

**THE OHIO DEPARTMENT OF MEDICAID  
OHIO MEDICAL ASSISTANCE PROVIDER AGREEMENT  
FOR MANAGED CARE PLAN**

This Provider Agreement (hereinafter "Agreement") is entered into this first day of July, 2018, at Columbus, Franklin County, Ohio, between the State of Ohio, The Ohio Department of Medicaid, (hereinafter referred to as ODM) whose principal offices are located in the City of Columbus, County of Franklin, State of Ohio, and \_\_\_\_\_, Managed Care Plan (hereinafter referred to as the MCP), an Ohio corporation, whose principal office is located in the city of \_\_\_\_\_, County of \_\_\_\_\_, State of Ohio.

The MCP is licensed as a Health Insuring Corporation by the State of Ohio, Department of Insurance (hereinafter referred to as ODI), pursuant to Chapter 1751 of the Ohio Revised Code (ORC) and is organized and agrees to operate as prescribed by Chapter 5160-26 of the Ohio Administrative Code (OAC), and other applicable portions of the OAC as amended from time to time. Upon request, the MCP shall submit to ODM any data submitted to ODI to establish the MCP has adequate provisions against the risk of insolvency as required under 42 CFR 438.116.

The MCP is an entity eligible to enter into a provider agreement in accordance with 42 CFR (Code of Federal Regulations) 438.3 and is engaged in the business of providing comprehensive health care services as defined in 42 CFR 438.2 through the managed care program for the Medicaid eligible population described in OAC rule 5160-26-02 and any other Medicaid eligible populations authorized by the Centers for Medicare and Medicaid Services (CMS) and described in Ohio's 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 MCP services for the benefit of certain Medicaid recipients. In so doing, the MCP has provided and will continue to provide proof of the MCP'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 MCP, provider of medical assistance, pursuant to the federal contracting provisions of 42 CFR 434.6 and 438.6 in which the MCP agrees to provide comprehensive Medicaid services through the managed care program as provided in 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. 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; and Section 1557 of the Affordable Care Act.

**ARTICLE I - GENERAL**

- A. ODM enters into this Agreement in reliance upon the MCP's representations that it has the necessary expertise and experience to perform its obligations hereunder, and the MCP represents and warrants that it does possess such necessary expertise and experience.
- B. The MCP agrees to communicate with the Director of the Office of Managed Care (OMC) (hereinafter referred to as OMC) or his or her designee as necessary in order for the MCP to ensure its understanding of the responsibilities and satisfactory compliance with this Agreement.

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- C. The MCP agrees to furnish its staff and services as necessary for the satisfactory performance of the services as enumerated in this Agreement.
- D. ODM may, from time to time as it deems appropriate, communicate specific instructions and requests to the MCP concerning the performance of the services described in this Agreement. Upon such notice and within the designated time frame after receipt of instructions, the MCP shall comply with such instructions and fulfill such requests to the satisfaction of the department. It is expressly understood by the parties that these instructions and requests are for the sole purpose of performing the specific tasks requested to ensure satisfactory completion of the services described in this Agreement and are not intended to amend or alter this Agreement or any part thereof.

**ARTICLE II - TIME OF PERFORMANCE**

- A. Upon approval by the Director of ODM, this Agreement shall be in effect from the date executed through June 30, 2019, unless this Agreement is suspended or terminated pursuant to Article VIII prior to the termination date, or otherwise amended pursuant to Article IX.

**ARTICLE III - REIMBURSEMENT**

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

**ARTICLE IV - RELATIONSHIP OF PARTIES**

- A. ODM and the MCP agree that, during the term of this Agreement, the MCP shall be engaged with ODM solely on an independent contractor basis, and neither the MCP nor its personnel shall, at any time or for any purpose, be considered as agents, servants or employees of ODM or the state of Ohio. The MCP shall therefore be responsible for all the MCP's business expenses, including, but not limited to, employee's wages and salaries, insurance of every type and description, and all business and personal taxes, including income and Social Security taxes and contributions for Workers' Compensation and Unemployment Compensation coverage, if any. Pursuant to ORC section 145.038, ODM is required to provide individuals and business entities with fewer than five employees the Independent Contractor Acknowledgment (Form PEDACKN). This form requires the MCP to acknowledge that ODM has notified the MCP 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 MCP, its employees, or its subcontractors for these services. If the MCP is a business entity with fewer than five employees, each employee shall complete the PEDACKN form.
- B. The MCP agrees to comply with all applicable federal, state, and local laws in the conduct of the work hereunder.
- C. ODM retains the right to ensure that the MCP's work is in conformity with the terms and conditions of this Agreement.
- D. Except as expressly provided herein, neither party shall have the right to bind or obligate the other party in any manner without the other party's prior written consent.

#### **ARTICLE V - CONFLICT OF INTEREST; ETHICS LAWS**

- A. In accordance with the safeguards specified in Section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423) and other applicable federal requirements, no officer, member or employee of the MCP, the Director of OMC, 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 shall, prior to the completion of such services or reimbursement, acquire any interest, personal or otherwise, direct or indirect, which is incompatible or in conflict with, or would compromise in any manner or degree the discharge and fulfillment of his or her functions and responsibilities with respect to the carrying out of such services. For purposes of this article, "members" does not include individuals whose sole connection with the MCP is the receipt of services through a health care program offered by the MCP.
- B. The MCP represents, warrants, and certifies that it and its employees engaged in the administration or performance of this Agreement are knowledgeable of and understand the Ohio Ethics and Conflicts of Interest laws and Executive Order 2011-03K. The MCP further represents, warrants, and certifies that neither the MCP nor any of its employees will do or cause any act or omit any action that is inconsistent with such laws and Executive Order. The Governor's Executive Orders may be found by accessing the following website: <http://www.governor.ohio.gov/MediaRoom/ExecutiveOrders.aspx>
- C. The MCP hereby covenants that the MCP, its officers, members and employees of the MCP, shall not, prior to the completion of the work under this Agreement, voluntarily acquire any interest, personal or otherwise, direct or indirect, which is incompatible or in conflict with or would compromise in any manner of degree the discharge and fulfillment of his or her functions and responsibilities under this Agreement. The MCP shall periodically inquire of its officers, members and employees concerning such interests.
- D. Any such person who acquires an incompatible, compromising or conflicting personal or business interest, on or after the effective date of this Agreement, or who involuntarily acquires any such incompatible or conflicting personal interest, shall immediately disclose his or her interest to ODM in writing. Thereafter, he or she shall not participate in any action affecting the services under this Agreement, unless ODM shall determine in its sole discretion that, in the light of the personal interest disclosed, his or her participation in any such action would not be contrary to the public interest. The written disclosure of such interest shall be made to: Director, OMC, ODM.
- E. No officer, member or employee of the MCP shall promise or give to any ODM employee anything of value that is of such a character as to manifest a substantial and improper influence upon the employee with respect to his or her duties. The MCP, along with its officers, members and employees, understand and agree to take no action, or cause ODM or its employees to take any action, which is inconsistent with the applicable Ohio ethics and conflict of interest laws including without limitation those provisions found in ORC Chapter 102 and 2921.
- F. The MCP hereby covenants that the MCP, its officers, members and employees are in compliance with ORC section 102.04, and that if MCP is required to file a statement pursuant to ORC section 102.04(D)(2), such statement has been filed with ODM in addition to any other required filings.

#### **ARTICLE VI - NONDISCRIMINATION OF EMPLOYMENT**

- A. The MCP agrees that in the performance of this Agreement or in the hiring of any employees for the performance of services under this Agreement, the MCP shall not by reason of race, color, religion, gender,

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gender identity, sexual orientation, age, disability, national origin, military status, health status, genetic information or ancestry, discriminate against any individual in the employment of an individual who is qualified and available to perform the services to which the Agreement relates.

- B. The MCP agrees that it shall not, in any manner, discriminate against, intimidate, or retaliate against any employee hired for the performance or services under the Agreement on account of race, color, religion, gender, sexual orientation, age, disability, national origin, military status, health status, genetic information or ancestry.
- C. In addition to requirements imposed upon subcontractors in accordance with OAC Chapter 5160-26, the MCP agrees to hold all subcontractors and persons acting on behalf of the MCP in the performance of services under this Agreement responsible for adhering to the requirements of paragraphs (A) and (B) above and shall include the requirements of paragraphs (A) and (B) above in all subcontracts for services performed under this Agreement, in accordance with OAC rule 5160-26-05.

**ARTICLE VII - RECORDS, DOCUMENTS AND INFORMATION**

- A. The MCP agrees that all records, documents, writings or other information produced by the MCP under this Agreement and all records, documents, writings or other information used by the MCP in the performance of this Agreement shall be treated in accordance with OAC rule 5160-26-06 and shall be provided to ODM, or its designee, if requested. The MCP shall maintain an appropriate record system for services provided to members. The MCP shall retain all records in accordance with 42 CFR 438.3(u).
- B. All information provided by the MCP to ODM that is proprietary shall be held to be strictly confidential by ODM. Proprietary information is information which, if made public, would put the MCP at a disadvantage in the market place and trade of which the MCP is a part [see ORC section 1333.61(D)]. ODM will not share or otherwise disclose proprietary information received from the MCP to any third party without the express written authorization of the MCP, except that ODM shall be permitted to share proprietary information with contracted entities who need the proprietary information for rate setting or other purposes connected to the administration of the Medicaid program. These contracted entities shall be bound by the same standards of confidentiality that apply to ODM in these situations. The MCP agrees to expressly indicate by marking the top or bottom of each individual record containing information the MCP deems proprietary, regardless of media type (CD-ROM, Excel file etc.), prior to its release to ODM, unless otherwise specified by ODM. Upon request from ODM, the MCP agrees to promptly notify ODM in writing of the nature of the proprietary information including all reasonable evidence regarding the nature of the proprietary information in records submitted to ODM, and specifically identify the proprietary information contained in each individual record. The MCP also agrees to provide for the legal defense of all proprietary information submitted to ODM. ODM shall promptly notify the MCP in writing or via email of the need to legally defend the proprietary information such that the MCP is afforded the opportunity to adequately defend such information. Failure to provide such prior notification or failure to legally defend the proprietary nature of such information is deemed to be a waiver of the proprietary nature of the information, and a waiver of any right of the MCP to proceed against ODM for violation of this Agreement or of any laws protecting proprietary information. Such failure shall also be deemed a waiver of trade secret protection in that the MCP will have failed to make efforts that are reasonable under the circumstances to maintain the information's secrecy. The provisions of this Article are not self-executing.
- C. The MCP shall 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 MCP agrees to be bound by the same standards of

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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 shall be included in any subcontracts executed by the MCP for services under this Agreement. The MCP shall implement procedures to ensure that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR Part 160 and 164.

- D. The MCP agrees, certifies and affirms that HHS, US Comptroller General or representatives of either entity will have access to books, documents, and other business records of the MCP.
- E. All records relating to performance, under or pertaining to this Agreement will be retained by the MCP 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 10 years as are the audit and inspection rights for those records. For the initial three (3) years of the retention period, the records shall be stored in a manner and place that provides readily available access. If any records are destroyed prior to the date as determined by the appropriate records retention schedule, the MCP agrees to pay to ODM all damages, costs, and expenses incurred by ODM associated with any cause, action or litigation arising from such destruction.
- F. The MCP agrees to retain all records in accordance with any litigation holds that are provided to them by ODM, and actively participate in the discovery process if required to do so, at no additional charge. Litigation holds may require the MCP to keep the records longer than the approved records retention schedule. The MCP will be notified by ODM when the litigation hold ends, and retention can resume based on the approved records retention schedule. If the MCP fails to retain the pertinent records after receiving a litigation hold from ODM, the MCP agrees to pay to ODM all damages, costs and expenses incurred by ODM associated with any cause, action or litigation arising from such destruction.
- G. The MCP shall promptly notify ODM of any legal matters and administrative proceedings including, but not limited to, litigation and arbitration, which involve or otherwise pertain to the activities performed pursuant to this Agreement and any third party. In the event that the MCP possesses or has access to information and/or documentation needed by ODM with regard to the above, the MCP agrees to cooperate with ODM in gathering and providing such information and/or documentation to the extent permissible under applicable law.

