27	13.2%
Subtotal EXP	**233,588**	**$ 579.59**	**$ 621.29**	**7.2%**
ABD				
ABD <21	17,735	$ 837.17	$ 922.56	10.2%
ABD 21+	48,824	1,201.39	1,272.08	5.9%
Subtotal ABD	**66,559**	**$ 1,104.34**	**$ 1,178.95**	**6.8%**
AFK	**8,297**	**$ 591.70**	**$ 493.46**	**(16.6%)**
MAGI & EXP Delivery	**1,070**	**$ 6,409.53**	**$ 6,722.41**	**4.9%**
Total	**758,127**	**$ 489.77**	**$ 516.65**	**5.5%**

Ohio Department of Medicaid
Medicaid Managed Care Program
Capitation Rates Effective January 1, 2025
Rate Change Summary

Region: Northeast Central

Rate Cell	Avg Monthly Enrollment / Deliveries	July 2024 Capitation Rate	CY 2025 Capitation Rate	% Change
MAGI				
HF/HST <1 M+F	4,494	$ 1,052.18	$ 1,192.65	13.4%
HF/HST 1 M+F	3,822	230.17	254.73	10.7%
HF/HST 2-13 M+F	49,314	184.28	199.39	8.2%
HF/HST 14-18 M	9,731	206.56	187.42	(9.3%)
HF/HST 14-18 F	9,690	247.68	258.21	4.3%
HF 19-44 M	4,950	282.02	261.82	(7.2%)
HF 19-44 F	19,029	397.32	426.20	7.3%
HF 45+ M+F	3,160	513.62	521.81	1.6%
HST 19-64 F	2,427	456.55	485.96	6.4%
Subtotal MAGI	**106,617**	**$ 288.82**	**$ 306.95**	**6.3%**
EXP				
EXP 19-34 M	9,885	$ 324.46	$ 357.26	10.1%
EXP 19-34 F	9,055	403.63	397.94	(1.4%)
EXP 35-44 M	5,376	553.92	583.24	5.3%
EXP 35-44 F	4,910	568.31	610.54	7.4%
EXP 45-54 M	4,477	698.29	701.70	0.5%
EXP 45-54 F	4,794	727.22	758.51	4.3%
EXP 55-64 M	3,853	843.01	939.37	11.4%
EXP 55-64 F	4,339	784.64	822.35	4.8%
Subtotal EXP	**46,689**	**$ 554.64**	**$ 583.30**	**5.2%**
ABD				
ABD <21	3,248	$ 784.80	$ 838.70	6.9%
ABD 21+	8,799	1,064.94	1,054.88	(0.9%)
Subtotal ABD	**12,047**	**$ 989.41**	**$ 996.60**	**0.7%**
AFK	**2,829**	**$ 535.14**	**$ 428.84**	**(19.9%)**
MAGI & EXP Delivery	**284**	**$ 5,512.09**	**$ 5,733.42**	**4.0%**
Total	**168,182**	**$ 426.25**	**$ 444.80**	**4.4%**

Ohio Department of Medicaid
Medicaid Managed Care Program
Capitation Rates Effective January 1, 2025
Rate Change Summary

Region: Statewide

Rate Cell	Avg Monthly Enrollment / Deliveries	July 2024 Capitation Rate	CY 2025 Capitation Rate	% Change
MAGI				
HF/HST <1 M+F	63,375	$ 1,294.10	$ 1,298.91	0.4%
HF/HST 1 M+F	56,483	262.21	281.07	7.2%
HF/HST 2-13 M+F	712,568	197.84	207.34	4.8%
HF/HST 14-18 M	139,375	217.29	209.97	(3.4%)
HF/HST 14-18 F	139,686	273.05	263.27	(3.6%)
HF 19-44 M	74,284	303.96	314.32	3.4%
HF 19-44 F	282,478	454.27	469.93	3.4%
HF 45+ M+F	52,357	562.94	610.45	8.4%
HST 19-64 F	32,670	495.05	539.58	9.0%
Subtotal MAGI	**1,553,276**	**$ 323.68**	**$ 333.27**	**3.0%**
EXP				
EXP 19-34 M	164,327	$ 443.89	$ 451.95	1.8%
EXP 19-34 F	139,237	445.50	467.62	5.0%
EXP 35-44 M	89,356	669.92	716.35	6.9%
EXP 35-44 F	71,432	671.35	729.13	8.6%
EXP 45-54 M	70,996	808.36	846.45	4.7%
EXP 45-54 F	69,836	794.27	839.00	5.6%
EXP 55-64 M	58,752	975.18	1,070.27	9.8%
EXP 55-64 F	62,648	835.53	928.83	11.2%
Subtotal EXP	**726,584**	**$ 640.38**	**$ 681.58**	**6.4%**
ABD				
ABD <21	52,325	$ 861.46	$ 940.82	9.2%
ABD 21+	144,483	1,218.32	1,274.71	4.6%
Subtotal ABD	**196,808**	**$ 1,123.45**	**$ 1,185.94**	**5.6%**
AFK	**33,282**	**$ 512.64**	**$ 463.19**	**(9.6%)**
MAGI & EXP Delivery	**3,833**	**$ 6,144.63**	**$ 6,460.23**	**5.1%**
Total	**2,509,950**	**$ 489.96**	**$ 512.55**	**4.6%**

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APPENDIX N – COMPLIANCE ACTIONS

1. General Requirements

a. Pursuant to OAC rule 5160-26-10 and 42 CFR 438 Subpart I, ODM may impose the compliance actions described in this appendix against the MCO if ODM finds that the MCO has failed to comply with the terms of this Agreement or any other federal or state requirements. Compliance actions include but are not limited to the administrative actions and sanctions described in this appendix. The compliance actions are not exclusive, meaning that ODM's imposition of any particular compliance action does not preclude ODM from taking additional compliance actions available under this Agreement or state and federal law.

b. The requirements within this appendix do not limit ODM's authority to investigate fraud, waste, and abuse, conduct audits, or pursue legal remedies arising from those investigations and audits.

c. ODM, at its sole discretion, will determine and impose the most appropriate compliance action based on considerations that include the severity of the noncompliance, a pattern of repeated noncompliance, and the number of eligible individuals and members affected. ODM will consider evidence provided by the MCO that the noncompliance was beyond its control and could not have reasonably been foreseen (e.g., a construction crew severs a phone line, a lightning strike disables a computer system) as a mitigating factor in determining a compliance action. ODM will not consider MCO subcontractor noncompliance to be beyond the MCO's control, unless the noncompliance was beyond the subcontractor's control.

d. The MCO must take immediate action to correct noncompliance identified by the MCO or ODM. The MCO's responsibility to correct noncompliance is not dependent upon ODM identification of noncompliance or compliance actions therefrom.

e. The MCO must report to ODM upon MCO awareness of any noncompliance that could impair a member's ability to obtain correct information regarding services, impair member rights, affect the ability of the MCO to deliver covered services, or affect a member's ability to access covered services.

f. The MCO is singularly responsible for fully complying with all terms in this Agreement. The MCO is precluded from using ODM technical assistance to help the MCO achieve compliance with this Agreement as a defense for MCO noncompliance.

g. ODM will issue notices of compliance actions in writing to the MCO contact identified in the Baseline Provider Agreement of this Agreement.

2. Administrative Actions

a. <u>Notice of Noncompliance</u>

i. ODM may issue a written Notice of Noncompliance to the MCO when ODM identifies MCO noncompliance and does not require any other compliance action (e.g., MCO developed corrective action plan, directed corrective action plan).

ii. The MCO must take immediate action to correct the identified noncompliance and notify ODM of the action taken to address noncompliance.

b. Corrective Action Plans

i. *General*

1. If ODM determines that the MCO is not in compliance with one or more requirements in this Agreement, including those requirements established by a transition plan in accordance with Appendix O, MCO Termination and Non-Renewal, ODM may issue a Notice of Compliance Action, identifying the deficiency or deficiencies and required MCO follow-up for each. The MCO follow-up may come in the form of an MCO-developed Corrective Action Plan (CAP) or a Directed CAP. ODM will also issue a Notice of Compliance Action when ODM determines that sanctions are necessary.

2. A CAP is a structured activity, process, or quality improvement (QI) initiative implemented by the MCO to address noncompliance. The MCO must submit all CAPs as specified by ODM. The MCO's CAP must, at a minimum, identify:

   a. The root cause or causes of a deficiency;

   b. The goals, objectives, methodologies, and actions/tasks to be taken to achieve compliance; and

   c. The staff responsible to carry out the CAP within the established timelines.

3. A CAP will remain in effect until the MCO has provided evidence to ODM's satisfaction that the MCO has fulfilled the requirements of the CAP to achieve and sustain compliance. Failure of the MCO to achieve compliance within the timeframes established within the CAP and sustain compliance thereafter may result in an escalation of compliance actions as provided in this appendix.

ii. *MCO-Developed Corrective Action Plan*

1. When directed by ODM, the MCO must submit a proposed CAP as specified in the Notice of Compliance Action for any instance of noncompliance with this Agreement or any federal or state requirement. The MCO's proposed CAP is subject to ODM approval.

iii. *Directed Corrective Action Plan*

1. When directed by ODM in a Notice of Compliance Action, the MCO must comply with an ODM-developed or "directed" CAP when ODM has determined the specific action that the MCO must implement.