**ARTICLE VIII - NONRENEWAL AND TERMINATION**

- A. This Agreement may be terminated, by the ODM or the MCP upon written notice in accordance with the applicable rule(s) of the OAC, with termination to occur at the end of the last day of the termination month.
- B. Subsequent to receiving a notice of termination from ODM, the MCP beginning on the effective date of the termination, shall 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 this Agreement, as of the date of receipt of notice of termination describing the status of all services under this Agreement.
- C. In the event of termination under this Article, the MCP shall be entitled to request reconciliation of reimbursements through the final month for which services were provided under this Agreement, in accordance with the reimbursement provisions of this Agreement. The MCP agrees to waive any right to,

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and shall make no claim for, additional compensation against ODM by reason of such suspension or termination.

- D. In the event of termination under this Article, the MCP shall return all records in their native format relating to cost, work performed, supporting documentation for invoices submitted to ODM, and copies of all materials produced under or pertaining to this Agreement.
- E. ODM may, in its sole discretion, terminate or fail to renew this Agreement if the MCP or MCP's subcontractors violate or fail to comply with the provisions of this Agreement or other provisions of law or regulation governing the Medicaid program. Where ODM proposes to terminate or refuse to enter into a provider agreement, the provisions of applicable sections of the OAC with respect to ODM's suspension, termination or refusal to enter into a provider agreement shall apply, including the MCP's right to request an adjudication hearing under ORC Chapter 119. The MCP does not have the right to request an adjudication hearing under ORC Chapter 119 to challenge any action taken or decision made by ODM with respect to entering into or refusing to enter into a provider agreement with the MCP pursuant to ORC section 5167.10.
- F. When initiated by the MCP, termination of or failure to renew the Agreement requires written notice to be received by ODM at least 240 calendar days in advance of the termination or renewal date, provided, however, that termination or non-renewal shall be effective at the end of the last day of a calendar month. In the event of non-renewal of the Agreement with ODM, if the MCP is unable to provide the required number of days of notice to ODM prior to the date when the Agreement expires, then the Agreement shall be deemed extended to the last day of the month that meets the required number of days from the date of the termination notice, and both parties shall, for that time, continue to fulfill their duties and obligations as set forth herein. If the MCP wishes to terminate or not renew their Agreement for a specific region(s), ODM reserves the right to initiate a procurement process to select additional MCPs to serve Medicaid consumers in that region(s). ODM, at its discretion, may use the MCP's termination or non-renewal of this Agreement as a factor in any future procurement process.
- G. The MCP 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 (Aged, Blind, Disabled, Modified Adjusted Gross Income, or Adult Extension) 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 P as of the date funding expires. If the Ohio General Assembly or the United States government fails at any time to provide sufficient funding for ODM or the State of Ohio to make payments due under this 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 writing 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 shall be prospective in nature.
- B. In the event that changes in state or federal law, regulations, an applicable waiver or state plan amendment, or the terms and conditions of any applicable federal waiver or state plan amendment, require ODM to modify this Agreement, ODM shall notify the MCP regarding such changes and this Agreement shall be

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automatically amended to conform to such changes without the necessity for executing written amendments pursuant to this Article of this 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 shall not constitute a continuing waiver by such party of any subsequent act in breach of or in default hereunder.
- E. If the MCP was not selected as a contractor as a result of a procurement process, the expiration of this Agreement shall not be considered a termination or failure to renew. The MCP will have the ability to protest the award of the contract in accordance with the process that will be described in the Request for Applications.

**ARTICLE X - LIMITATION OF LIABILITY**

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

**ARTICLE XI - ASSIGNMENT**

- A. Medicaid members may not be transferred by one MCP to another entity without the express prior written approval of ODM. Even with ODM's prior written approval, ODM reserves the right to offer such members the choice of MCPs outside the normal open enrollment process and implement an assignment process as ODM determines is appropriate. Any member transfer shall be submitted for ODM's review 120 calendar days prior to the desired effective date. ODM shall 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

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

- B. MCPs shall not assign any interest in this Agreement and shall not transfer any interest in the same (whether by assignment or novation) without the prior written approval of ODM and subject to such conditions and provisions as ODM may deem necessary. No such approval by ODM of any assignment shall be deemed in any event or in any manner to provide for the incurrence of any obligation by ODM in addition to the total agreed-upon reimbursement in accordance with this Agreement. Any assignments of interest shall be submitted for ODM's review 120 calendar days prior to the desired effective date. ODM shall 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 MCP to successfully complete a readiness review process before the transfer of obligations under this Agreement.
- C. The MCP shall not assign any interest in subcontracts of this Agreement and shall not transfer any interest in the same (whether by assignment or novation) without the prior written approval of ODM and subject to such conditions and provisions as ODM may deem necessary. Any such assignments of subcontracts shall be submitted for ODM's review 30 calendar days prior to the desired effective date. No such approval by ODM of any assignment shall be deemed in any event or in any manner to provide for the incurrence of any obligation by ODM in addition to the total agreed-upon reimbursement in accordance with this Agreement.

**ARTICLE XII - CERTIFICATION MADE BY THE MCP**

- A. This Agreement is conditioned upon the full disclosure by the MCP to ODM of all information required for compliance with state and federal regulations.
- B. The MCP certifies that no federal funds paid to the MCP through this or any other Agreement with ODM shall be or have been used to lobby Congress or any federal agency in connection with a particular contract, grant, cooperative agreement or loan. The MCP further certifies its continuing compliance with applicable lobbying restrictions contained in 31 U.S.C. 1352 and 45 CFR Part 93. If this Agreement exceeds \$100,000, the MCP 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 MCP certifies that neither the MCP nor any principals of the MCP (i.e., a director, officer, partner, or person with beneficial ownership of more than 5% of the MCP's equity) is presently debarred, suspended, proposed for debarment, declared ineligible, or otherwise excluded from participation in transactions by any Federal agency. The MCP 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 MCP also certifies that the MCP 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 MCP'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 SCHIP, except for emergency services. If it is ever determined that the MCP knowingly executed this certification erroneously, then in addition to any other remedies, this Agreement shall be terminated pursuant to Article VIII, and ODM shall advise the Secretary of the appropriate federal agency of the knowingly erroneous certification.



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- D. The MCP certifies that the MCP is not on the most recent list established by the Secretary of State, pursuant to ORC section 121.23, which identifies the MCP 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 MCP agrees not to discriminate against individuals who have or are participating in any work program administered by a County Department of Job and Family Services (CDJFS) under ORC Chapters 5101 or 5107.
- F. The MCP certifies and affirms that, as applicable to the MCP, 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 one thousand dollars (\$1,000.00) to the present Governor or to the Governor's campaign committees during any time he/she was a candidate for office. This certification is a material representation of fact upon which reliance was placed when this Agreement was entered into. If it is ever determined that the MCP's certification of this requirement is false or misleading, and notwithstanding any criminal or civil liabilities imposed by law, the MCP shall return to ODM all monies paid to the MCP under this Agreement. The provisions of this section shall survive the expiration or termination of this Agreement.
- G. The MCP agrees to refrain from promising or giving to any ODM employee anything of value that is of such a character as to manifest a substantial and improper influence upon the employee with respect to his or her duties.
- H. The MCP agrees to comply with the false claims recovery requirements of 42 U.S.C 1396a(a)(68) and to also comply with ORC section 5162.15.
- I. The MCP, its officers, employees, members, any subcontractors, and/or any independent contractors (including all field staff) associated with this Agreement agree to comply with all applicable state and federal laws regarding a smoke-free and drug-free workplace. The MCP will make a good faith effort to ensure that all MCP 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 MCP certifies and confirms that any performance of experimental, developmental, or research work shall provide for the rights of the Federal Government and the recipient in any resulting invention.
- K. The MCP certifies and confirms that it agrees to comply with all applicable standards orders or regulations of the Clean Air Act and Federal Water Pollution Control Act.
- L. The MCP agrees that it is in compliance with the Federal Acquisition Regulation (FAR) for Combatting 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.

### **ARTICLE XIII - CONSTRUCTION**

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

### **ARTICLE XIV - INCORPORATION BY REFERENCE**

- A. OAC Chapter 5160-26 is hereby incorporated by reference as part of this Agreement having the full force and effect as if specifically restated herein.
- B. Appendices A through Q and any additional appendices are hereby incorporated by reference as part of this Agreement having the full force and effect as if specifically restated herein. Appendix P and any other applicable obligations set forth in this Agreement will survive the termination or non-renewal of this Agreement.
- C. In the event of inconsistency or ambiguity between the provisions of OAC Chapter 5160-26 and this Agreement, the provisions of OAC Chapter 5160-26 shall 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 this Agreement, in which case such federal or state law shall be determinative of the obligations of the parties. In the event OAC Chapter 5160-26 is silent with respect to any ambiguity or inconsistency, the Agreement (including Appendices B through Q and any additional appendices), shall be determinative of the obligations of the parties. In the event that a dispute arises which is not addressed in any of the aforementioned documents, the parties agree to make every reasonable effort to resolve the dispute, in keeping with the objectives of the Agreement and the budgetary and statutory constraints of ODM.

### **ARTICLE XV – NOTICES**

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

### **ARTICLE XVI – HEADINGS**

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

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

**MCP NAME:**

BY: \_\_\_\_\_ DATE: \_\_\_\_\_  
PRESIDENT & CEO  
ADDRESS: \_\_\_\_\_

**THE OHIO DEPARTMENT OF MEDICAID:**

BY: \_\_\_\_\_ DATE: \_\_\_\_\_  
BARBARA R. SEARS, DIRECTOR  
50 West Town Street, Suite 400, Columbus, Ohio 43215

**Ohio Department of Medicaid (ODM)  
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**OAC RULES**

The managed care program rules are located in Ohio Administrative Code (OAC) Chapter 5160-26 and can be accessed electronically through the Ohio Department of Medicaid's Managed Care webpage.

**APPENDIX B**

**SERVICE AREA SPECIFICATIONS**

- 1. Service Areas.** The MCP agrees to provide services to Aged, Blind or Disabled (ABD) members, Modified Adjusted Gross Income (MAGI) members, and Adult Extension members residing in the following service area(s):

- Central/Southeast Region
- Northeast Region
- West Region

The ABD and MAGI categories of assistance are described in OAC rule 5160-26-02. The Adult Extension category is defined in Ohio’s Medicaid State Plan as authorized by the Centers for Medicare and Medicaid Services (CMS).

The MCP shall serve all counties in any region they agree to serve.

- 2. Ohio MCP Regions.** Counties are grouped into three regions as identified below.

**Counties in the Central/Southeast Region**

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

**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

**Counties in the West Region**

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

## APPENDIX C

### PLAN RESPONSIBILITIES

The following are Managed Care Plan (MCP) responsibilities not otherwise specifically stated in Ohio Administrative Code (OAC) rule or elsewhere in this Agreement.

1. The MCP shall implement program modifications as soon as reasonably possible or no later than the required effective date, in response to changes in applicable state and federal laws and regulations.
2. The MCP shall submit a current copy of its Certificate of Authority (COA) to the Ohio Department of Medicaid (ODM) within 30 calendar days of issuance by the Ohio Department of Insurance (ODI).
3. The MCP shall designate the following:
  - a. A primary contact person (the Contract Compliance Officer) who will dedicate a majority of his or her time to the Medicaid product line and coordinate overall communication between ODM and the MCP. ODM may also require the MCP to designate contact staff for specific program areas. The Medicaid Contract Compliance Officer will be responsible for ensuring the timeliness, accuracy, completeness and responsiveness of all MCP submissions to ODM.
  - b. A provider relations representative for each service area included in this Agreement. This provider relations representative can serve in this capacity for only one service area.
4. **Communications.** The MCP shall take all necessary and appropriate steps to ensure all MCP staff are aware of, and follow, the following communication process:
  - a. All MCP employees are to direct all day-to-day submissions and communications to their ODM-designated Contract Administrator within the Office of Managed Care (OMC) unless otherwise notified by ODM. If the MCP needs to contact another area of ODM in any other circumstance, the Contract Administrator within the OMC shall also be copied or otherwise included in the communication.
  - b. Entities that contract with ODM should never be contacted by the MCP unless ODM has specifically instructed the MCP to contact these entities directly.
  - c. Because the MCP is ultimately responsible for meeting program requirements, ODM will only discuss MCP issues with the MCP's subcontractor when the MCP is also participating in the discussion or when the MCP grants ODM permission to do so. MCP subcontractors should communicate with ODM when the MCP is participating, or when the MCP grants authorization to communicate directly with ODM.
5. The MCP shall be represented at all meetings and events designated by ODM that require mandatory attendance.
6. The MCP shall have an administrative office located in Ohio.

7. The MCP shall have its Ohio Medicaid Managed Care program member call center(s) located in the state of Ohio.
8. **Required MCP Staff.** The MCP shall have the key Ohio Medicaid Managed Care program staff identified below based and working in the state of Ohio. Key management and supervisory staff for positions associated with new products and services shall be in place at least 60 calendar days prior to the effective date of the new products and services. Each key staff person identified below may occupy no more than one of the positions listed below, unless the MCP receives prior written approval from ODM stating otherwise. These key staff are:
  - a. **Administrator/CEO/COO** or their designee shall serve in a full time (40 hours weekly) position available during ODM business hours to fulfill the responsibilities of the position and to oversee the entire operation of the MCP. The Administrator shall devote sufficient time to the MCP's operations to ensure adherence to program requirements and timely responses to ODM.
  - b. **Medical Director/CMO** who is a physician with a current, unencumbered license through the Ohio State Medical Board. The Medical Director shall have at least three years of training in a medical specialty. The Medical Director shall devote full time (minimum 32 hours weekly) to the MCP's operations to ensure timely medical decisions, including after-hours consultation as needed. The Medical Director shall be actively involved in all major clinical and quality management components of the MCP. At a minimum, the Medical Director shall be responsible for:
    - i. Development, implementation and medical interpretation of medical policies and procedures including, but not limited to, service authorization, claims review, discharge planning, credentialing and referral management, and medical review included in the MCP grievance system;
    - ii. Administration of all medical management activities of the MCP; and
    - iii. Serve as director of the Utilization Management committee and chairman or co-chairman of the Quality Assessment and Performance Improvement committee.
  - c. **Behavioral Health (BH) Administrative Director** who possesses an independent, current and unrestricted Ohio license to provide BH services in the State of Ohio (MD, DO, RN with Advanced Practice Certification, Psychologist, LISW, PCC, IMFT) and has a minimum of five years of experience in the provision and supervision of treatment service for mental illness and substance use disorders. The BH Administrative Director shall demonstrate knowledge and understanding of Ohio's overall BH system which includes mental health, alcohol and drug addiction, and developmental disabilities services. He or she shall be responsible for the daily operational activities of BH services across the full spectrum of care to members, inclusive of mental health and substance abuse services. The primary functions of the BH Administrative Director are:
    - i. Ensuring access to BH services including mental health and substance abuse services;



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- ii. Ensuring systematic screening for BH related disorders by utilizing standardized and/or evidence-based approaches;
  - iii. Promoting preventive BH strategies;
  - iv. Identifying and coordinating assistance for identified Beneficiary needs specific to BH;
  - v. Participating in management and program improvement activities with other key staff (including the BH Clinical Director) for enhanced integration with primary care and coordination of BH services and achievement of outcomes; and
  - vi. Working with the BH Clinical Director, as needed, in the development and maintenance of programs and systems.
- d. **Behavioral Health (BH) Clinical Director** who is a dedicated part-time staff, at a minimum, with continuous engagement to perform the functions of a BH Clinical Director. These personnel must be practicing within the scope of his or her license and must hold a current unrestricted Ohio license as either a Clinical Psychologist, or a Board Certified Psychiatrist, with a minimum of three years professional experience in a clinical setting.
- i. The MCP must include at least one Board Certified Psychiatrist, who shall be a prescriber, to perform the following BH Clinical Director functions:
    - 1. Play a lead role in monitoring the overall safety of patients with a BH diagnosis, with a special focus on safe prescribing;
    - 2. Serving as a key clinical lead in developing and implementing evidenced based clinical policies and practices;
    - 3. Participating in regulatory/accreditation reviews;
    - 4. Assuming key role in quality improvement initiatives, case management activities and member safety activities (i.e. incident management);
  - ii. All other duties and responsibilities of the BH Clinical Director staff shall include:
    - 1. BH coverage determination for utilization management to ensure members receive appropriate and medically necessary care in the most cost-effective setting;
    - 2. Oversight and quality improvement activities associated with case management activities;
    - 3. Providing guidance to BH orientation and network development/ recruitment in conjunction with provider relations, value-based contracting, support of

episodes of care and full integration of BH services;

4. Assisting in the review of utilization data to identify variances in patterns, and providing feedback and education to MCP staff and providers as appropriate; and
  5. Representing the MCP as the primary clinical liaison to members, providers and ODM.
- e. **Contract Compliance Officer** who will serve as the primary point-of-contact for all MCP operational issues. The primary functions of the Contract Compliance Officer may include but are not limited to coordinating the tracking and submission of all contract deliverables; fielding and coordinating responses to ODM inquiries, coordinating the preparation and execution of contract requirements, random and periodic audits and site visits.
- f. **Provider Services Representatives** who will resolve provider issues, including, but not limited to, problems with claims payment, prior authorizations (PA) and referrals.
- g. **Care Management (CM) Director** who is an Ohio-licensed registered nurse or an Ohio-licensed independent social worker preferably with a designation as a Certified Case Manager (CCM) from the Commission for Case Manager Certification (CCMC). The CM Director is responsible for overseeing the day-to-day operational activities of the Care Management Program in accordance with state guidelines. The CM Director is responsible for ensuring the functioning of care management activities across the continuum of care (assessing, planning, implementing, coordinating, monitoring, and evaluating). The CM Director shall have experience in the activities of care management as specified in 42 CFR 438.208. Primary functions of the CM Director position are to ensure:
- i. The implementation of mechanisms for identifying, assessing, and developing a treatment plan for an individual with special health care needs;
  - ii. Access to primary care, behavioral health, and coordination of health care services for all members; and
  - iii. The coordination of services furnished to the enrollee with the services the enrollee receives from any other health care entity.
- h. **Utilization Management (UM) Director** who is an Ohio-licensed registered nurse or a physician with a current unencumbered license through the Ohio State Medical Board. This person may have a certification as a Certified Professional in Health Care Quality (CPHQ) by the National Association for Health Care Quality (NAHQ) and/or Certified in Health Care Quality and Management (CHCQM) by the American Board of Quality Assurance and Utilization Review Providers. The UM Director is responsible for overseeing the day-to-day operational activities of the Utilization Management Program in accordance with state guidelines. The UM Director shall have experience in the activities of utilization management as specified in 42 CFR 438.210. Primary functions of the Director of Utilization Management position are to ensure:

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- i. There are written policies and procedures regarding authorization of services and that these are followed;
  - ii. Consistent application of review criteria for authorization decisions;
  - iii. Decisions to deny or reduce the amount of services are made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease;
  - iv. Notices of adverse action meet the requirements of 42 CFR 438.404; and
  - v. All decisions are made within the specified allowable time frames.
- i. **Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Maternal Child Health Manager** who is 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 other related field and/or a CPHQ or CHCQM. Staffing under this position should be sufficient to meet quality and performance measure goals. The primary functions of the EPSDT/MCH Manager are:
  - i. Ensuring receipt of EPSDT services;
  - ii. Ensuring receipt of maternal and postpartum care;
  - iii. Promoting family planning services;
  - iv. Promoting preventive health strategies;
  - v. Identifying and coordinating assistance for identified member needs specific to maternal/child health and EPSDT;
  - vi. Interfacing with community partners; and
  - vii. Pregnancy Related Services Coordinator
- j. **Quality Improvement (QI) Director** is a member of the MCP QI leadership team who is either an Ohio-licensed registered nurse, physician or physician's assistant, or who is certified as a CPHQ by the National Association for Healthcare Quality, CQIA by the American Society for Quality (ASQ), and/or a CHCQM by the American Board of Quality Assurance and Utilization Review Providers (ABQAURP) within six months of employment. The QI Director shall have experience in quality management and quality improvement as specified in 42 CFR 438.206 through 438.370. The primary functions of the QI Director position are:
  - i. Developing and managing the MCP's portfolio of improvement projects, including identifying and prioritizing initiatives;

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- ii. Assisting the MCP's leadership team in communicating the cross-cutting nature of improvement efforts and their relationship to the MCP and ODM quality strategies and improved state health outcomes;
  - iii. Ensuring individual and systemic quality of care and services through modeling and encouraging systems thinking;
  - iv. Assisting the MCP leadership team (as defined in Appendix K) in integrating quality throughout the organization's culture through working with staff from different program areas to identify improvement opportunities, test improvement strategies using proven methods, and assess results using frequent measurements;
  - v. Supporting MCP improvement teams, including elevating resource, IT, analytic, and staffing needs by bringing to the attention of the leadership team;
  - vi. Ensuring appropriate members of MCP improvement teams are fully prepared for QI discussions with ODM (i.e. team members should be able to independently describe the current status of intervention testing, the theory of change, etc. for projects in which they are involved);
  - vii. Increasing MCP staff effectiveness through providing ODM-approved training in quality improvement science and reinforcing the application of quality improvement tools and methods within MCP improvement projects and initiatives;
  - viii. Articulating the methods and data used to assess the effectiveness of improvement activities;
  - ix. Incorporating the results of quality improvement assessments and evaluations into the MCP's quality strategy;
  - x. Monitoring, reporting, and presenting quality improvement initiative status and results over time, including lessons learned from failures, to both internal and external audiences; and
  - xi. Working collaboratively with all MCPs and ODM to improve population health outcomes.
- k. **Community Engagement Coordinator** is a position that formalizes current MCP engagement activities in priority communities. Depending on the size of the population being served, at least one FTE will be devoted to Community Engagement Coordinator responsibilities. These responsibilities may be filled by multiple individuals. Community Engagement Coordinator responsibilities shall include:
- i. Serving as the MCP's primary point(s) of contact for ODM-sanctioned improvement efforts involving community-based organizations and requiring community outreach and active involvement in priority communities (e.g., community-based infant mortality

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- reduction);
- ii. Attending or overseeing MCP attendance at community events in priority communities (e.g., trainings, racism dialogues, infant mortality awareness events);
  - iii. In-person communication with funded community-based organizations in order to bolster the presence of the MCP itself as a collaborative and trusted partner of the CBO and as a supporter of the ODM initiative;  
Collaborating with other MCPs' coordinators to communicate and address community concerns;
  - iv. Coordinating the tracking and submission of process measures, as needed, related to MCP improvement efforts in communities (e.g. infant mortality reduction efforts in high priority areas);
  - v. Responding to ODM inquiries related to MCP community engagement activities; and
  - vi. Identifying additional community engagement opportunities and developing a Community Engagement Plan to participate in or support those opportunities. The Community Engagement Plan shall be submitted as specified by ODM.
9. Upon request by ODM, the MCP shall submit information on the current status of their company's operations not specifically covered under this Agreement unless otherwise excluded by law.
  10. The MCP shall ensure employees, including subcontractor staff, receive training on applicable program requirements, and represent, warrant and certify to ODM that such training occurs, or has occurred. Training will be commensurate with provider function and will include at a minimum an introduction to: behavioral health benefits, evidence-based practices for both behavioral health and medical conditions, person-centered care delivery approaches and other subjects as specified by ODM. Individuals who oversee training shall have demonstrable experience and expertise in the topic for which they are providing training.
  11. All employees of the MCP and the MCP's subcontractors who have in-person contact with a member in the member's home shall comply with criminal record check requirements as specified by ODM.
  12. If the MCP determines that it does not wish to provide, reimburse, or cover a counseling service or referral service due to an objection to the service on moral or religious grounds, it shall immediately notify ODM to coordinate the implementation of this change. The MCP is required to notify their members of this change at least 30 calendar days prior to the effective date. The MCP's member handbook and provider directory, as well as all marketing materials, will need to include information specifying any such services that the MCP will not provide.
  13. For any data and/or documentation that the MCP is required to maintain, ODM may request that the MCP provide analysis of this data and/or documentation to ODM in an aggregate format to be solely determined by ODM.

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14. The MCP is responsible for determining medical necessity for services and supplies requested for its members as specified in OAC rule 5160-26-03. Notwithstanding such responsibility, ODM retains the right to make the final determination on medical necessity in specific member situations. In accordance with OAC rule 5160-26-03.1, the MCP shall make its medical necessity review policies and procedures available to ODM, contracting and non-contracting providers.