2. ODM may also issue a directed CAP if the MCO fails to submit a CAP.

3. Sanctions

a. Pre-Determined Financial Sanctions

i. In addition to other compliance actions available to ODM, ODM may impose the following pre-determined financial sanctions in accordance with Table N.1 below.

Table N.1 Pre-Determined Financial Sanctions

	Noncompliance	Financial Sanction
1.	Failure to demonstrate readiness within the timeframe established by ODM as part of the MCO's readiness review as specified in Appendix A, General Requirements.	• $2,000 per calendar day for each readiness requirement until the MCO demonstrates readiness to ODM's satisfaction
2.	Failure to comply with staffing requirements as specified in Appendix A, General Requirements.	• $1,000 per calendar day per position
3.	Failure to have appropriate MCO staff members attend meetings as requested by ODM as specified in Appendix A, General Requirements.	• $1,000 per appropriate staff person, per meeting occurrence or portion thereof
4.	Failure to operate a toll-free member services call center and 24/7 medical advice call center with appropriately trained medical personnel as specified in Appendix A, General Requirements.	• $5,000 per calendar day for failure to operate each line (member services and 24/7 medical advice) **OR** • $5,000 per calendar day for failure to have appropriately trained medical personnel for the MCO's 24/7 medical advice call center
5.	Failure to meet monthly call center metrics for member services, provider services or the 24/7 medical advice call center as specified in Appendix A, General Requirements.	• $10,000 per month, per metric

	Noncompliance	Financial Sanction
6.	Failure to secure protected health information as defined by Health Insurance Portability and Accountability Act (HIPAA) as specified in Appendix A, General Requirements.	• $1,000 per member, per occurrence **AND** • Costs associated with credit monitoring and/or identity theft, safeguard services, as determined necessary by ODM
7.	Failure to forward a grievance, appeal, or request for state hearing received in error by the MCO to the appropriate ODM-contracted managed care entity, as required by Appendix A, General Requirements.	• $1,000 per member, per occurrence
8.	Failure to resolve at least 98% of expedited appeals within required timelines, as specified in Appendix A, General Requirements.	• $10,000 per month.
9.	Failure to resolve at least 95% of standard appeals within required timelines, as specified in Appendix A, General Requirements.	• $10,000 per month
10.	Failure to resolve at least 98% of access related member grievances or 95% of non-access related member grievances within required timelines, as specified in Appendix A, General Requirements.	• $10,000 per month.
11.	Failure to continue services during a pending appeal or state hearing as specified in Appendix A, General Requirements.	• Cost of services that should have been continued as determined by ODM **AND** • $500 for each calendar day the service should have been continued
12.	Failure to authorize services after receiving a reversal of MCO decision resulting from an appeal or state hearing as specified in Appendix A, General Requirements.	• Cost of services that should have been authorized as determined by ODM **AND** • $500 for each calendar day the service should have been authorized

	Noncompliance	Financial Sanction
13.	Failure to ensure appropriate MCO representatives attend state hearings as scheduled as specified in Appendix A, General Requirements.	• $2,500 per occurrence
14.	Failure to provide necessary witnesses or evidentiary materials for state hearings as specified in Appendix A, General Requirements.	• $1,000 per occurrence
15.	Failure to meet FDR notification requirements as specified in Appendix A, General Requirements.	• $25,000 per occurrence
16.	Failure to comply with denial of inpatient behavioral health pre-certification/claims and OhioRISE Plan notification requirements for members eligible for OhioRISE, as specified in Appendix A, General Administrative Requirements and the OhioRISE Mixed Services Protocol.	• $1,000 per occurrence AND • Corrective Action Plan
17.	Failure to comply with HealthTrack complaint requirements and outreach providers within the required timeline.	• $100 per business day
18.	Failure to comply with timeframes for at least 98% of expedited service authorization requests, as specified in Appendix B, Coverage and Services.	• $10,000 per month
19.	Failure to comply with timeframes for at least 95% of standard service authorization requests, as specified in Appendix B, Coverage and Services.	• $10,000 per month
20.	Failure to follow ODM or ODM-approved clinical coverage policies as specified in Appendix B, Coverage and Services.	• $2,500 per occurrence, per member

	Noncompliance	Financial Sanction
21.	Failure to submit clinical coverage policies and any subsequent proposed changes to ODM for review and prior approval prior to implementation as specified in Appendix B, Coverage and Services.	• $10,000 per occurrence **AND** • $1,000 for each calendar day the policy or policy change is in effect before being submitted to ODM
22.	Failure to notify network and out-of-network providers of changes to clinical coverage policies at least 30 calendar days prior to implementation as specified in Appendix B, Coverage and Services.	• $10,000 per occurrence **AND** • $1,000 for each calendar day of the MCO's noncompliance with the 30 calendar day prior notification requirement
23.	Failure to authorize and provide timely, medically necessary services for a child at risk of entering Children's Services, as required under Appendix B, Coverage and Services.	• $500 per calendar day, per member, per service **AND** • The amount paid by Children's Services
24.	Failure to provide a timely and content-compliant Notice of Action as required by OAC rule 5160-26-08.4 and Appendix B, Coverage and Services.	• $500 per calendar day, per person
25.	Failure to authorize and provide timely access to covered services as specified in Appendix B, Coverage and Services.	• $500 per calendar day, per member, per service
26.	Failure to authorize and provide medically necessary early and periodic screening, diagnosis, and treatment (EPSDT) services as specified in Appendix B, Coverage and Services.	• $750 per occurrence **AND** • Cost of services not provided, as determined by ODM
27.	Failure to meet transportation requirements as specified in Appendix B, Coverage and Services.	• $1,000 per member, per occurrence

	Noncompliance	Financial Sanction
28.	Failure to comply with requirements related to abortion and sterilizations as specified in Appendix B, Coverage and Services.	• $2,000 per occurrence
29.	Failure to cooperate with ODM's external quality review organization (EQRO) as specified in Appendix C, Population Health and Quality.	• $5,000 per occurrence
30.	Failure to actively participate in QI projects or performance improvement projects facilitated by ODM and/or the EQRO as specified in Appendix C, Population Health and Quality.	• $5,000 per occurrence
31.	Failure to complete a required assessment (e.g., health risk assessment, Child and Adolescent Needs and Strengths [CANS] assessment), develop a person-centered care plan, or authorize or initiate all services specified in the care plan for a member within specified timelines as specified in Appendix D, Care Coordination.	• $500 per member, per calendar day, per service **AND** • Cost of services not provided, as determined by ODM
32.	Failure to develop or maintain a person-centered care plan for a member receiving private duty nursing services or receiving services in a skilled nursing facility, as specified in Appendix D, Care Coordination.	• $500 per member, per occurrence
33.	Failure to meet member safeguard requirements as specified in Appendix A, General Requirements, placing a member at risk for a negative health outcome or jeopardizing the member's health, safety, or welfare.	• $50,000 per occurrence
34.	Failure to comply with transition of care requirements for members transitioning to the MCO from fee-for-service (FFS) or another ODM-contracted MCO, as specified in Appendix D, Care Coordination.	• $500 per calendar day, per member **AND** • The value of the services the MCO failed to cover during the applicable transition of care period, as determined by ODM

	Noncompliance	Financial Sanction
35.	Failure to comply with transition of care requirements for members transitioning between health care settings, as specified in Appendix D, Care Coordination.	• $500 per calendar day, per member **AND** • The value of the services the MCO failed to cover during the applicable transition of care period, as determined by ODM
36.	Failure to comply with transition of care requirements for members transitioning between the MCO and the OhioRISE Plan due to OhioRISE enrollment and eligibility, as specified in Appendix D, Care Coordination.	• $500 per calendar day, per member **AND** • The value of the services the MCO failed to cover during the applicable transition of care period, as determined by ODM
37.	Failure to meet care coordination requirements for members enrolled in the OhioRISE Plan, as specified in Appendix D, Care Coordination.	• $500 per calendar date, per member
38.	Engaging in prohibited marketing activities or discriminatory practices or failure to market in an entire region as specified in Appendix E, Marketing and Member Materials.	• $5,000 per occurrence **AND** • An additional $5,000 per occurrence if determined to be a discriminatory practice
39.	Failure to obtain ODM's approval prior to using marketing or member materials that require ODM's approval prior to distribution as specified in Appendix E, Marketing and Member Materials.	• $500 for every calendar day the unapproved materials are used
40.	Failure to cease use of any member or marketing material within the timeframe established by ODM as specified in Appendix E, Marketing and Member Materials.	• $500 for every calendar day the materials continue to be used past the ODM established deadline
41.	Failure to comply with the timeframes for providing member materials as specified in Appendix E, Marketing and Member Materials.	• $1,000 per occurrence