15. The MCP shall submit medical records at no cost to ODM and/or its designee upon request.

**16. Provider Panel Changes.**

a. In addition to the provisions in OAC rule 5160-26-05, the MCP shall notify the OMC:

- i. Within one business day of becoming aware that an MCP panel provider that served 500 or more of the MCP's members in the previous 12 months failed to notify the MCP that they are no longer available to serve as an MCP panel provider;
- ii. At least 4 months before the effective date of a systemic change in panel. ODM defines a systemic change in panel as an MCP-initiated termination or change in availability of any single provider or combination of providers, which are included in the provider contract termination in question, serving 500 or more of the MCP's members in the previous 12 months. For example, the MCP terminates ten providers each serving 450 members. This termination shall be reported, even though the providers individually do not meet the 500-member requirement. Overall, the group termination impacts 4,500 members and shall be reported. ODM reserves the right to require that the MCP align an MCP initiated systemic change in panel to the annual open enrollment month;
- iii. Prior to any MCP-initiated provider panel changes that will result in provider network availability being reduced by 10% or more of available panel providers as of the date of the notice. MCP-initiated changes may include, but are not limited to, restricting contracts for any service or with any providers by limiting subcontracts (including sole source contracting), terminating or restricting any providers or group of providers or by reducing payment rates; or
- iv. Within one business day of becoming aware of a provider-initiated hospital unit closure.

b. When a plan has been notified of a hospital termination, the MCP may request ODM authorize an alternative notification area, in accordance with OAC rule 5160-26-05. Upon request, ODM will determine the authorized notification area no later than 7 business days after receipt of the MCP's submission. The notification timelines outlined in OAC rule 5160-26-05 will not be waived. The MCP must submit the following details to ODM:

- i. Provider information including name, provider type, address and county where services were rendered, including details for all primary care providers (PCPs) or specialists if the provider is a hospital;
- ii. Copy of the termination notice including the termination date;

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- iii. Number of members who used services from, or were assigned to, a PCP in the previous 12 months; and
- iv. Results of an evaluation of the remaining contracts completed 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 contracts that can meet the access requirements.
- v. For hospital terminations:
  - 1. Zip codes or counties of residence for members who used services in the previous 12 months;
  - 2. Percentage of the plans' membership that use the terminating hospital and compare with the percent of the plans' membership that use the next closest contract hospital; and
  - 3. Plan to ensure continuity of services for members in their third trimester, receiving chemotherapy, and/or receiving radiation treatment.

17. **Additional Benefits.** The MCP may elect to provide services in addition to those covered under the Ohio Medicaid fee-for-service (FFS) program. Before the MCP notifies potential or current members of the availability of those services, the MCP shall first notify ODM of its plans to make such services available. If the MCP elects to provide additional services, the MCP shall ensure to the satisfaction of ODM that the services are readily available and accessible to members who are eligible to receive them. Additional benefits shall be made available to members for at least six calendar months from the date approved by ODM. Additional benefits may not vary by county within a region except out of necessity for transportation arrangements (e.g., bus versus cab). MCPs approved to serve members in more than one region may vary additional benefits between regions.

- a. The MCP is required to make transportation available to any member requesting transportation when the member shall travel 30 miles or more from his or her home to receive a medically-necessary Medicaid-covered service provided by the MCP pursuant to OAC rule 5160-26-03 and Appendices G and H of this Agreement. If the MCP offers transportation to their members as an additional benefit and this transportation benefit only covers a limited number of trips, the required transportation listed above may not be counted toward this trip limit.
- b. The MCP shall give ODM and members 90 calendar days prior notice when decreasing or ceasing any additional benefits. When the MCP finds that it is impossible to provide 90 calendar days prior notice for reasons beyond its control, as demonstrated to ODM's satisfaction, ODM shall be notified within at least one business day.

18. **Behavioral Health Crisis Services.** The MCP shall ensure protocols, policies and processes are in place for MCP and/or delegated staff to appropriately address member contacts related to behavioral health crisis needs. Protocols shall include, at a minimum, the involvement of qualified health professionals whose scope of practice and licensure permits them to perform the required functions associated with the services. Staff shall have: experience with behavioral health crisis assessment and intervention as

applicable, a mechanism to validate that the individual received the needed services (e.g. connection to crisis counseling services), and the ability to activate the MCP's process 24/7.

19. **Provision of Transportation Services.** The MCP shall ensure transportation pick-up is completed not more than 15 minutes before or 15 minutes after the pre-scheduled pick-up time, ensuring the member is on time for their appointment. Following a scheduled appointment, transportation pick-up shall be completed no more than 30 minutes after a request for pick-up following a scheduled appointment. The vendor shall attempt to contact the member if he/she does not respond at pick-up.
  - a. The vendor shall not leave the pick-up location prior to the pre-scheduled pick-up time.
  - b. The MCP shall identify and accommodate the special transportation assistance needs of their members (e.g., door-to-door assistance, attendant support, member-specific timeliness requirements). Member-specific needs shall be communicated to the transportation vendor and updated as frequently as is needed to support the member's needs. Where applicable, these needs shall be documented in the member's care plan.
  - c. The MCP shall submit a plan for the provision of transportation services during winter snow and other weather emergencies, specifying identification, triage, transportation of consumers requiring critical services, notification to consumers of canceled transportation and rescheduling. The plan shall specify the snow emergency level and any other weather-related criteria that require a change to scheduled transportation. The MCP shall notify the Contract Administrator immediately when transportation is canceled in accordance with the plan.
20. **Member Rights.** The MCP shall comply with 42 CFR 438.100, OAC rule 5160-26-08.3 and any applicable federal and state laws that pertain to member rights and ensure its staff adhere to such laws when furnishing services to its members. The MCP shall include a requirement in its contracts with affiliated providers that such providers also adhere to applicable Federal and State laws when providing services to members.
21. **Cultural Competency and Communication Needs.** The MCP is responsible for promoting the delivery of services in a culturally competent manner, as defined by the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care (<https://www.thinkculturalhealth.hhs.gov/clas>), to all members, including those with limited English proficiency (LEP) and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. The MCP shall make oral interpreter services for all languages available free of charge to all members and eligible individuals pursuant to 42 CFR 438.10(d)(4). The MCP shall comply with the requirements specified in OAC rules 5160-26-03.1, 5160-26-05, and 5160-26-05.1 for providing assistance to LEP members and eligible individuals. In addition, the MCP shall provide written translations of certain MCP materials in the prevalent non-English languages of members and eligible individuals in accordance with the following:
  - a. If ODM identifies prevalent non-English languages in the MCP's service area, the MCP, as specified by ODM, shall translate marketing and member materials, including but not limited to HIPAA privacy notices, into the primary languages of those groups. The MCP shall make these marketing and member materials available to eligible individuals free of charge.



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- b. The MCP shall utilize a centralized database which records the special communication needs of all MCP members (i.e., those with LEP, limited reading proficiency [LRP], visual impairment, and hearing impairment) and the provision of related services (i.e., MCP materials in alternate format, oral interpretation, oral translation services, written translations of MCP materials, and sign language services). This database shall include all MCP member primary language information (PLI) as well as all other special communication needs information for MCP members, as indicated above, when identified by any source including but not limited to ODM, the Hotline, MCP staff, providers, and members. This centralized database shall be readily available to MCP staff and be used in coordinating communication and services to members, including the selection of a primary care provider (PCP) who speaks the primary language of an LEP member, when such a provider is available.
- c. The MCP shall share specific communication needs information with its providers [e.g., PCPs, Pharmacy Benefit Managers (PBMs), and Third-Party Administrators (TPAs)], as applicable.
- d. The MCP shall submit to ODM, upon request, information regarding the MCP's members with special communication needs, which could include individual member names, their specific communication need, and any provision of special services to members (i.e., those special services arranged by the MCP as well as those services reported to the MCP which were arranged by the provider).
- e. The MCP is responsible for ensuring that all member materials use easily understood language and format. The determination of whether materials comply with this requirement is in the sole discretion of ODM.
- f. The MCP shall participate in ODM's cultural competency initiatives.
- g. The MCP will use person-centered language in all communication with eligible individuals and members. Person-first language resources are available from national organizations, including The Centers for Disease Control and Prevention, The Arc, and the National Inclusion Project.

**22. Healthchek and Pregnancy Related Services.** Healthchek, Ohio's early and periodic screening, diagnostic and treatment (EPSDT) and Pregnancy Related Services programs are outlined in OAC rules 5160:1-2-15, 5160:1-2-16, and 5160-1-14.

- a. Informing members about Healthchek, the MCP shall:
  - i. 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 5 calendar days of receipt of the 834C enrollment file. The MCP may meet this requirement by including information with the new member materials as specified in Appendix F. In addition, the MCP may be required to communicate with the member's local County Department of Job and Family Services (CDJFS) agency any requests made by the member for County coordinated services and/or supports (e.g. social services).
  - ii. Provide members with accurate information in the member handbook regarding Healthchek. The MCP's member handbooks shall be provided to members within the

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time frames specified in this appendix, and shall include verbatim the model language developed by ODM. The model language at a minimum will include:

1. A description of the types of screening and treatment services covered by Healthchek;
  2. A list of the intervals at which individuals under age 21 should receive screening examinations, as indicated by the most recent version of the document entitled "Recommendations for Preventive Pediatric Health Care," published by Bright Futures/American Academy of Pediatrics;
  3. Information that Healthchek services are provided at no additional cost to the member; and
  4. Information that providers may request prior authorization for:
    - a. Coverage of services that have limitations; and/or
    - b. Services not covered for members age 21 and older if the services are medically necessary EPSDT services.
- iii. Provide the information included in the member handbook above regarding Healthchek on the MCP's member website specified in this appendix.
- iv. Deliver Healthchek information as provided, or as approved, by ODM to its members at the following intervals:
1. When the member is 9 months old;
  2. When the member is 18 months old;
  3. When the member is 30 months old;
  4. January of each calendar year to all members under the age of 21; and
  5. At the beginning of each school year in the month of July for members from age 4 to under 21.
  6. When the member is identified as pregnant.
- v. 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 MCP shall populate the materials with appropriate Healthchek information as required (e. g. type of service, rendering provider, date of service and age of member on the date of service).
- b. Informing Members about Pregnancy Related Services (PRS):

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- i. Upon the identification of a member as pregnant, the MCP shall deliver to the member within 5 calendar days a PRS form as designated by ODM.
    - ii. The MCP may be required to communicate with the member's local CDJFS agency any requests made by the member for County coordinated services and supports (e.g. social services).
  - c. Informing providers about Healthchek, the MCP shall:
    - i. Provide Healthchek education to all contracted providers on an annual basis which shall include, at a minimum:
      1. The required components of a Healthchek exam as specified in OAC rule 5160-01-14;
      2. A list of the intervals at which individuals under age 21 should receive screening examinations, as indicated by the most recent version of the document "Recommendations for Preventive Pediatric Health Care" published by Bright Futures/American Academy of Pediatrics;
      3. A statement that Healthchek includes a range of medically necessary screening, diagnostic and treatment services; and
      4. A list of common billing codes and procedures related to the Healthchek services (e.g., immunizations, well child exams, laboratory tests, and screenings).
    - ii. Provide the above information on the MCP's provider website as specified in this appendix.
  - d. The MCP shall maintain documentation to verify members and providers were informed of Healthchek and PRS as specified by ODM.

23. **Advance Directives.** The MCP shall comply with the advance directives requirements specified in 42 CFR 422.128. At a minimum, the MCP shall:

- a. Maintain written policies and procedures that meet the requirements for advance directives, as set forth in 42 CFR Part 489 Subpart I (42 CFR 489.100—489.104).
- b. Maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical and/or behavioral health care by or through the MCP to ensure the MCP:
  - i. Provides written ODM-approved information to all adult members concerning:
    1. The member's rights under state law to make decisions concerning his or her medical and/or behavioral health care, including the right to accept or refuse

medical or surgical treatment and the right to formulate advance directives.

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

24. **Call Center Standards.** The MCP shall provide assistance to members and providers through a toll-free call-in system.

- a. Provider call center standards.
  - i. 85% of calls answered within 120 seconds.
  - ii. Maintain a capture rate of 95%.
  - iii. At least semi-annually, the MCP shall self-report its monthly and semi-annual performance in the following three areas for their Provider Call Center, as specified: capture rate, average call time and average speed of answer. If the MCP has separate telephone lines for different Medicaid populations, the MCP shall report performance for each individual line separately. The MCP shall report their July through December performance to ODM by January 10<sup>th</sup> and their January through June performance by July 10<sup>th</sup>. ODM reserves the right to require more frequent reporting by the MCP if ODM becomes aware of what it perceives to be an access issue or consecutive months of noncompliance.
- b. The Member telephone system shall have services available to assist:

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- i. Hearing-impaired members; and
  - ii. Limited English Proficiency (LEP) members in the primary language of the member.
- c. The member services program shall assist MCP members, and as applicable, eligible individuals seeking information about MCP membership with the following:
  - i. Accessing Medicaid-covered services;
  - ii. Obtaining or understanding information on the MCP's policies and procedures;
  - iii. Understanding the requirements and benefits of the plan;
  - iv. Resolution of concerns, questions, and problems;
  - v. Filing of grievances and appeals as specified in OAC rule 5160-26-08.4;
  - vi. Obtaining information on state hearing rights;
  - vii. 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;
  - viii. 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, genetic information, ancestry, health status, or need for health services in the receipt of health services; and
  - ix. Accessing sign language, oral interpretation, and oral translation services. The MCP shall ensure these services are provided at no cost to the eligible individual or member. The MCP shall designate a staff person to coordinate and document the provision of these services.
- d. In the event the consumer contact record (CCR) does not identify a member-selected primary care provider (PCP) for each assistance group member, or if the member-selected PCP is not available, the MCP shall:
  - i. Select a PCP for each member based on the PCP assignment methodology prior-approved by ODM;
  - ii. Simultaneously notify each member with an MCP-selected PCP of the ability within the first month of initial MCP membership to change the MCP-selected PCP effective on the date of contact with the MCP; and
  - iii. Explain that PCP change requests after the initial month of MCP membership shall be processed according to the procedures outlined in the MCP member handbook.

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- e. MCP member services staff shall be available nationwide to provide assistance to members through the toll-free call-in system every Monday through Friday, at all times during the hours of 7:00 am to 7:00 pm Eastern Time, 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.
- f. Two optional closure days can be used independently or in combination with any of the major holiday closures, but cannot both be used within the same closure period. Before announcing any optional closure dates to members and/or staff, the MCP shall receive ODM prior approval which verifies that the optional closure days meet the specified criteria.
- g. If a major holiday falls on a Saturday, the MCP member services line may be closed on the preceding Friday. If a major holiday falls on a Sunday, the member services line may be closed on the following Monday. MCP member services closure days shall be specified in the MCP's member handbook, member newsletter, or other some general issuance to the MCP's members at least 30 calendar days in advance of the closure. The MCP shall request prior approval from ODM of any extended hours of operation of the member services line outside the required days and time specified above.
- h. The MCP shall also provide access to medical advice and direction through a centralized twenty-four-hour, seven day a week (24/7), toll-free call-in system, available nationwide. The 24/7 call-in system shall be staffed by appropriately trained medical personnel. For the purposes of meeting this requirement, trained medical professionals are defined as physicians, physician assistants, licensed practical nurses (LPNs), and registered nurses (RNs).
- i. The MCP shall meet the current American Accreditation HealthCare Commission/URAC-designed Health.
- j. Standards (HCC) for call center abandonment rate, blockage rate and average speed of answer. At least semi-annually, the MCP shall self-report its monthly and semi-annual performance in these three areas for their member services and 24/7 hour toll-free call-in systems to ODM as specified. If the MCP has separate telephone lines for different Medicaid populations, the MCP shall report performance for each individual line separately. The MCP shall report their July through December performance to ODM by January 10 and their January through June performance by July 10<sup>th</sup>. ODM reserves the right to require more frequent reporting by the MCP if it becomes aware of an egregious access issue or consecutive months of noncompliance with URAC standards. ODM will inform the MCP of any changes/updates to these URAC call center standards.
- k. The member services call center requirement may not be delegated through a sub-contractual relationship as specified in this appendix, without prior approval by ODM. With the exception of transportation vendors, the MCP is prohibited from publishing a delegated entity's general call center number.

**25. Notification of Voluntary MCP Membership.** To comply with the terms of the ODM State Plan Amendment for the managed care program, the MCP shall inform Indians who are members of federally-recognized tribes that MCP membership is voluntary. Except as permitted under 42 CFR

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438.50(d)(2) this population is not required to select an MCP in order to receive their Medicaid healthcare benefit. The MCP shall inform these members of steps to take if they do not wish to be a member of an MCP. Pursuant to 42 CFR 438.14, the MCP shall provide to any enrolled Indian, access to an Indian healthcare provider.

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

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

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

- a. **Permitted Uses and Disclosures.** The MCP will not use or disclose PHI except as provided in this Agreement or as otherwise required under HIPAA regulations or other applicable law.
- b. **Safeguards.** The MCP shall implement sufficient safeguards and comply with Subpart C of 45 CFR Part 164 pertaining to electronic PHI to prevent the use or disclosure of PHI other than as provided for under this Agreement. Safeguards will be implemented for all paper and electronic PHI created, received, maintained, or transmitted on behalf of ODM.
- c. **Reporting of Disclosures.** The MCP agrees to 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 at 45 CFR 164.410 and any security incident the MCP has knowledge of or reasonably should have knowledge of under the circumstances.
- d. **Mitigation Procedures.** The MCP agrees to coordinate with ODM to determine specific actions that will be required of the Business Associates for mitigation, to the extent practical, of the breach. These actions will include notification to the appropriate individuals, entities, or other authorities. Notification or communication to any media outlet shall be approved, in writing, by ODM prior to any such communication being released. The MCP shall report all of its mitigation activity to ODM and shall preserve all relevant records and evidence.
- e. **Incidental Costs.** The MCP shall bear the sole expense of all costs to mitigate any harmful effect, of any breaches or security incidents which were caused by the MCP, or its subcontractors, in violation of the terms of this Agreement. These costs will include, but are not limited to, the cost

of investigation, remediation and assistance to the affected individuals, entities or other authorities.

- f. **Agents and Subcontractors.** The MCP, in compliance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2) as applicable, shall ensure all its agents and subcontractors that create, receive, maintain, or transmit PHI from or on behalf of the MCP and/or ODM agree to have, in a written agreement, the same restrictions, conditions, and requirements that apply to the MCP with respect to the use or disclosure of PHI.
- g. **Accessibility of Information.** The MCP shall make available to ODM such information as ODM may require to fulfill its obligations to provide access to, provide a copy of any information or documents with respect to PHI pursuant to HIPAA and regulations promulgated by the United States Department of Health and Human Services, including, but not limited to, 45 CFR 164.524 and 164.528 and any amendments thereto.
- h. **Amendment of Information.** The MCP shall make any amendment(s) to PHI as directed by, or agreed to, by ODM pursuant to 45 CFR 164.526, or take other steps as necessary to satisfy ODM's obligations under 45 CFR 164.526. In the event that the MCP receives a request for amendment directly from an individual, agent, or subcontractor, the MCP shall notify ODM prior to making any such amendment(s). The MCP's authority to amend information is explicitly limited to information created by the MCP.
- i. **Accounting for Disclosure.** The MCP shall maintain and make available to ODM or individuals requesting the information as appropriate, records of all disclosures of PHI in a Designated Record Set as necessary to satisfy ODM's obligations under 45 CFR 164.528. For every disclosure, the record shall include, at a minimum, the name of the individual who is the subject of the disclosure, the date of the disclosure, reason for the disclosure if any, and the name and address of the recipient to which the PHI was disclosed.
- j. **Obligations of ODM.** When the MCP is required to carry out an obligation of ODM under Subpart E of 45 CFR Part 164, the MCP agrees to comply with all applicable requirements of Subpart E that would apply to ODM in the performance of such obligation.
- k. **Access to Books and Records.** The MCP shall make available to ODM and to the Secretary of the U.S. Department of Health and Human Services any and all internal practices, documentation, books, and records related to the use and disclosure of PHI received from ODM, or created or received on behalf of ODM. Such access is for the purposes of determining compliance with the HIPAA Rules.
- l. **Material Breach.** In the event of material breach of the MCP's obligations under this Article, ODM may immediately terminate this Agreement as set forth in the baseline of this Agreement. Termination of this Agreement will not affect any provision of this Agreement, which, by its wording or its nature, is intended to remain effective and to continue to operate after termination.
- m. **Return or Destruction of Information.** Upon termination of this Agreement and at the request of ODM, the MCP will return to ODM or destroy all PHI in MCP's possession stemming from this



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Agreement as soon as possible but no later than 90 calendar days, and will not keep copies of the PHI except as may be requested by ODM or required by law, or as otherwise allowed for under this Agreement. If the MCP, its agent(s), or subcontractor(s) destroy any PHI, then the MCP will provide to ODM documentation evidencing such destruction. Any PHI retained by the MCP will continue to be extended the same protections set forth in this section, HIPAA regulations and this Agreement for as long as it is maintained.

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

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

28. **Managed Care Day One.** Individuals will enroll in managed care beginning the first day of the month in which Medicaid eligibility is determined. There will be no fee-for-service time period for most services. For members identified on the 834C as being determined Medicaid eligible, during their first month of managed care enrollment the MCP shall pay for all medically-necessary covered services provided during the first month.

29. **MCP Membership Acceptance, Documentation, and Reconciliation.**

- a. **Medicaid Consumer Hotline Contractor.** The MCP shall provide to the Medicaid Consumer Hotline contractor ODM prior-approved MCP materials and directories for distribution to eligible individuals who request additional information about the MCP.
- b. **Plan PBM Contractor.** Eligibility additions for the current month received in the 834C file must be sent to the MCP's PBM within 24 hours of the MCP's receipt of the file, except during state cutoff when plans have the option to follow the 834 file loading process as stated in the 834 companion guide.
- c. **Monthly Remittance Advice.** The HIPAA 820 (Monthly Remittance Advice) will contain the following: a capitation payment for each member listed on the HIPAA 834F, a capitation payment/recoupment for changes listed in the daily HIPAA 834C, any other capitation payment/recoupment, and delivery payment/recoupment from the previous calendar month.
- d. **Enrollment and Capitation Reconciliation.** The MCP shall maintain the integrity of its membership data through processing and loading of the daily HIPAA 834C (Daily Benefit Enrollment and Maintenance File) and reconciling the daily changes with the monthly HIPAA 834F (Monthly Benefit Enrollment and Maintenance File) transactions. Discrepancies between the HIPAA 834C and 834F that have a negative impact on a member's access to care shall be reported to ODM within one business day. Reconciliation for any discrepancies between the HIPAA 834 and HIPAA 820 is due and shall be submitted, as instructed by ODM, no later than 60 calendar days after the issuance of the HIPAA 834F. Please reference the Processing Dates for Calendar Year memo issued annually. In the event of changes in the processing dates, the due date will be adjusted accordingly.

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For special reconciliation requests beyond the 60 day limit, the request should be submitted on company letterhead and include the nature of the request, the reason the request was not submitted within the 60 day limit and the anticipated outcome of the request. No requests will be considered beyond 18 months after the capitation month.

- e. **Reconciliation Request Format.** All reconciliation requests shall be submitted in the format specified by ODM. ODM may reject reconciliation requests submitted after the initial 60 calendar day due date. Reconciliation requests submitted after the initial 60 calendar day due date will be processed at the discretion of ODM. Recoupments, date of death, duplicative payments made to the same plan due to multiple IDs will always be processed.
- f. **Change in Member Circumstance.** In accordance with 42 CFR 438.608, the MCP shall promptly notify ODM when it becomes aware that a member is deceased. The notification must be made following the submission guidelines and in the format prescribed by ODM.
- g. **Institution for Mental Disease (IMD) Stays.** If a member age 21 through 64 has an IMD stay exceeding 15 days per calendar month, ODM will recover a percentage of the MCP’s monthly capitation payment based on the total number of days the member was in the IMD; *e.g.*, if the member is in the community for 10 days and admitted to an IMD for the remainder of the month, ODM will reconcile 20 days.
- h. **MCP-Initiated Nursing Facility (NF) disenrollment requests.** Excluding Adult Extension, pursuant to OAC rule 5160-26-02.1, MCP-initiated nursing facility (NF) disenrollment requests for MAGI and ABD shall be submitted in the format specified by ODM. See disenrollment table below:

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
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)

- i. If a member is admitted to a NF while enrolled with the MCP and the MCP disenrollment request is submitted after the Earliest Disenrollment Date, the member will be disenrolled as of the last calendar day of the submission month.
- ii. When a member is admitted to a NF while enrolled with one MCP, then changes to a different MCP, either:

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1. The admission date is three months or less prior to the initial enrollment month, and the MCP disenrollment request shall align with the Disenrollment Table dates; or
  2. The admission date is more than three months prior to the initial enrollment month, and the MCP disenrollment request shall be submitted during the initial enrollment month to disenroll the member the last calendar day of the month prior to the initial enrollment.
- iii. If a member is admitted to a NF prior to being enrolled with the MCP and was admitted under fee-for-service Medicaid, the MCP disenrollment request shall be submitted 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.
- iv. In instances where the initial enrollment month is accompanied by an enrollment span with a start reason of First Month Enrollment (FME) due to Day 1 Managed Care enrollment, the FME span will also be removed. For example, if HIPAA 834 contains a 1/1/2018 to 1/31/2018 enrollment with an FME start reason and a 2/1/2018 to 12/31/2299 enrollment with ASG start reason then:
1. The MCP submits a NF disenrollment request on 2/12/2018, which is prior to 2/28/2018. Both the initial enrollment of 2/1/2018 and FME of 1/1/2018 will be deleted.
  2. The MCP submits a NF disenrollment request on 3/15/2018, which is after 2/28/2018. The FME of 1/1/2018 to 1/31/2018, the initial enrollment of 2/1/2018 through the month of submission (3/31/2018) will be covered by the Managed Care Plan.
- v. In all cases, the MCP is responsible for coverage through the disenrollment date.
- i. **Change in Enrollment During Hospital/Inpatient Facility Stay.** When the MCP learns of a currently hospitalized member's intent to disenroll through the CCR or the HIPAA 834, the disenrolling MCP shall notify the hospital/inpatient facility and treating providers as well as the enrolling MCP, if applicable, of the change in enrollment. The disenrolling MCP shall notify the inpatient facility that it will remain responsible for the inpatient facility charges through the date of discharge; and shall notify the treating providers that it will remain responsible for provider charges through the date of disenrollment. The disenrolling MCP shall not request and/or require that a disenrolled member be discharged from the inpatient facility for transfer to another inpatient facility. Should a discharge and transfer to another inpatient facility be medically necessary, the disenrolling MCP shall notify the treating providers to work with the enrolling MCP or ODM as applicable to facilitate the discharge, transfer and authorization of services as needed.