	Noncompliance	Financial Sanction
42.	Failure to include and distribute single pharmacy benefit manager (SPBM)-prepared, ODM-approved, new member materials, as specified in Appendix E, Marketing and Member Materials.	• $1,000 per occurrence
43.	Failure to notify ODM and impacted members of provider termination of network provider within required timeframes as specified in Appendix F, Provider Network.	• $250 per calendar day, per member, for ODM notification • $100 per calendar day, per member, for member notification
44.	Failure to provide timely notification to ODM of network changes that impact 500 or more members or reduce the MCO's network by 10% or more as specified in Appendix F, Provider Network.	• $5,000 per occurrence
45.	Failure to meet minimum provider capacity standards as specified in Appendix F, Provider Network. Provider capacity is measured on a quarterly basis.	• $1,000 for each category (e.g., primary care provider [PCP], hospitals), for each county, per quarter
46.	Failure to meet access (time and distance) requirements as specified in Appendix F, Provider Network. Access compliance is measured on a quarterly basis.	• $1,000 per county, per provider type, per quarter
47.	Failure to meet provider network information performance standards, as specified in Appendix F, Provider Network.	• $50,000 for each performance standard not met
48.	Failure to comply with requirements related to utilizing PMF required data elements as specified in Appendix F, Provider Network.	• $5,000 for each calendar day of the MCO's noncompliance with the daily reconciliation of the PNM system generated PMF
49.	Failure to respond to information or witness requests within specified timeframe as specified in Appendix G, Program Integrity.	• $1,000 per calendar day per request
50.	Payment to a terminated or suspended provider as specified in Appendix G, Program Integrity.	• Twice the amount of the payment made to the terminated or suspended provider

	Noncompliance	Financial Sanction
51.	Failure to report credible allegations of fraud, waste, or abuse as specified in Appendix G, Program Integrity.	• $1,000 per occurrence
52.	Failure to follow deconfliction processes as specified in Appendix G, Program Integrity.	• CAP for first and non-consecutive noncompliance • $1,000 per occurrence for the second and subsequent occurrence(s) • ODM may impose additional sanctions as may be determined by ODM
53.	Failure to report recoveries as specified in Appendix G, Program Integrity.	• Twice the amount of recovery that was not reported
54.	Failure to adjust claims/encounters to reflect recovery as specified in Appendix G, Program Integrity.	• Twice the amount of the value of the adjustment
55.	Failure to meet quality measure requirements in Appendix I, Quality Measures.	• For the first instance of noncompliance, 0.25% of the amount calculated based upon the MCO's monthly average capitation amount for the greater of the 12 months prior to the month in which the compliance action is issued, or the 12 months of the measurement year for each established minimum performance standard (MPS), under each quality measure • For consecutive instances of noncompliance, 0.5% of the amount calculated based upon the MCO's monthly average capitation amount for the greater of the 12 months prior to the month in which the compliance action is issued, or the 12 months of the measurement year for each established MPS, under each quality measure
56.	Failure to submit self-reported, audited HEDIS data as specified in Appendix I, Quality Measures.	• $300,000 per occurrence

	Noncompliance	Financial Sanction
57.	Failure to submit data for measures designated as "reporting only" with self-reported, audited HEDIS data, as specified in Appendix I, Quality Measures.	• Disqualification from participation in quality withhold for the corresponding contract period
58.	Failure to submit the Annual Submission of Final HEDIS Audit Report as specified in Appendix I, Quality Measures.	• $300,000 per occurrence **AND** • Disqualification from participation in quality withhold for the corresponding contract period, as determined by ODM
59.	Failure to administer a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and submit the survey data to National Committee for Quality Assurance (NCQA), the CAHPS Database, and ODM's designee, as specified in Appendix I, Quality Measures.	• $300,000 per occurrence **AND** • The MCO will be considered non-compliant with the standards for the CAHPS performance measure in Appendix I, Quality Measures, for the corresponding contract period
60.	Failure to meet requirements to adjudicate claims to final status, notify out-of-network providers of procedures for claims submissions when requested, and/or notify network and out-of-network providers of the status of submitted claims as specified in Appendix K, Information Systems, Claims, and Data.	• $20,000 per calendar day for the period of noncompliance
61.	Failure to meet the encounter data volume standards for every service category in all quarters of the measurement period for each of the following populations: Aged, Blind, And Disabled (ABD) adults, ABD children, Modified Adjusted Gross Income (MAGI) members, and Group VIII-Expansion members, as specified in the Methodology for Encounter Data Quality Measures document referenced in Appendix K, Information Systems, Claims, and Data.	• CAP for first and non-consecutive noncompliance • 2% of the amount calculated based upon the MCO's capitation for second consecutive noncompliance within five reporting periods • New member enrollment freeze for third consecutive noncompliance within five reporting periods

	Noncompliance	Financial Sanction
62.	Failure to meet the requirements for rejected encounters as specified in the Methodology for Encounter Data Quality Measures document referenced in Appendix K, Information Systems, Claims, and Data.	• CAP for first and non-consecutive noncompliance • 2% of the amount calculated based upon the MCO's capitation for second consecutive noncompliance within five reporting periods • New member enrollment freeze for third consecutive noncompliance within five reporting periods
63.	Failure to meet acceptance rate requirement as specified in the Methodology for Encounter Data Quality Measures document referenced in Appendix K, Information Systems, Claims, and Data.	• CAP for first and non-consecutive noncompliance • 2% of the amount calculated based upon the MCO's capitation for second consecutive noncompliance within five reporting periods • New member enrollment freeze for third consecutive noncompliance within five reporting periods
64.	Failure to meet payment accuracy measures for encounter data accuracy studies as specified in the Methodology for Encounter Data Quality Measures document referenced in Appendix K, Information Systems, Claims, and Data.	• CAP for first time noncompliance • 1% of the amount calculated based upon the MCO's capitation for all subsequent noncompliance
65.	Failure to meet delivery payment measures for encounter data accuracy studies as specified in the Methodology for Encounter Data Quality Measures document referenced in Appendix K, Information Systems, Claims, and Data.	• Return of duplicate delivery payments or delivery payments not validated to ODM
66.	Failure to meet the minimum record submittal rate for encounter data accuracy studies as specified in the Methodology for Encounter Data Quality Measures document referenced in Appendix K, Information Systems, Claims, and Data.	• $10,000

	Noncompliance	Financial Sanction
67.	Failure to meet standards for rendering provider data for all quarters of the measurement period as specified in the Methodology for Encounter Data Quality Measures document referenced in Appendix K, Information Systems, Claims, and Data.	• CAP for first and non-consecutive noncompliance • 2% of the amount calculated based upon the MCO's capitation for second consecutive noncompliance within five reporting periods • New member enrollment freeze for third consecutive noncompliance within five reporting periods
68.	Failure to meet standards for National Provider Identifier (NPI) provider number usage as specified in the Methodology for Encounter Data Quality Measures document referenced in Appendix K, Information Systems, Claims, and Data.	• CAP for first and non-consecutive noncompliance • 2% of the amount calculated based upon the MCO's capitation for second consecutive noncompliance within five reporting periods • New member enrollment freeze for third consecutive noncompliance within five reporting periods
69.	Failure to meet encounter submission requirements as specified in the Methodology for Encounter Data Quality Measures document referenced in Appendix K, Information Systems, Claims, and Data.	• 1% of the amount calculated for first measurement period of noncompliance • 2% of the amount calculated for subsequent noncompliance
70.	Failure to meet encounter timeliness standards as specified in Appendix K, Information Systems, Claims, and Data, and the Methodology for Encounter Data Quality Measures document referenced in Appendix K, Information Systems, Claims, and Data.	• 1% of the amount calculated based upon the MCO's capitation for first measurement period of noncompliance • 2% of the amount calculated based upon the MCO's capitation for subsequent noncompliance
71.	Failure to comply with claims payment systemic error (CPSE) policies and activities to correct CPSEs as specified in Appendix K, Information Systems, Claims, and Data.	• $5,000 per occurrence

	Noncompliance	Financial Sanction
72.	Failure to comply with timeframes when implementing ODM rate changes, as specified in Appendix K, Information Systems, Claims, and Data.	• $10,000 per calendar day for the period of noncompliance
73.	Failure to meet medical loss ratio (MLR) requirements as specified in Appendix L, Payment and Financial Performance.	• MCO must remit a rebate to ODM of the difference between the calculated MLR and the target MLR multiplied by the revenue paid to the MCO during the contract year.
74.	Failure to comply with any of the following reinsurance requirements as specified in Appendix L, Payment and Financial Performance: • Failure to maintain reinsurance coverage as required; • Failure to obtain approval from ODM for deductibles in excess of $100,000; or • Failure to obtain approval from ODM when reinsurance for non-transplant services covers less than 80% of inpatient costs in excess of the deductible incurred by one member for one year.	The lesser of: • 10% of the difference between the estimated amount of what the MCO would have paid in premiums for the reinsurance policy if it had been in compliance and what the MCO actually paid while it was out of compliance **OR** • $50,000

	Noncompliance	Financial Sanction
75.	Failure to comply with prompt pay requirements as specified in Appendix L, Payment and Financial Performance.	• For the first instance of noncompliance, 0.04% of the amount calculated based upon the MCO's capitation for each claim type and timeframe separately • For the second instance of noncompliance, 0.08% of the amount calculated based upon the MCO's capitation for each claim type and timeframe separately • For additional violations during a rolling 12-month period, a new enrollment freeze of no less than three months duration or until the MCO has attained and maintained compliance as determined by ODM
76.	Failure to comply with the TPL provider recoupments requirements as specified in Appendix L, Payment and Financial Performance.	• $500 for each violation • ODM may impose additional sanctions may be assessed as determined by ODM
77.	Failure to submit a proposed Transition Plan within 10 business days of receiving notice from ODM in accordance with Appendix O, MCO Termination and Non-Renewal.	• $5,000 per calendar day • ODM may impose additional financial sanctions if the MCO fails to revise the proposed Transition Plan as necessary to obtain ODM approval
78.	Failure to submit a deliverable or respond to ODM's requests within the required timeframe under this Agreement.	• $100 per deliverable or request, per calendar day
79.	Failure to complete or comply with a CAP as described in this appendix.	• $500 for each calendar day the CAP is not completed, implemented, or complied with as determined by ODM

b. Pre-Determined Non-Financial Sanctions

i. In addition to other compliance actions available to ODM, ODM may impose the following pre-determined non-financial sanctions in accordance with Table N.2 below.