When the enrolling MCP learns through the disenrolling MCP, through ODM or other means, that a new member who was previously enrolled with another MCP was admitted prior to the

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effective date of enrollment and remains an inpatient on the effective date of enrollment, the enrolling MCP shall contact the hospital/ inpatient facility. The enrolling MCP shall verify that it is responsible for all medically necessary Medicaid covered services from the effective date of MCP membership, including professional charges related to the inpatient stay; the enrolling MCP shall inform the hospital/inpatient facility that the admitting/disenrolling MCP remains responsible for the hospital/inpatient facility charges through the date of discharge. The enrolling MCP shall work with the hospital/inpatient facility to facilitate discharge planning and authorize services as needed.

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

- j. **Just Cause Requests.** As specified by ODM in OAC rule 5160-26-02.1, the MCP shall assist in resolving member-initiated Just Cause requests affecting membership.
- k. **Newborn Notifications.** MCP membership for newborns will be in accordance with OAC rule 5160-26-02, unless otherwise notified by ODM. In order to encourage the timely addition of newborns, authorization for Medicaid and enrollment in the MCP, the MCP shall provide notification of the birth to the CDJFS within five business days of birth or immediately upon learning of the birth. The MCP shall 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 format designated by ODM. The information shall be sent to the CDJFS again at 60 calendar days from the date of birth if the MCP has not received confirmation by ODM of a newborn's MCP membership via the membership roster. If no newborn information is provided by the county within two weeks after the 60 day submission, the MCP shall follow established reconciliation procedures.
- l. **Eligible Individuals.** If an eligible individual, as defined in OAC rule 5160-26-01, contacts the MCP, the MCP shall provide any MCP-specific managed care program information requested. The MCP shall not attempt to assess the eligible individual's health care needs. However, if the eligible individual inquires about continuing/ transitioning health care services, the MCP shall provide an assurance that all MCPs shall cover all medically necessary Medicaid-covered health care services and assist members with transitioning their health care services.
- m. **Pending Member.** If a pending member (i.e., an eligible individual subsequent to MCP selection or assignment to an MCP, but prior to their membership effective date) contacts the selected MCP, the MCP shall provide any membership information requested, including but not limited to explaining how to access services as an MCP member and assistance in determining whether current services require prior authorization. The MCP shall also ensure any care coordination (e.g., PCP selection, prescheduled services and transition of services) information provided by the pending member is logged in the MCP's system and forwarded to the appropriate MCP staff for processing as required.

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

30. The MCP shall use ODM-provided utilization and prior authorization data files for care coordination/management activities and to adhere to transition of care requirements.

**31. Behavioral Health Redesign - Transition of Care Requirements for Managed Care Members Receiving Behavioral Health Services.** The MCP is required to cover behavioral health services provided by a Community Behavioral Health Center (CBHC) to its members as directed by ODM. The MCP shall allow a member who is receiving behavioral health services prior to July 1, 2018 to continue to receive services as follows:

- a. The MCP shall follow the Medicaid fee-for service (FFS) behavioral health coverage policies through December 31, 2019. The MCP may implement less restrictive policies than FFS. Beginning January 1, 2020, the MCP may conduct a medical necessity review pursuant to OAC rule 5160-26-03.1.
- b. The MCP shall honor any prior authorizations approved by Medicaid FFS prior to July 1, 2018 through the expiration of the authorization.
- c. The MCP shall allow the member to continue with out-of-network providers through June 30, 2019. For continuity of care purposes, the MCP will make the following efforts:
  - i. Work with the service provider to add the provider to their network; or
  - ii. Implement a single case agreement with the provider; or
  - iii. Assist the member in finding a provider currently in the MCP's network.
- d. The MCP shall maintain Medicaid FFS payment rates as a floor for behavioral health services through December 31, 2019 when the MCP's provider contracts are based on FFS rates. This does not apply to CBHC Laboratories.

**32. Transition of Care Requirements for Existing Members of an Exiting MCP.** When the enrolling MCP is informed by ODM, or its designee, of a member transitioning from an MCP that no longer has a provider agreement in the member's service area, the enrolling MCP shall follow the transition of care requirements as specified by ODM.

**33. Retroactive Coverage Requirements.** The MCP shall pay for claims for covered services provided to members during retroactive enrollment periods. For services provided during retroactive enrollment periods that require FFS prior authorization as documented in Appendix DD of OAC rule 5160-1-60, OAC rule 5160-9-03 (regarding pharmacy claims), and all other FFS regulations that set forth prior authorization policy, the MCP may conduct a medical necessity review for payment. However, if the service was already reviewed and approved by FFS, the MCP shall also approve the service.

**34. Transition of Care Requirements for New Members.** The MCP shall follow the transition of care requirements as outlined below for any new member, regardless of if the individual is transitioning from FFS or another MCP.

- a. Upon notification from ODM that an individual will be switching to a different MCP or MyCare Ohio plan, the disenrolling MCP shall provide specific information related to the disenrolling member to the enrolling plan as specified by ODM.
- b. **Continuation of Services for Members.** The MCP shall allow a new member to receive services from network and out-of-network providers, as indicated, if any of the following apply:
  - i. If the MCP confirms that the Adult Extension member is currently receiving care in a nursing facility on the effective date of enrollment with the MCP, the MCP shall 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 care plan.
  - ii. Upon learning or receiving notification of a pregnant woman's enrollment, the MCP shall identify the member's maternal risk and facilitate connection to services and supports in accordance with ODM's *Guidance for Managed Care Plans for the Provision of Enhanced Maternal Care Services*. These services and supports include delivery at an appropriate facility and continuation of progesterone therapy covered by Medicaid FFS or another MCP for the duration of the pregnancy. In addition, the MCP shall allow the pregnant member to continue with an out-of-network provider if she is in her third trimester of pregnancy and/or has an established relationship with an obstetrician and/or delivery hospital.
  - iii. The MCP shall 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 MCP.
    1. The MCP may conduct a medical necessity review for previously authorized services if the member's needs change to warrant a change in service. The MCP must render an authorization decision pursuant to OAC rule 5160-26-03.1.
    2. The MCP may assist the member to access services through a network provider when any of the following occur
      - a. The member's condition stabilizes and the MCP can ensure no interruption to services;
      - b. The member chooses to change to a network provider; or
      - c. If there are quality concerns identified with the previously authorized provider.

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3. Scheduled inpatient or outpatient surgeries approved and/or pre-certified shall be covered pursuant to OAC rule 5160-2-40 (surgical procedures would also include follow-up care as appropriate);
  4. Organ, bone marrow, or hematopoietic stem cell transplant shall be covered pursuant to OAC rule 5160-2-07.1 and Appendix G of this Agreement;
- iv. The MCP shall 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 MCP:
1. Ongoing chemotherapy or radiation treatment;
  2. Hospital treatment plan (if member was released from hospital 30 days prior to enrollment);
  3. Private duty nursing, home care services, and Durable Medical Equipment (DME) shall be covered at the same level with the same provider as previously covered until the MCP conducts a medical necessity review and renders an authorization decision pursuant to OAC rule 5160-26-03.1.
  4. Prescribed drugs shall be covered without prior authorization (PA) for at least the first 90 days of membership, or until a provider submits a prior authorization and the MCP completes a medical necessity review, whichever date is sooner. The MCP shall educate the member that further dispensation after the first 90 days will require the prescribing provider to request a PA. If applicable, the MCP shall offer the member the option of using an alternative medication that may be available without PA. Written member education notices shall use ODM-specified model language. Verbal member education may be substituted for written education, but shall contain the same information as a written notice. Written notices or verbal member education shall be prior approved by ODM.
  5. Upon notification from a member and/or provider of a need to continue services, the MCP shall 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.
- c. **Out-of-Network Provider Reimbursement.** The MCP shall reimburse out-of-network providers who provide services during the transition at 100% of the current Medicaid FFS provider rate for the specific service.
- d. **Documentation of Services.** The MCP shall document the provision of transition of services as follows:

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- i. The MCP shall seek confirmation from an out-of-network provider that the provider agrees to provide the service and accepts the Medicaid FFS rate as payment.
    1. If the provider agrees, the MCP shall distribute materials to the out-of-network provider as specified in Appendix G of this Agreement.
    2. If the provider does not agree, the MCP shall notify the member of the MCP's availability to assist with locating another provider as expeditiously as the member's health condition warrants.
  - ii. If the service will be provided by a panel provider, the MCP shall notify the panel provider and the member to confirm the MCP's responsibility to cover the service.
  - iii. The MCP shall 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.
- e. **Pre-Enrollment Planning.** The MCP shall utilize data provided by ODM or an MCP and/or collected by the MCP through assessments, new member outreach in advance of the member's enrollment effective date, etc., to identify existing sources of care and to assure each new member is able to obtain continuation of services in accordance with this appendix.
- f. **Provision of Care Management.** In accordance with Appendix K, the MCP shall assess new members using the standardized health risk assessment within 90 calendar days of enrollment for the purpose of risk stratification and to identify potential needs for care management.
35. **Health Information System Requirements.** The ability to develop and maintain information management systems capacity is crucial to successful plan performance. ODM therefore requires the MCP to demonstrate their ongoing capacity in this area by meeting several related specifications.
- a. **Health Information System.**
    - i. As required by 42 CFR 438.242(a), the MCP shall maintain a health information system that collects, analyzes, integrates, and reports data. The system shall provide information on areas including, but not limited to, utilization, grievances and appeals, and MCP membership terminations for other than loss of Medicaid eligibility.
    - ii. As required by 42 CFR 438.242(b)(1), the MCP shall collect data on member and provider characteristics and on services furnished to its members.
    - iii. As required by 42 CFR 438.242(b)(2), the MCP shall 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.



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- iv. As required by 42 CFR 438.242(b)(3), the MCP shall make all collected data available upon request by ODM or CMS.
- v. Acceptance testing of any data electronically submitted to ODM is required:
  - 1. Before the MCP may submit production files;
  - 2. Whenever the MCP changes the method or preparer of the electronic media; and/or
  - 3. When ODM determines that the MCP's data submissions have an unacceptably high error rate.
- vi. When the MCP changes or modifies information systems involved in producing any type of electronically submitted files, either internally or by changing vendors, it is required to submit to ODM for review and approval a transition plan that includes the submission of test files in the ODM-specified formats. Once an acceptable test file is submitted to ODM, as determined solely by ODM, the MCP can return to submitting production files. ODM will inform the MCP in writing when a test file is acceptable. Once the MCP's new or modified information system is operational, the MCP will have up to 90 calendar days to submit an acceptable test file and an acceptable production file.
- vii. Submission of test files can start before the new or modified information system is in production. ODM reserves the right to verify the MCP's capability to report elements in the minimum data set prior to executing the provider agreement for the next contract period.

**b. Electronic Data Interchange (EDI), Claims Adjudication and Payment Processing Requirements.**

- i. **Timely Filing for Behavioral Health (BH) Claims.** The MCP shall accept claims for BH services described in OAC Chapter 5160-27 for 365 calendar days from the date of service when the service date is prior to December 31, 2019. An MCP may negotiate timely filing requirements within these limitations through their contract with the BH provider.
- ii. **Claims Adjudication.** The MCP shall have the capacity to electronically accept and adjudicate all claims to final status (payment or denial). Information on claims submission procedures shall be provided to non-contracting providers within 30 calendar days of a request. The MCP shall inform providers of its ability to electronically process and adjudicate claims and the process for submission. Such information shall be initiated by the MCP and not only in response to provider requests.
- iii. The MCP shall notify providers who have submitted claims of claims status [paid, denied, pended (suspended)] within one month of receipt by the MCP 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.

- iv. **Inpatient and Outpatient Grouper.** When the MCP uses a grouper to pay inpatient and/or outpatient claims, they are expected to utilize the same grouper software and version as ODM uses to process fee for service claims.
- v. **Electronic Visit Verification (EVV).** The MCP shall implement the ODM-established EVV system no later than August 5, 2019, unless ODM specifies a later date, for the following services: Private Duty Nursing; State Plan Home Health Aide; State Plan Home Health Nursing; RN Assessment. The MCP shall use data collected from the EVV data collection system data to validate all claims against EVV data (100% review) during the claim adjudication process. Prior to implementation, the MCP shall inform providers of the use of the EVV data collection system and how the data will be utilized by the MCP. The MCP shall also provide assistance on utilization of the data collection system, as appropriate, to individuals receiving services, direct care workers and providers.
- vi. The MCP is prohibited from recovering back or adjusting any payments beyond two years from the date of payment of the claim due to the MCP member's retroactive termination of coverage from the MCP, unless the MCP is directed to do so by CMS, ODM, or applicable state or federal law and regulation. However, this does not prohibit the MCP or ODM from initiating a recovery or adjustment more than two years after the payment of a claim in the event of fraud, abuse, or as otherwise provided by applicable state or federal law and regulation.
- vii. **Claims Payment Systemic Errors (CPSEs).** For the purpose of this appendix, a CPSE is defined as the MCP's claims adjudication, either electronic or manual, incorrectly underpaying, overpaying, or denying claims that impact five or more providers. ODM reserves the right to request and receive additional information for ODM to classify an issue as a CPSE.
  1. The MCP shall have policies and procedures implemented to identify, communicate, and correct CPSEs.
  2. The MCP shall inform ODM monthly of the status of CPSEs as follows:
    - a. The definition and scope of any identified or newly identified CPSE, including the number and type of providers impacted;
    - b. The date of provider notification of the CPSE;
    - c. The projected timeline for fixing the CPSE, including any UAT testing;
    - d. The date(s) for corrected payment/adjustment to providers.
  3. **Policies and Procedures.** The MCP shall submit their policies and procedures to ODM for prior approval and include, at a minimum:
    - a. The use of input from internal and/or external sources to identify a CPSE, including but not limited to, claims processing activities,

configuration checks, user acceptance testing (UAT) activities, provider complaints/inquiries, audits, and quality initiative activities;

- b. The identification of issues impacting smaller provider types (i.e., independent providers, etc.);
  - c. A description of the process, including timelines, to escalate from initial intake to definition of the error, for example, how the MCOP tracks if internal or external sources have identified that an issue has occurred;
  - d. A description of the process to inform ODM at least monthly of the status of CPSEs as specified above;
  - e. A communication strategy to timely notify applicable providers of a CPSE identification, how claims will be re-adjudicated, the expected date(s) for corrected payment/adjustment, and for providers to contact the MCOP regarding re-adjudicated claims from the fix;
  - f. A description of the process and timeline to determine the root cause of the issue including UAT, time frame to re-adjudicate claims, and address any provider disputes regarding corrected payments/adjustments.
- vii. The MCP shall correct errors in provider payments that do not meet the definition of claims payment systematic errors per this appendix within 60 calendar days from the date of identification of the error.
  - viii. The MCP shall load rate changes into applicable systems by either the rate change implementation date or within 30 calendar days of being notified by ODM of the change, whichever date is later.
  - ix. The MCP is prohibited from engaging in practices that unfairly or unnecessarily delay the processing or payment of any claim for MCP members.
  - x. The MCP is required to give a 30 calendar day advance notice to providers of any new edits or system changes related to claims adjudication or payments processing.

**c. Electronic Data Interchange (EDI).**

- i. The MCP shall comply with all applicable provisions of HIPAA including EDI standards for code sets and the following electronic transactions:
  - 1. Health care claims;
  - 2. Health care claim status request and response;
  - 3. Health care payment and remittance status;

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- ii. Each EDI transaction processed by the MCP shall be implemented in conformance with the appropriate version of the transaction implementation guide, as specified by applicable federal rule or regulation.
  - iii. The MCP shall have the capacity to accept the following transactions from ODM consistent with EDI processing specifications in the transaction implementation guides and in conformance with the 820 and 834 Transaction Companion Guides issued by ODM:
    - 1. ASC X12 820 - Payroll Deducted and Other Group Premium Payment for Insurance Products; and
    - 2. ASC X12 834 - Benefit Enrollment and Maintenance.
  - iv. The MCP shall comply with the HIPAA-mandated EDI transaction standards and code sets no later than the required compliance dates as set forth in the federal regulations.
  - v. **Documentation of Compliance with Mandated EDI Standards.** The capacity of the MCP and/or applicable trading partners and business associates to electronically conduct claims processing and related transactions in compliance with standards and effective dates mandated by HIPAA shall be demonstrated, to the satisfaction of ODM.
  - vi. **Trading Partner Agreement with ODM.** The MCP shall complete and submit an EDI trading partner agreement in a format specified by ODM. Submission of the copy of the trading partner agreement prior to entering into this Agreement may be waived at the discretion of ODM; if submission prior to entering into this Agreement is waived, the trading partner agreement shall be submitted at a subsequent date determined by ODM.
- d. **Encounter Data Submission Requirements.**
- i. **General Requirements.** The MCP shall collect data on services furnished to members through a claims system and shall report encounter data to the ODM. The MCP is required to submit this data electronically to ODM as specified in Appendix L.
  - ii. For sub-contracted payment arrangements in which a vendor directly pays particular claims (i.e. delegated arrangements in which the delegate is responsible for paying claims on behalf of the MCP to providers), the MCP shall submit encounters that include the amounts paid by the vendor to the provider at the claim-level.
  - iii. **Acceptance Testing.** The MCP shall have the capability to report all elements in the Minimum Data Set as set forth in the ODM Encounter Data Specifications and shall submit a test file in the ODM-specified medium in the required formats prior to contracting or prior to an information systems replacement or update. Acceptance testing of encounter data is required as specified in this appendix.

- iv. **Encounter Data File Submission Procedures.** A certification letter shall accompany the submission of an encounter data file in the ODM-specified medium. The certification letter shall be signed by the MCP's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for, and who reports directly to, the MCP's CEO or CFO. Pursuant to 42 CFR 438.606, the CEO or CFO remains responsible for certification regardless of delegated signee.
- e. **IDSS Data Submission and Audit Report Requirements.** In accordance with 42 CFR 438.606, the MCP shall submit a signed data certification letter to ODM attesting to the accuracy and completeness of its audited HEDIS IDSS data submitted to ODM. The MCP shall also submit to ODM a signed data certification letter attesting to the accuracy and completeness of its final HEDIS audit report (FAR) submitted to ODM. Each data certification letter is due to ODM on the same day the respective HEDIS IDSS data/FAR is to be submitted. For complete instructions on submitting the data certification letters, see ODM Methodology for MCP Self-Reported, Audited HEDIS Results.
- f. **Information Systems Review.** ODM or its designee may review the information system capabilities of the MCP at the following times: before ODM enters into a provider agreement with a new MCP, when a participating MCP undergoes a major information system upgrade or change, when there is identification of significant information system problems, or any time at ODM's discretion. The MCP shall participate in the review. The review will assess the extent to which the MCP is capable of maintaining a health information system including producing valid encounter data, performance measures, and other data necessary to support quality assessment and improvement, as well as managing the care delivered to its members.

The following activities, at a minimum, will be carried out during the review. ODM or its designee will:

- i. Review the Information Systems Capabilities Assessment (ISCA) forms, as developed by CMS, which the MCP will be required to complete;
- ii. Review the completed ISCA and accompanying documents;
- iii. Conduct interviews with MCP staff responsible for completing the ISCA, as well as staff responsible for aspects of the MCP's information systems function;
- iv. Analyze the information obtained through the ISCA, conduct follow-up interviews with MCP staff, and write a statement of findings about the MCP's information system;
- v. Assess the ability of the MCP to link data from multiple sources;
- vi. Examine MCP processes for data transfers;
- vii. If the MCP has a data warehouse, evaluate its structure and reporting capabilities;

- viii. Review MCP processes, documentation, and data files to ensure they comply with state specifications for encounter data submissions; and
- ix. Assess the claims adjudication process and capabilities of the MCP.

**36. Delivery (Childbirth) Payments for MAGI and Adult Extension Members.** The MCP will be reimbursed for MAGI and Adult Extension member childbirth deliveries identified in the submitted encounters, using the methodology outlined in the Modified Adjusted Gross Income (MAGI) and MAGI Adult Extension Delivery Payment Reporting Procedures and Specifications for ODM Managed Care Plans - MITS (ICD-10) document. 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.

- a. If a delivery occurred, but the MCP did not reimburse providers for any costs associated with the delivery, then the MCP shall not submit the delivery encounter to ODM and is not entitled to receive payment for the delivery. Delivery encounters submitted by the MCP shall be received by ODM no later than 460 calendar days after the last date of service (pending ODM IT capacity). Delivery encounters which are received by ODM after this time will be denied payment. Prior to the implementation of the 460 calendar day criteria, delivery encounters which are submitted later than 365 calendar days after the last date of service will be denied payment. The MCP will receive notice of the payment denial on the remittance advice.
- b. To capture deliveries outside of institutions (e.g., hospitals) and deliveries in hospitals without an accompanying physician encounter, both the institutional encounters (UB-92) and the non-institutional encounters (NSF) are searched for deliveries.
- c. If a physician and a hospital encounter are found for the same delivery, only one payment will be made. The same is true for multiple births; if multiple delivery encounters are submitted, only one payment will be made.
- d. **Rejections.** If a delivery encounter is not submitted according to ODM specifications, it will be rejected and the MCP will receive this information on the exception report (or error report) that accompanies every file in the ODM-specified format. Tracking, correcting and resubmitting all rejected encounters is the responsibility of the MCP and is required by ODM.
- e. **Timing of Delivery Payments.** The MCP will be paid monthly for deliveries. For example, payment for a delivery encounter submitted with the required encounter data submission in March, will be reimbursed in May. This payment will be a part of the weekly update (adjustment payment) in place currently. The third weekly update of the month will include the delivery payment. The remittance advice is in the same format as the capitation remittance advice which is sent once each month.
- f. **Updating and Deleting Delivery Encounters.** The process for updating and deleting delivery encounters can be found in the Modified Adjusted Gross Income (MAGI) and MAGI Adult Extension Delivery Payment Reporting Procedures and Specifications for ODM Managed Care

Plans - MITS (ICD-10) document.