Table N.2 Pre-Determined Non-Financial Sanctions

	Noncompliance	Non-Financial Sanction
	Failure to maintain required accreditation status with the NCQA as specified in Appendix A, General Requirements.	• If the MCO receives a Provisional accreditation status, the MCO must complete a resurvey within 12 months of the accreditation decision. If the resurvey results are in a Provisional or Denied status, ODM will consider this a material breach of this Agreement and may terminate this Agreement. • If the MCO receives a Denied accreditation status, ODM will consider this a material breach of this Agreement and may terminate this Agreement.
	Failure to comply with the provider engagement council requirements listed in Appendix C, Population Health and Quality	• CAP for first and non-consecutive noncompliance. • MCO failure to demonstrate compliance by the specified date may result in a new enrollment freeze.
	Failure to submit quarterly Financial Statements to ODM as specified in Appendix L, Payment and Financial Performance.	• ODM may require the MCO to complete a CAP. • MCO's failure to demonstrate compliance by the specified date may result in a new enrollment freeze.

	Noncompliance	Non-Financial Sanction
	Failure to submit annual Financial Statements to ODM as specified in Appendix L, Payment and Financial Performance.	• ODM may require the MCO to complete a CAP. • MCO's failure to demonstrate compliance by the specified date may result in a new enrollment freeze.
	Failure to meet financial performance requirements as specified in Appendix L, Payment and Financial Performance.	• ODM may require the MCO to complete a CAP. • MCO failure to demonstrate compliance by the specified date may result in a new enrollment freeze.
	Failure to notify ODM no later than one business day after the receipt of a proposed or implemented regulatory action by Ohio Department of Insurance (ODI) as specified in Appendix L, Payment and Financial Performance.	• MCO failure to comply with this requirement will result in an immediate new enrollment freeze.
	Failure to comply with the time frame for the provider engagement council activity reporting as listed in Appendix P, Chart of Deliverables	• CAP for first and non-consecutive noncompliance • MCO failure to demonstrate compliance by the specified date may result in a new enrollment freeze.

c. Financial Sanctions

i. *General*

1. ODM may impose financial sanctions for noncompliance that does not fall into pre-determined sanctions. The amount of the financial sanction may vary depending upon the level of severity (Level 1, Level 2, or Level 3) of the MCO noncompliance, repeated violations, failure to meet the requirements in a CAP, and the impact of the noncompliance to members.

ii. *Level 1 Sanctions*

1. ODM may impose a Level 1 sanction up to a maximum of $15,000 per occurrence of the MCO's failure to comply with a term of this Agreement and federal and state requirements that does not result in a member being unable to receive a medically necessary service or in a poor health outcome for the member. Examples may include:

a. Failure to ensure staff performing care management functions are operating within their professional scope of practice or are complying with the state's licensure/credentialing requirements;

b. Failure to update the person-centered care plan in a timely manner when the needs of the member change;

c. Failure to coordinate care for a member across providers, specialists, and team members, as appropriate;

d. Failure to adhere to a documented communication plan, including the contact schedule for in-person visits and telephone calls;

e. Failure to make reasonable attempts to obtain a discharge/transition plan from an inpatient facility; and

f. Failure to notify providers of claim reprocessing or payment recovery within the timeframe specified in Appendix K, Information Systems, Claims, and Data.

iii. *Level 2 Sanctions*

1. ODM may impose a Level 2 sanction up to a maximum of $25,000 per occurrence of the MCO's failure to comply with a term of this Agreement and/or state and federal requirements.

2. Level 2 sanctions include but are not limited to the following types of MCO noncompliance:

a. Noncompliance that is associated with a poor health outcome for the member;

b. Failure to provide medically necessary services that the MCO must provide under the terms of this Agreement to its enrolled members, such as:

i. Failure to assist a member in accessing needed services in a timely manner after receiving a request from the member;

ii. Failure to meet requirements related to discharge planning;

iii. Failure to provide services specified in the member's discharge plan;

iv. Failure to ensure staff performing care management functions are appropriately responding to a member's care management needs; and

v. Failure to complete a care gap analysis that identifies gaps between recommended care and care received by a member.

c. Assessing member premiums or charges in excess of the amounts permitted by ODM (the greater of the maximum financial sanction of $25,000 or double the amount of the excess charges);

d. Misrepresentation or falsification of information furnished to an eligible individual, member, or provider;

e. Failure to comply with physician incentive plan requirements; and

f. Distribution directly, or indirectly through any agent or independent contractor, of marketing or outreach materials that have not been approved by ODM or that contain false or materially misleading information.

iv. *Level 3 Sanctions*

1. ODM may impose a Level 3 sanction up to a maximum of $100,000 per occurrence of the MCO's failure to comply with a term of this Agreement and/or state and federal requirements.

2. Level 3 sanctions include but are not limited to the following types of MCO noncompliance:

a. Discrimination among members on the basis of their health status or need for health care services (this includes any practice that would reasonably be expected to encourage termination or discourage selection of members or eligible individuals whose medical condition indicates probable need for substantial future medical services); and

b. Misrepresentation or falsification of information provided to ODM or Centers for Medicare and Medicaid Services (CMS).

v. *Financial Sanction Calculation*

1. ODM will evaluate MCO noncompliance and, in its sole discretion, determine the appropriate level and amount of the financial sanction to impose. ODM will consider relevant information regarding noncompliance, as well as the following aggravating and mitigating factors:

a. The extent, severity, duration, and impact of noncompliance;

b. Whether the noncompliance poses or results in a quality of care or safety concern;

c. Whether noncompliance was intentional;

d. Whether the MCO promptly identified, reported, and remediated the noncompliance;

e. MCO enrollment size relative to the amount of the financial sanction;

f. Financial implications to providers; and

g. Financial harm and risk to the State.

d. Compounded Financial Sanctions

i. ODM will compound pre-determined and financial sanctions if the MCO fails to achieve compliance within the timeframe established by ODM or maintain compliance for the same requirement for a six month timeframe after demonstrating compliance.

ii. ODM will calculate compounded financial sanctions as follows:

1. For each subsequent measurement period (e.g., daily, monthly, quarterly), ODM will assess the lesser of two times the amount of the pre-determined or financial sanction, or the maximum amount for Level 1, Level 2, or Level 3 financial sanctions, if:

a. The MCO fails to demonstrate compliance within the timeframe identified in the Notice of Compliance Action; or

b. The MCO fails to comply with the same requirement throughout a six month timeframe after demonstrating compliance.

e. Collection of Pre-Determined and Financial Sanctions

i. ODM will directly deduct pre-determined and financial sanctions imposed against the MCO from the net capitation paid to the MCO. ODM will specify on the invoice the date ODM will deduct the funds.

ii. If ODM requests an Electronic Funds Transfer (EFT) from the MCO, the MCO must pay the pre-determined and financial sanction to ODM within 30 calendar days of the date of the invoice or as otherwise directed by ODM in writing. Pursuant to ORC section 131.02, ODM will certify to the Attorney General's (AG's) Office payments owed by the MCO to the State that are not received within 45 calendar days. The AG's Office will impose the appropriate collection fee for MCO payments certified to the AG's Office.

iii. ODM may require the MCO to deposit its pre-determined and financial sanctions into the Quality Withhold Innovation fund. This must be done within 30 days after ODM issues such notice unless otherwise directed by ODM. Upon request from ODM, proof of deposit must be submitted to ODM.

iv. For pre-determined and financial sanctions calculated in accordance with this appendix, ODM will use the MCO's average monthly net capitation, disregarding the financial sanctions for the 12 months prior to the month in which ODM issues the compliance action to the MCO.

f. New Enrollment Freezes

i. ODM may prohibit the MCO from receiving new enrollment through the selection of the MCO by an eligible individual or ODM's auto-assignment process if any of the following occur:

1. The MCO fails to implement a CAP fully within the designated timeframe.

2. Circumstances exist that potentially jeopardize member access to care, as solely determined by ODM.

3. ODM finds that the MCO has a pattern of repeated or ongoing noncompliance, 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:

a. Failure to comply with the prompt payment or out-of-network provider payment requirements;

b. Failure to comply with the provider network requirements specified in Appendix F, Provider Network;

c. MCO refusal to comply with a program requirement after ODM has directed the MCO to comply with the specific program requirement;

d. MCO receipt of proposed or implemented adverse action by the ODI; or

e. Failure to provide adequate provider or administrative capacity.

ii. If ODM imposes an enrollment freeze, the enrollment freeze will be imposed concurrent with the Notice of Compliance Action to the MCO.

iii. ODM will not make capitation payments to the MCO for new members under this Agreement when and for so long as CMS denies payments for those members in accordance with the requirements in 42 CFR 438.726.

iv. Unless otherwise specified, ODM may lift new enrollment freezes issued under this appendix after ODM determines that the MCO is in full compliance with the applicable program requirement, and MCO noncompliance is resolved to the satisfaction of ODM.

g. Reduction of Assignments

i. ODM has discretion over how ODM makes member enrollment auto-assignments. ODM may reduce the number of auto-assignments the MCO receives to ensure program stability within a region, or upon a determination that the MCO lacks sufficient capacity to meet the needs of the increased enrollment volume.

ii. ODM's determination that the MCO has demonstrated a lack of sufficient capacity will include but is not limited to the following considerations:

1. Failure to maintain an adequate provider network;
2. Failure to provide new member materials by the member's effective date;
3. Failure to meet the minimum call center requirements;
4. Failure to meet the minimum performance standards for members with special health care needs; or
5. Failure to provide complete and accurate data files required for meeting requirements for the grievance and appeals system, primary care providers, or its Care Management System (CAMS) files.

h. Member Disenrollment

i. ODM may require member disenrollment as a result of MCO noncompliance. As directed by ODM, the MCO must either:

1. Disenroll members; or
2. Notify members of their right to disenroll and permit its members to disenroll from the MCO without cause.

ii. If ODM determines the MCO has violated any of the requirements of sections 1903(m) or 1932 of the Social Security Act not specifically identified within this Agreement, ODM may require the MCO to permit any of its members to disenroll from the MCO without cause, or suspend any further new member enrollments to the MCO, or both.

iii. The MCO must comply with the transition of care requirements in Appendix C, Population Health and Quality, to transition the care for members who must or choose to disenroll.

i. Temporary Management

i. Pursuant to OAC rule 5160-26-10 and 42 CFR 438.706, ODM may impose temporary management when the MCO has repeatedly failed to comply with the requirements in this Agreement.

ii. The MCO must bear all costs incurred from the appointment of temporary management.

iii. ODM's imposition of temporary management against the MCO will not be delayed to provide the MCO with an opportunity to request reconsideration. Temporary management will remain in place until ODM determines that the noncompliance will not reoccur.

j. Termination

i. In accordance with 42 CFR 438.708, ODM may terminate this Agreement if ODM determines that the MCO has failed to carry out the substantive terms of this

Agreement or failed to meet the applicable requirements in Sections 1932, 1903(m) or 1905(t) of the Social Security Act.

ii. ODM may terminate or amend this Agreement if at any time ODM determines that continuation of this Agreement is not in the best interest of members or the state of Ohio, pursuant to OAC rule 5160-26-10.

iii. Nothing in this appendix precludes ODM from terminating this Agreement pursuant to Article VIII of the Baseline Provider Agreement.

4. Request for Reconsideration

a. Other than as specified below, pursuant to OAC rule 5160-26-10, the MCO may seek reconsideration of any compliance action in this appendix imposed by ODM.

i. The MCO may not seek reconsideration of a compliance action by ODM that results in:

1. Changes to the auto-assignment of members; or

2. The imposition of a Notice of Noncompliance, CAP, or directed CAP, as defined in this appendix.

b. The MCO may only seek reconsideration of a CAP when a CAP is required for the first violation in a series of progressive compliance actions.

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

i. The MCO must submit a request for reconsideration to ODM no later than 30 days from the date appearing on the Notice of Compliance Action sent to the MCO.

ii. The MCO's request for reconsideration must explain in detail why ODM should not impose the specified compliance action. At a minimum, the MCO's reconsideration request must include a statement of the proposed compliance action being contested, the basis for the MCO's request, and any supporting documentation. In considering the MCO's request for reconsideration, ODM will review only the written material submitted by the MCO.

iii. ODM will take reasonable steps to issue a final written decision or request additional information within 30 business days after receiving the MCO's request for reconsideration. If ODM requires additional time, ODM will notify the MCO in writing.

iv. If ODM approves the MCO's reconsideration request in whole, ODM will rescind the associated compliance actions.

v. If ODM approves the MCO's reconsideration request in part, ODM at its sole discretion may rescind or reduce the associated compliance actions.

vi. If ODM denies the MCO's reconsideration request in whole, ODM will take the compliance actions outlined in the original notification of noncompliance.

APPENDIX O – MCO TERMINATION AND NON-RENEWAL

1. General Requirements

a. This Agreement may be terminated or not renewed in whole or part (i.e., for a specific region or regions) as specified in Article VIII of the Baseline Provider Agreement.

i. MCO-Initiated Termination and Non-Renewal

1. When initiated by the MCO, the MCO must provide ODM written notice of the termination or non-renewal of this Agreement in whole or part (i.e., for a specific region or regions) as required in Article VIII of the Baseline Provider Agreement.

ii. ODM-Initiated Termination for Cause Under OAC Rule 5160-26-10

1. If ODM initiates the proposed termination, non-renewal, or amendment of this Agreement pursuant to OAC rule 5160-26-10 by issuing a proposed adjudication order pursuant to ORC section 5164.38, and the MCO submits a valid appeal of that proposed action pursuant to ORC Chapter 119, this Agreement will be extended through the issuance of an adjudication order of the MCO's appeal under ORC Chapter 119.

2. Pursuant to OAC rule 5160-26-10, ODM may notify the MCO's members of the proposed action and inform the members of their right to immediately terminate their enrollment with the MCO without cause. If ODM has proposed the termination, non-renewal, denial, or amendment of this Agreement and access to medically necessary covered services is jeopardized, ODM may propose to terminate the enrollment of all of the MCO's members. The MCO may request reconsideration of a proposed enrollment termination of members as follows:

a. ODM will notify the MCO of the proposed enrollment termination via certified or overnight mail to the MCO. The MCO will have three business days from the date of receipt to request reconsideration.

b. The MCO must submit reconsideration requests to ODM's Director by mail. ODM must receive the request by 3:00 pm Eastern Time on the third business day following the MCO's receipt of the ODM notification of termination.

c. The MCO's request must explain in detail why the proposed enrollment termination is not justified. ODM will not consider justification other than what is submitted in writing by the MCO.

d. The Director will issue a final decision or request for additional information within five business days of receipt of the MCO's request for reconsideration. ODM will notify the MCO in writing if the Director requires additional time in rendering the final reconsideration decision.

e. The proposed MCO enrollment termination will not occur while the reconsideration is under review and pending the Director's decision. If the Director denies the reconsideration, the MCO enrollment termination will proceed at the first possible effective date.

iii. *Termination due to ODM MCO Procurement Process*

1. In the event this Agreement terminates as a result of ODM's procurement of managed care organizations pursuant to ORC section 5167.10, the MCO has no right to appeal under the authorities in ORC Chapter 119 pursuant to ORC section 5164.38. This requirement applies whether the MCO is or is not selected as a result of the ODM procurement.

iv. *Termination or Modification of this Agreement due to Lack of Funding*

1. In the event this Agreement terminates or is modified due to a lack of available funding, the MCO has no right to appeal under the authorities in ORC Chapter 119 pursuant to ORC section 5164.38.

b. If for any reason this Agreement is terminated or not renewed in whole or part (i.e., for a specific region or regions), the MCO must comply with the transition requirements as described in this appendix.

c. The MCO will continue to be subject to compliance actions as specified in Appendix N, Compliance Actions, of this Agreement until ODM approves the MCO's final report documenting that the MCO has fulfilled all outstanding obligations.

2. Transition Requirements

a. Upon notice of the termination/non-renewal of this Agreement in whole or part (i.e., for a specific region or regions) the MCO must comply with the following transition requirements:

i. *Member Care Responsibilities.*

1. The MCO must comply with all duties and obligations, including all responsibilities related to member care.

ii. *Transition Plan*

1. The MCO must submit a proposed Transition Plan within ten business days of the notice of termination/non-renewal of this Agreement for ODM approval. The MCO must revise the proposed Transition Plan as necessary to obtain ODM's approval. The MCO's proposed Transition Plan must include the following:

a. The MCO's agreement to comply with all duties and obligations incurred prior to the effective date of this Agreement termination/non-renewal, including the performance of ongoing functions, and the submission of all reports and deliverables;

b. The identification of the MCO's Transition Coordinator, the MCO's single point of contact responsible for coordinating the MCO's transition activities;

c. The proposed submission timeframes for all outstanding reports and deliverables as identified by ODM;

d. If applicable, the member outreach workflow identifying the approach and timing of outreach to members impacted by the termination/non-renewal of this Agreement;

e. The MCO's proposed communication plan, including the MCO's written notifications and proposed timeline to notify all subcontractors, providers, and members impacted by the termination/non-renewal of this Agreement. The MCO's proposed communication plan must include the following standardized notifications:

i. *Provider Notification*

1. If applicable, the MCO must notify network providers impacted by the termination/non-renewal of this Agreement at least 55 calendar days prior to the effective date of the termination/non-renewal. The provider notification language and process must be approved by ODM prior to distribution.

ii. *Member Notification*

1. If applicable, unless otherwise notified by ODM, the MCO must notify its members impacted by the termination/non-renewal of this Agreement at least 45 calendar days in advance of the effective date of termination/non-renewal. A member outreach workflow identifying the approach and timing of outreach to the members impacted must be included. The member notification language and process must be approved by ODM prior to distribution.

iii. *Prior Authorization Redirection Notification*

1. If applicable, the MCO must create two notices to assist members and providers with prior authorization requests received or approved during the last month of enrollment. The first notice is for prior authorization requests for services to be provided after the effective date of

termination/non-renewal; this notice will direct members and providers to contact the enrolling MCO. The second notice is for prior authorization requests for services to be provided before and after the effective date of termination/non-renewal. The MCO must use ODM model language to create the notices and receive approval by ODM prior to distribution. The notices must be mailed to the provider and copied to the member for all requests received during the last month of MCO enrollment.

f. The MCO's member transition of care plan, including the transition of care narrative, timeline, and member services workflow to support an efficient and seamless transition of members from coverage under this Agreement to coverage under ODM's designee. The transition of care plan must identify at risk populations and prioritize those members. The member transition plan must include a review of prior authorized services and a plan to continue authorization of those services, excluding prescribed drugs, for 90 calendar days after the effective date of the termination/non-renewal of this provider agreement. The plan must also include a newborn reconciliation approach. The prioritization and newborn reconciliation tracking must be submitted to ODM biweekly.

iii. *Transition Plan Updates*

1. The MCO must report Transition Plan updates to ODM detailing MCO's progress toward completing MCO obligations under this Agreement and the Transition Plan on a monthly basis, on the fifth day of the month following the month reported.

iv. *Fulfill Existing Duties and Obligations*

1. During the term of this Agreement and after termination/non-renewal of this Agreement, the MCO must fulfill all duties and obligations as required under OAC Chapter 5160-26 and any provider agreements related to the provision of services for the Medicaid population during periods of time when the MCO was under contract with ODM. MCO duties and obligations include the performance of ongoing functions and the submission of all outstanding reports and deliverables as identified in the Transition Plan. Specific examples of functions and reporting include the following:

a. *Member Grievances and Appeals, Provider Complaints, and State Hearings*

i. The MCO must resolve all provider complaints and member grievances and appeals related to the MCO's decisions and responsibilities exercised under this Agreement. The MCO must also participate in state hearings related thereto. The MCO must provide a monthly report of:

1. Member complaint, grievance, appeal, and state hearing information; and

2. Provider complaint information, as outlined in the MCO's ODM-approved Transition Plan.

b. *Claims Payment*

i. The MCO must pay all outstanding obligations for services and benefits rendered to members during the period of time when the MCO was under contract with ODM in accordance with the requirements in this Agreement and OAC rule 5160-26-09.1. This includes, without limitation, the payment of funds owed as a result of the concurrent risk analysis process as well as the reporting, data integration, and payment requirements related to quality improvement (QI) strategies and value-based initiatives such as:

1. Care Innovation and Community Improvement Program (CICIP), per-member-per-month (PMPM), and QI payments;

2. Comprehensive Maternal Care (CMC) reimbursement activities, including PMPM payments; and

3. Comprehensive Primary Care (CPC) reimbursement activities, including shared savings.

c. *Encounter and Claims Data*

i. As directed by ODM, the MCO must provide encounter data, cost report data, and claims aging reports, including incurred but not reported amounts, related to time periods through the final date of service every 30 calendar days as part of the monthly Transition Plan reporting requirement. The MCO must continue encounter reporting until all services rendered prior to the termination/non-renewal of this Agreement have reached adjudicated status and data

validation of the information has been completed to the satisfaction of ODM.

d. *Population Health and Performance Data*

i. After the termination date of this Agreement for any reason, the MCO must continue to provide population health, care coordination, and quality data files as specified in Appendix C, Population Health and Quality; Appendix D, Care Coordination; and Appendix I, Quality Measures, for all periods prior to the termination of this Agreement. In addition, the MCO must continue to provide all data files required to determine the status of the Quality Withhold after the termination date.

e. *Financial Reports*

i. The MCO must provide financial reports as outlined in the MCO's ODM-approved Transition Plan, including:

1. Audited financial statements, inclusive of a balance sheet;

2. Reinsurance audit activities on prior contract years; and

3. Finalization of any open or pending reconciliations.

v. *Cooperation*

1. The MCO must fully cooperate with ODM, ODM's designee(s), ODM vendors, and other MCOs as directed by ODM to support a seamless transition of members and administrative responsibilities under this Agreement. The MCO must participate in any meetings, workgroups, or other activities as directed by ODM to support the transition, both before and after the date of termination of this Agreement for any reason, as determined necessary by ODM. The MCO must promptly respond to ODM requests related to the transition, including but not limited to ODM programmatic requests, ODM data requests, and ODM information technology requests and meet all deliverable timelines required by ODM.

2. ODM will offset all additional costs and expenses incurred by ODM as a result of the MCO’s failure to cooperate and/or promptly respond as set forth in this section by deducting the additional costs and expenses from the monetary assurance.

vi. *Maintenance of Financial Requirements and Insurance*

1. The MCO must comply with financial and insurance requirements under this Agreement until ODM provides the MCO written notice that all continuing MCO obligations under this Agreement have been fulfilled.

vii. *Refundable Monetary Assurance*

1. The MCO must submit a refundable monetary assurance within ten business days of receiving the invoice. This monetary assurance will be held by ODM and must be in an amount of 10% of the capitation amount paid by ODM for the specific region or regions subject to termination/non-renewal in the month the termination/non-renewal notice is issued.

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

3. If the monetary assurance is not received as specified above, ODM will withhold the MCO's next month's capitation payment until such time that ODM receives documentation that the monetary assurance is received by the Treasurer of State. This transaction will be created as an accounts receivable and will show up on the remittance advice.

4. Upon ODM's approval of the MCO's final report, ODM will refund the monetary assurance to the MCO, less any costs and expenses as set forth above.

viii. *Quality Withhold*

1. Unreturned funds from the quality withhold program of this Agreement set forth in Appendix J, Quality Withhold, will be retained by ODM.

ix. *Final Accounting of Amounts Outstanding*

1. The MCO must submit to ODM a final accounting list of any outstanding monies owed by ODM under this Agreement no later than six months after the termination/non-renewal date. ODM's payment will be limited to only those amounts properly owed by ODM. Failure by the MCO to submit a list of outstanding items, or to include all outstanding items on that list, within the timeframe will be deemed a forfeiture of any additional compensation due to the MCO.

x. *Member Transitions*

1. The MCO must conduct all member transition activities in accordance with the ODM-approved Transition Plan and in accordance with ODM requirements. When transitioning members to ODM and/or ODM designees (MCOs, OhioRISE Plan, SPBM), the MCO is responsible for notifying ODM and/or ODM designees of pertinent information related to the special needs of transitioning members. The MCO must transfer member data to ODM and/or ODM designees within the time period and in a file format as specified by ODM.

xi. *Data Files*

1. If applicable, in order to assist members with transition and continuity of care, the MCO must create data files to share with each receiving ODM designee. The MCO must provide the data files in a consistent format specified by ODM and may include information on the following: care management, prior authorizations, inpatient facility stays, PCP assignments, and pregnant members. The timeline for the MCO providing these files will be at the discretion of ODM. The terminating MCO will be responsible for all costs associated with data sharing and for ensuring the accuracy and data quality of the files.

xii. *Program Integrity Activities*

1. The MCO must continue program integrity activities for two years from the end of this Agreement. Program integrity activities include requesting deconfliction and abiding by the ODM response, promptly submitting fraud referrals, conducting post-payment reviews and audits, and continuing to identify overpayments and recoupment. The MCO shall submit to ODM quarterly inventory reports on all of these activities. Each quarterly inventory report submitted, and any subsequent revision to an inventory report, must be certified as accurate by the MCO CFO.

    a. Overpayment Recovery. The MCO may recover overpayments made to providers if the overpayment is identified and the provider is notified within two years of the date the MCO improperly paid the provider, within six months of the MFCU returning a fraud referral to the MCO, or if ODM recovers the payment to the provider from the MCO, whichever is later.

    b. ODM Audits. The MCO must allow ODM to audit capitation payments made to the MCO and payments made to providers by the MCO, as well as recover overpayments under the time limits in ORC section 5164.57.

    c. Cooperation with Law Enforcement and Record Retention. The MCO must continue to cooperate with law enforcement and federal audits for ten years following the termination of this Agreement.

2. The MCO must retain records for ten years and allow auditing and inspection of those records for ten years.

xiii. *MCO Release*

1. ODM will release the MCO from its responsibilities under the Transition Plan upon ODM's approval of the MCO's final report documenting that the MCO has fulfilled all outstanding obligations. Following ODM release, the MCO will retain ongoing responsibility for providing data to support audits related to the Medicaid population served by the MCO during the term of this Agreement.

APPENDIX P — CHART OF DELIVERABLES

1. General

a. The MCO must submit all deliverables required by this Agreement and as requested by ODM. Deliverables include but are not limited to policies, procedures, plans, member and provider notices, member materials, notifications to ODM, data, and reports.

b. The MCO must submit each deliverable as specified by ODM, including but not limited to the format and timeframe for submission. Format means the content, form, and manner of submission.

c. ODM may, at its discretion, change the format or timeframe for submission of a deliverable or deliverables.

d. ODM may, at its discretion, require the MCO to submit additional deliverables in the format and timeframe specified by ODM.

e. If this Agreement or ODM otherwise requires ODM prior review or approval of a deliverable, the MCO must receive written notice of review or approval from ODM prior to the deliverable taking effect.

f. Unless otherwise specified by ODM, the MCO must submit deliverables to the email address provided by ODM for submission of deliverables.

g. Unless otherwise specified by this Agreement or ODM, deliverables are due by 3:00 pm Eastern Time on the due date indicated. If the due date falls on a weekend or a state holiday, the due date is 3:00 pm Eastern Time on the next business day.

h. The MCO must review all deliverables prior to submission to ODM and ensure the MCO submits timely, accurate, and complete deliverables to ODM.

i. The MCO's failure to submit timely, accurate, and complete deliverables to ODM is subject to compliance actions as specified in Appendix N, Compliance Actions.

j. If ODM requests a revision to a deliverable, the MCO must make the changes and resubmit the deliverable in the format and timeframe specified by ODM. ODM will determine the MCO's compliance with the requirement to submit timely, accurate, and complete deliverables based on the original submission.

k. The MCO must review the content of deliverables to determine whether performance as documented in the deliverable complies with this Agreement. If the MCO identifies deficient performance, the MCO, in the submission of the deliverable, must include written documentation to ODM that identifies the area or areas of deficiency, and the steps taken by the MCO to bring performance into compliance with this Agreement. The MCO's self-identification of a deficiency does not impact ODM's ability to take a compliance action under Appendix N, Compliance Actions; however, ODM may consider the MCO's self-identification when determining the appropriate compliance action.

2. Ad Hoc Deliverables

a. The MCO must submit notifications and other ad hoc deliverables (deliverables that are not scheduled, but the MCO must submit to ODM under specific circumstances) to ODM as specified in this Agreement or as otherwise directed by ODM.

b. Unless otherwise specified by this Agreement or ODM, the MCO must submit all notifications and other ad hoc deliverables to ODM in writing.

3. Scheduled Deliverables

a. The Chart of Scheduled Deliverables in Section 4 below summarizes the scheduled deliverables specified in this Agreement, including the reference to the applicable appendix, the deliverable name, the frequency of the deliverable, and the due date.

b. The Chart of Scheduled Deliverables is presented for convenience only and does not limit the MCO's responsibility to provide all deliverables required by ODM in the format and frequency specified by ODM.

4. Chart of Scheduled Deliverables

#	Provider Agreement Appendix	Deliverable Name	Frequency	Due Date
1.	Appendix A	Accreditation Reports	Varies	• Within 30 calendar days, or as soon as practicable, of receiving accreditation.
2.	Appendix A	Protected Health Information (PHI) Breach Report	Annual	• January 31 for the year ending the previous December
3.	Appendix A	Member Services Call Center Report	Monthly	• 15th of the month
4.	Appendix A	24/7 Medical Advice Call Center Report	Monthly	• 15th of the month

#	Provider Agreement Appendix	Deliverable Name	Frequency	Due Date
5.	Appendix A	Member and Family Advisory Council Report	Quarterly	• January 30 for the quarter ending December 31 • April 30 for the quarter ending March 31 • July 30 for the quarter ending June 30 • October 30 for the quarter ending September 30
6.	Appendix A	Monthly Appeal and Grievance Activity Report	Monthly	• 15th of the month
7.	Appendix A	Grievance and Appeal Summary Report	Quarterly	• January 15 for the quarter ending December 31 • April 15 for the quarter ending March 31 • July 15 for the quarter ending June 30 • October 15 for the quarter ending September 30
8.	Appendix A	Provider Call Center Report	Monthly	• 15th of the month
9.	Appendix A	Provider Claim Inquiry Report	Monthly	• 15th of the month
10.	Appendix A	Provider Claim Dispute Report	Monthly	• 15th of the month
11.	Appendix A	MCO Organizational and Functional Chart	Annual and Upon Key Staff Changes	• January 15 • Upon Key Staff Changes
12.	Appendix A	MCO Staff Training Plan	Annual	• January 15
13.	Appendix A	FDR Oversight Report	Annual	• January 15
14.	Appendix B	Medication Therapy Management (MTM) Program Updates	Quarterly	• January 31 for the quarter ending December 31 • April 30 for the quarter ending March 31 • July 31 for the quarter ending June 30 • October 31 for the quarter ending September 30
15.	Appendix B	Unstaffed Home Care Report	Monthly	• 15th of the month

#	Provider Agreement Appendix	Deliverable Name	Frequency	Due Date
16.	Appendix B	Coordinated Services Program (CSP) via "Inbound from MCO" file process	Monthly, and upon change	• No later than the last day of the month preceding enrollment for new enrollments or reenrollments Upon change of assigned provider
17.	Appendix B	Ohio Medicaid Coordinated Services Program (CSP) Managed Care Organization (MCO) Program Description	Initial and upon change	• Sept 1, 2024 • Upon change
18.	Appendix B	PASRR Report	Monthly	• 15th of the month
19.	Appendix B	Institution for Mental Diseases (IMD) for Extended Stay	Quarterly	• January 31 for the quarter ending December 31 • April 30 for the quarter ending March 31 • July 31 for the quarter ending June 30 • October 31 for the quarter ending September 30
20.	Appendix B	Transportation Performance Report	Quarterly	• January 31 for the quarter ending December 31 • April 30 for the quarter ending March 31 • July 31 for the quarter ending June 30 • October 31 for the quarter ending September 30
21.	Appendix B	Utilization Management Tracking Database (UMTD) report	Monthly	• 5th of the month
22.	Appendix B	Mental Health Parity and Addiction Equity Act (MHPAEA) Compliance Assessment Tool and Attestation of Compliance	Annual	• December 31
23.	Appendix B	Strategic Plan for Increasing Access to Maternal Infant Support Program (MISP) Services	Annual	• Initial report due March 31, 2025; and • December 31 annually thereafter
24.	Appendix C	Population Health Management Strategy (PHMS)	Triennial	• September 1
25.	Appendix C	MMC Risk Stratification Data Submission File	Quarterly	• January 31 • April 30 • July 31 • October 31

#	Provider Agreement Appendix	Deliverable Name	Frequency	Due Date
26.	Appendix C	Community Reinvestment Evaluation	Annual	• March 31
27.	Appendix C	Community Reinvestment Plan	Annual	• October 15
28.	Appendix C	Evidence of QI Training Completion	Within 1 month of completion	• Varies
29.	Appendix C	QAPI Evaluation Template	Annual	• July 15
30.	Appendix C	QI Template	Weekly	• At least 2 business days prior to the weekly QI meeting
31.	Appendix C	Report of PRAF-Identified Needs Met	Monthly	• 15th day of following Month
32.	Appendix C	Provider Engagement Council Activity Report	Semi Annual	• January 15 for the 6-month period ending December 31 • July 15 for the 6-month period ending June 30
33.	Appendix C	Provider Engagement Council Collective Presentation	Annual	• October 1
34.	Appendix D	Care Coordination Program Submission	Annual	• October 15
35.	Appendix D	Care Coordination Status Submission File	Quarterly	• January 31 • April 30 • July 31 • October 31
36.	Appendix D	Care Coordination Contact Lists	Quarterly	• January 31 • April 30 • July 31 • October 31
37.	Appendix D	Health Risk Assessment Submission File	Quarterly	• January 31 • April 30 • July 31 • October 31
38.	Appendix F	Change in Circumstance Report (formerly Provider Termination Report)	Monthly	• 5th of the month
39.	Appendix F	Network Development and Management Plan	Annual	• January 15
40.	Appendix F	Centralized Credentialing Member Grievances	Monthly	• 15th of the month

#	Provider Agreement Appendix	Deliverable Name	Frequency	Due Date
41.	Appendix F	Time and Distance Report	Quarterly	• First Monday of January • First Monday of April • First Monday of July • First Monday of October
42.	Appendix F	Telehealth Report	Annual	• January 15
43.	Appendix G	Compliance Plan	Annual	• January 15
44.	Appendix G	EOB Mailing Date	Annual	• June 30th
45.	Appendix G	EOB Results	Annual	• 60 calendar days after the EOB mailing date
46.	Appendix G	Fraud, Waste, and Abuse Plan	Annual	• January 15
47.	Appendix G	Fraud, Waste, and Abuse Report	Annual	• February 28
48.	Appendix G	Fraud, Waste, and Abuse Inventory Report	Quarterly	• January 31 • April 30 • July 31 • October 31
49.	Appendix H	CPC Attribution Files	Quarterly	• Files must be submitted by the 2nd Friday of the month following the end of the calendar year quarter. For example, for Q1 2024, attribution and payment files must be submitted by October 13, 2023.
50.	Appendix H	APM Strategy	Triennial	• September 1
51.	Appendix H	Value-Based Payment Progress Report	Annual	• July 15
52.	Appendix H	APM Data Set	Quarterly	• May 15, for January 1 – March 31, and October 1 – December 31 • August 15, for April 1-June 30 • November 15, for July 1- September 30
53.	Appendix I	Self-Reported, Audited HEDIS Results and HEDIS IDSS Data Certification Letter	Annual	• Mid-June
54.	Appendix I	HEDIS Final Audit Report	Annual	• Mid-July
55.	Appendix I	CAHPS Survey Data	Annual	• June 15
56.	Appendix J	Quality Withhold Innovation Fund Expenditures	Quarterly	• Jan 15 • May 15 • August 15 • Nov 15

#	Provider Agreement Appendix	Deliverable Name	Frequency	Due Date
57.	Appendix K	Summary of BC-DR Plan Test Results	Annual	• Within 30 days of receiving results
58.	Appendix K	Systems Audit Results	Annual	• Within 2 weeks of receiving results
59.	Appendix K	CPSE Report	Monthly	• 15th of the month
60.	Appendix K	Network Provider HIE Participation Report	Annual	• January 15
61.	Appendix K	HIE Provider Support Plan	Annual	• January 15
62.	Appendix K	MCE Non-Claims Reporting	Quarterly	• 15th of the first month of the calendar quarter
63.	Appendix K	Electronic Visit Verification (EVV) Data	Monthly	• 15th of every month
64.	Appendix L	NAIC Quarterly Financial Statement	Quarterly	• May 15 • August 15 • November 15
65.	Appendix L	NAIC Annual Financial Statement	Annual	• March 1
66.	Appendix L	Annual Audit Report	Annual	• June 1
67.	Appendix L	NAIC/Cost Report Reconciliation	Annual	• April 30
68.	Appendix L	HIC Tax Report	Quarterly	• March 15 • May 15 • August 15 • November 15
69.	Appendix L	MLR Reporting Tool and Documentation	Annual	• For each MLR reporting year
70.	Appendix L	Prompt Pay Report	Quarterly	• 15th of the first month of the calendar quarter
71.	Appendix L	Third Party Liability Data File	Weekly	• No later than 11:00 pm Eastern Time Thursday night
72.	Appendix L	Quarterly Cost Report	Quarterly	• January 31 • April 30 • July 31 • October 31
73.	Appendix L	Annual Cost Report	Annual	• April 30
74.	Appendix R	CMS Annual Drug Utilization Review (DUR) Survey	Annual	• April 30

APPENDIX Q

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APPENDIX R – PRESCRIBED DRUGS AND PHARMACY

1. General Provisions

a. In providing the Medicaid Provider Administered Drugs (PAD) benefit to their members, the MCO must cover all Covered Outpatient Drugs, as defined in Section 1927(k) of the Social Security Act, that are provider administered, and marketed by a drug manufacturer (or labeler) that participates in the Medicaid Drug Rebate Program within ten calendar days of the drug's availability in the marketplace. In providing this benefit, plans must comply with the provisions of 42 USC 1396r-8(d)(5) including the requirement to provide a response within 24 hours of receipt for a prior authorization request. A response is defined as a decision if sufficient information is provided to make a decision. Alternatively, a notification of request for additional information should be sent within 24 hours. The MCO must comply with ODM guidance concerning coverage of medications that are available via both the medical and pharmacy benefit. All applicable medications must align in prior authorization status and clinical criteria between MCO coverage and the ODM Unified Preferred Drug List (UPDL). The MCO must also not implement utilization management or site-of-care strategies that intend to shift medication coverage to the pharmacy benefit without prior approval of ODM.

b. ODM may specify carve-out of selected provider administered drugs from the MCO. Carved-out medications will be covered under the Medicaid fee-for-service benefit. A current listing of these medications is located at https://medicaid.ohio.gov/stakeholders-and-partners/phm/carved-out-drugs. Notification of ODM's intent to carve-out a medication will be made to the MCO at least 30 calendar days prior to implementation. Regardless of the setting and the payer (fee-for-service or Managed Care), these medications must be prior authorized through fee-for-service (FFS). The approved prior authorization will be shared with the appropriate MCO for care coordination purposes. Carved out medications will not be included in capitation rates and the MCO will continue to be responsible for any and all medically necessary costs associated with the administration and/or monitoring of any of these carved-out medications.

c. The MCO must convene with ODM, at a minimum quarterly, to review new drugs to market and proposed prior authorization criteria. These considerations may be presented to the ODM Pharmacy & Therapeutics (P&T) Committee, operating under ORC section 5164.7510, which meets quarterly. The MCO must convene to meet with ODM at a minimum annually to review ODM's Preferred Drug List and prior authorization criteria. These considerations may be presented to the ODM P&T Committee annually. The MCO Pharmacy Director must participate in P&T Committee and DUR Board and/or Committee as specified by ODM.

d. The MCO must provide members with a warm hand-off to the SPBM for any pharmacy benefit related inquiries.

e. The MCO must continue to work with ODM to create a consistent utilization management and prior authorization approach for all opioids and Medication Assisted Treatment (MAT).

f. The MCO must, at a minimum, ensure same day coverage of the first dose of a long-acting injectable opioid antagonist for substance use disorders.

g. The MCO must provide a Public Children Services Association (PCSA) requested targeted medication review report up to and including provisions for a secure transfer portal for children in custody, as specified by ODM.

2. Drug Rebate Reporting Requirements

a. Section 1927 of the Social Security Act, 42 U.S.C. 1396r-8, mandates that drug companies or labelers shall sign a Medicaid Drug Rebate Agreement with the federal government to provide federal drug rebates to the State in order to have their products covered by the Medicaid Program. Additionally, the Affordable Care Act (ACA) requires ODM to obtain federal drug rebates for drugs paid for by the MCO. In order to ensure compliance with federal law, the MCO must:

i. Report the necessary encounter data to ODM for the invoicing of manufacturer rebates for all applicable Covered Outpatient Drugs. This includes provider-administered drugs, drugs personally furnished by a prescriber, and drugs provided in clinics and non-institutional settings.

ii. Work cooperatively with ODM and its designees, providing ODM with sufficient data and information to enable ODM to secure federal drug rebates for all utilization and administration of applicable Covered Outpatient Drugs as described above. The MCO must also assist ODM and its designees with the resolution of drug manufacturer disputes regarding claims for federal drug rebates for drugs administered to MCO Members.

iii. Report applicable Covered Outpatient Drug utilization as described above and information that is necessary for ODM to bill manufacturers for rebates in accordance with section 1927(b)(1)(A) of the Social Security Act no later than 45 calendar days after the end of each quarterly rebate period. Such utilization information must include, at a minimum, information on the total number of units of each dosage form, strength, and package size by National Drug Code of each Covered Outpatient Drug dispensed or covered by the MCO.

iv. Report all applicable Covered Outpatient Drug as described above and information, including National Drug Codes (NDCs) and accurate NDC units for all drug claim types, NCPDP, 837 Professional, 837 Institutional, etc. as designated by ODM. The MCO is prohibited from negotiating their own supplemental rebates for pharmaceutical products listed on the UPDL and the Preferred Diabetic Supply List with drug manufacturers.

v. Report all drugs billed to the MCO that were acquired through the 340B drug pricing program using standard modifiers so they can be properly excluded from federal drug rebates. The MCO must accommodate for the reporting of an SE, JG, and/or TB modifier for drugs acquired through the 340B Drug Pricing Program.

3. Drug Utilization Management

a. The MCO must actively participate in an ODM operated Drug Utilization Review (DUR) program designed to promote the appropriate clinical prescribing of covered drugs that complies with the requirements described in Section 1927(g) of the Social Security Act and

42 CFR Part 456 subpart K. As specified by ODM, the MCO must submit information to fulfill the requirements of the annual report detailed in 42 CFR 456.712 of subpart K, including a detailed description of the program as required by 42 CFR 438.3(s)(5). Pursuant to ORC section 5167.12, the MCO may implement strategies for the management of drug utilization. ODM may request details of drug utilization management programs and require changes to such programs. The MCO may, subject to ODM prior-approval, place limitations on the type of provider and locations where certain drugs may be administered; however, the MCO cannot require prior authorization for drugs used to prevent preterm birth nor can they require prior authorization for the location of administration (e.g., home or office).

4. CMS Cell and Gene Therapy (CGT) Access Model

a. The MCO must ensure compliance with all state requirements, to the extent that they are applicable to the MCO, under the CMS Cell and Gene Therapy Access Model, no later than October 1, 2025. This includes, but is not limited to, the following requirements:

i. The MCO must align with the state's standardized access policy for each gene therapy included in the Model. The standardized access policy will include prior authorization policies, other utilization management processes, provider qualifications, and patient eligibility criteria for each model drug.

ii. The MCO must ensure that an adequate network of providers is maintained to administer and care for members receiving a model drug.

iii. The MCO must honor state approved prior authorizations for model drugs as described above in this appendix. While the model drug will be authorized and payable through the fee-for-service benefit, the MCO must cover any and all medically necessary costs associated with the administration, monitoring, and follow-up/subsequent care related to the administration of model drugs. This includes payment and coverage for necessary inpatient, outpatient, and transportation services for members receiving (or scheduled to receive) a model drug to at least the same extent as specified in the Ohio Medicaid State Plan.

iv. The MCO must ensure continuity of care for members receiving a model drug that switch between MCOs, by ensuring that all approved prior authorizations for model drugs and related care are honored through their original expiration dates.

v. The MCO must ensure that members receiving model drugs have access to their same Sickle Cell Disease gene therapy providers until at least one year after receiving their gene therapy infusion.

vi. The MCO must coordinate with ODM regarding prior authorizations and single case agreements, when necessary, for members receiving a model drug.

vii. The MCO must submit documentation, as requested by ODM, to satisfy state reporting requirements under the model.