- g. **Auditing of Delivery Payments.** A delivery payment audit will be conducted periodically. If medical records do not substantiate that a delivery (at least 22 weeks gestation) occurred related to the payment that was made, then ODM will recoup the delivery payment from the MCP. Also, if it is determined that the encounter which triggered the delivery payment was not a paid encounter, then ODM will recoup the delivery payment.
- 37. If the MCP will be using the Internet functions that will allow approved users to access member information (e.g., eligibility verification), the MCP shall ensure the proper safeguards, firewalls, etc., are in place to protect member data.
- 38. Pursuant to 42 CFR 438.106(b), the MCP acknowledges that it is prohibited from holding a member liable for the cost of services provided to the member in the event that ODM fails to make payment to the MCP.
- 39. In the event of an insolvency of the MCP, the MCP, as directed by ODM, shall cover the continued provision of services to members until the end of the month in which insolvency has occurred, as well as the continued provision of inpatient services until the date of discharge for a member who is institutionalized when insolvency occurs.
- 40. Information Required for MCP Websites.**

  - a. The MCP shall have a secure internet-based website for contracting providers through which providers can confirm a consumer's enrollment and through which providers can submit and receive responses to prior authorization requests (an e-mail process is an acceptable substitute if the website includes the MCP's e-mail address for such submissions).
  - b. The MCP provider website shall also include, at a minimum, the following information which shall be accessible to providers and the general public without any log-in restrictions:

    - i. MCP contact information, including the MCP's designated contact for provider issues.
    - ii. A listing of the counties the MCP serves unless the MCP serves the entire state in which case the MCP may indicate it services the entire state.
    - iii. The MCP's provider manual including the MCP's claims submission process, as well as a list of services requiring PA, recent newsletters and announcements.
    - iv. The MCP's policies and procedures for out-of-network providers to seek payment of claims for emergency, post-stabilization and any other services authorized by the MCP.
    - v. The MCP's internet provider directory as referenced in this appendix and Appendix H.
    - vi. The MCP's PDL, including an explanation of the list and identification of any preferred drugs that require PA, the MCP's list of drugs that require PA, including an explanation of the list, identification of first line drugs for drugs that require PA for step therapy,

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how to initiate a PA, and the MCP's policy for coverage of generic versus brand name drugs. The MCP shall publish a notice of changes to the MCP's PDL 30 calendar days in advance.

- vii. The MCP shall publish a notice of changes to the MCP's list of drugs requiring PA or any other service or device requiring prior authorization via their website 30 calendar days in advance. In addition, 30 calendar days prior to all PA requirement changes, the MCP shall notify providers, via email or standard mail, the specific location of prior authorization change information on the website, pursuant to ORC section 5160.34(B)(9-10).
  - viii. The MCP shall provide documentation specifics for PA completion and details about Medicaid programs and their services requiring PA (e.g., drugs, devices) pursuant to ORC section 5160.34(B)(11).
  - ix. The MCP shall provide prescribers with in-office access to their preferred drug and PA lists via the availability of at least one hand-held software application.
  - x. The MCP shall provide all Healthchek information as specified in this appendix.
  - xi. ODM may require the MCP to include additional information on the provider website as needed.
  - xii. The MCP shall publish the requirements and process for submitting an appeal related to Maximum Allowable Costs (MAC) for pharmacy providers on their website. Prior to implementation, the MCP shall submit its MAC appeal auditing process to ODM for approval to ensure a reasonable process is established for pharmacy providers.
41. **Provider Feedback.** The MCP shall have the administrative capacity to offer feedback to individual providers on their adherence to evidence-based practice guidelines; and positive and negative care variances from standard clinical pathways that may impact outcomes or costs. In addition, the feedback information may be used by the MCP for activities such as provider performance improvement projects that include incentive programs or the development of quality improvement programs.
42. Unless otherwise indicated, MCP submissions with due dates that fall on a weekend or holiday are due the next business day.
43. **Trial Member Level Incentive Programs.** The MCP shall submit a description of a proposed trial member-level incentive program to ODM for review and approval prior to implementation. A trial member level incentive program is defined as 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 MCP (e.g., recommended health screenings) in the submission. The incentive shall not be considered a medically-necessary Medicaid-covered service or an additional benefit as offered in the MCP's Member Handbook. The MCP should refer to the *Guidance Document for Managed Care Plan Submission for Trial Member Level Incentive Programs* for additional clarification.



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44. **Distribution List Subscriptions.** The MCP shall subscribe to the appropriate distribution lists for notification of all OAC rule clearances, and final rules published with medical assistance letters (MALs), Medicaid handbook transmittal letters (MHTLs), and other transmittal letters affecting managed care program requirements. The MCP is solely responsible for submitting its names and email addresses to the appropriate distribution lists and is also responsible for ensuring the validity of any e-mail addresses maintained on those distribution lists.
45. Pursuant to ORC section 5167.14, the MCP shall enter into a data security agreement with the State of Ohio's Board of Pharmacy that governs the MCP's use of the Board's drug database established and maintained under ORC section 4729.75.
46. Upon request by ODM, the MCP shall share data with ODM's actuary. ODM and the MCP are covered entities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). ODM represents and warrants that separate from this Agreement, a Business Associate agreement that complies fully with HIPAA and the Health Information Technology for Economic and Clinical Health Act ("HITECH") and the implementing federal regulations under both Acts, has been executed by ODM's actuary, is currently in effect, and will remain in effect for the term of this Agreement.
47. As outlined in OAC rule 5160-26-05, MCP subcontractors and referral providers may not bill enrollees any amount greater than would be owed if the entity provided the services directly (i.e., no balance billing by providers).
48. **Conducting Business Outside the United States.**
- a. The MCP shall comply with Executive Order 2011-12K. A copy of Executive Order 2011-12K can be found at <http://governor.ohio.gov/MediaRoom/ExecutiveOrders.aspx>. This Executive Order prohibits the use of public funds to purchase services that will be provided outside of the United States except under certain circumstances. Such services include the use of offshore programming or call centers. Additionally, the MCP shall not transfer PHI to any location outside the United States or its territories.
  - b. Pursuant to 42 CFR 438.602(i), no MCP claim paid to any provider, out-of-network provider, subcontractor, or financial institution located outside of the United States is considered in capitation rates. In addition, no contracting ODM MCP shall be located outside the United States or its territories.
49. **National Committee for Quality Assurance (NCQA) Accreditation.** The MCP shall hold and maintain, or shall be actively seeking and working towards, accreditation by the NCQA for the Ohio Medicaid line of business. The MCP shall achieve and/or maintain an Excellent, Commendable or Accredited status. If the MCP receives a Provisional or Denied status from NCQA, the MCP will be subject to sanctions as noted in Appendix N. Compliance will be assessed annually based on the MCP's accreditation status as of September 15th of each year.  
For the purposes of meeting this accreditation requirement, ODM will only accept the use of the NCQA Corporate Survey Process to the extent deemed allowable by NCQA.

Upon completion of the accreditation survey, the MCP shall submit to ODM a copy of the "Final Decision Letter" no later than 10 calendar days upon receipt from NCQA. Thereafter and on an annual basis

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between accreditation surveys, the MCP shall submit a copy of the “Accreditation Summary Report” issued as a result of the Annual HEDIS Update no later than 10 calendar days upon receipt from NCQA. Upon ODM’s request, the MCP shall provide any and all documents related to achieving accreditation.

50. **MCP Family Advisory Council.** The MCP shall convene an MCP Family Advisory Council at least quarterly in each region that the MCP serves consisting of the MCP’s current members. The purpose of the Council is to engage members in such a way as to elicit meaningful input related to the MCP’s strengths and challenges with respect to serving members. The composition of the group shall be diverse and representative of the MCP’s current membership throughout the region with respect to the members’ race, ethnic background, primary language, age, Medicaid eligibility category (Adult Extension, MAGI and ABD), and health status. As new populations are enrolled in managed care, the MCP shall actively pursue ensuring the Council’s membership reflects the diversity of its enrolled population.

The MCP shall report the following to ODM on or before the 15th of July, October, January and April of each calendar year:

- a. A list of attending members during the prior quarter for each regional Advisory Council; Meeting dates,
  - b. Agenda and the minutes from each regional meeting that occurred during the prior quarter; and
  - c. Improvement recommendations developed by each Council.
51. **MCP Pharmacy & Therapeutics (P&T) Committee.** The MCP shall convene a P&T Committee that is in substantial compliance with CMS’s Medicare requirements set forth in 42 CFR 423.120(b)(1), Development and Revision by a Pharmacy and Therapeutics Committee. In order to comply with CMS’s Medicare requirements in the Medicaid program, the plans shall substitute the terms, Medicaid Covered Outpatient Drug and MCP, for the terms, part D drug and plan sponsor, respectively, and are not required to include members who are experts regarding the care of elderly or disabled individuals. The P&T Committee shall submit to ODM upon request:
- a. The P&T Committee membership list for ODM review and approval.
  - b. The minutes pertaining to the Medicaid program from each the MCP P&T committee meeting within 10 calendar days of the date of the meeting at which the minutes are approved. Minutes shall include all voting results.
52. The MCP shall participate in the development, implementation, and operation of initiatives for early managed care enrollment and care coordination for inmates to be released from state prisons or state psychiatric hospitals and youths in Department of Youth Services custody.
53. If the MCP uses a Diagnosis Related Grouper (DRG) to pay for inpatient hospital claims, then the MCP shall use the All-Patient Refined (APR) DRG that is the same version that ODM uses.
54. **Nursing Facility Services.** For Medicaid covered nursing facility stays, the MCP shall evaluate the member’s need for the level of services provided by a nursing facility. To make this decision, the MCP shall use the criteria for nursing facility-based level of care pursuant to OAC rules 5160-3-08, 5160-3-09

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and 5160-1-01. The MCP shall provide documentation of the member's level of care determination to the nursing facility. The MCP shall maintain a written record that the criteria were met, or if not met, the MCP shall maintain documentation that a Notice of Action was issued in accordance with OAC rule 5160-26-08.4.

The MCP shall 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. Patient liability shall be applied as an offset against the amount Medicaid would otherwise reimburse for the claim. If the patient liability exceeds the amount Medicaid would reimburse, the claim shall be processed with a payment of zero dollars. . The MCP is prohibited from paying for nursing facility services during restricted Medicaid coverage periods (RMCP). The MCP shall utilize HIPAA compliant enrollment files for patient liability obligations and RMCPs.

**55. Payment and Adjustment to Capitation in Consideration of the ACA Section 9010 Health Insurance Providers Fee.** The following payment and adjustment to capitation information applies only to MCPs that are covered entities under Section 9010 of the Patient Protection and Affordable Care Act, as amended by Section 10905 of the same Act, and as further amended by Section 1406 of the Health Care and Education Reconciliation Act of 2010 (collectively, the "ACA"), and thus required to pay an annual fee ("Annual Fee") for United States health risks.

- a. The ACA requires the MCP to pay the Annual Fee no later than September 30th (as applicable to each relevant year, the "Fee Year") with respect to premiums paid to the MCP in the preceding calendar year (as applicable to each relevant year, the "Data Year"), and continuing similarly in each successive year.
- b. In order to satisfy the requirement for actuarial soundness set forth in 42 CFR 438.6(c) with respect to amounts paid by ODM under this Agreement, the parties agree that ODM shall make a payment or an adjustment to capitation to the MCP for the full amount of the Annual Fee allocable to this Agreement, as follows:
  - i. **Amount and Method of Payment.** For each Fee Year, ODM shall make a payment or an adjustment to capitation to the MCP for that portion of the Annual Fee attributable to the premiums paid by ODM to the MCP (the "Ohio Medicaid-specific Premiums") for risks in the applicable Data Year under the Agreement, less any applicable exclusions and appropriate credit offsets. These payments or adjustments to be made by ODM will include the following:
    1. The amount of the Annual Fee attributable to this Agreement;
    2. The corporate income tax liability, if any, that the MCP incurs as a result of receiving ODM's payment for the amount of the Annual Fee attributable to this Agreement; and
    3. Any Ohio state and local Sales and Use taxes and Health Insuring Corporation taxes.

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

ii. **Documentation Requirements.** ODM shall pay the MCP after it receives sufficient documentation, as determined by ODM, detailing the MCP's Ohio Medicaid-specific liability for the Annual Fee. The MCP shall provide documentation that includes the following:

1. Total premiums reported on IRS Form 8963;
2. Ohio Medicaid-specific premiums included in the premiums reported on Form 8963;
3. The amount of the Annual Fee as determined by the IRS; and
4. The corporate income tax rate applicable to the year of such payments.

Payment by ODM is intended to put the MCP in the same position as the MCP would have been in had no Annual Fee been imposed upon the MCP. This provision shall survive the termination of the Agreement.

**56. Hepatitis C Risk Pool Arrangement.** Pursuant to the Hepatitis C Risk Pool Arrangement described in Appendix E, Rate Methodology, the MCP shall participate in a Hepatitis C risk pool arrangement on a calendar year (CY) basis. The amount of the risk pool is determined by the projected Hepatitis C costs incorporated into the CY rates. ODM will redistribute funds among MCPs based on the actual Hepatitis C costs. This risk pool will be used to account for any MCP getting a disproportionate share of members using Hepatitis C drugs by giving plans that experience adverse selection or relatively adverse claims experience a greater proportion of the risk pool funds. The MCP shall follow FFS clinical criteria for Hepatitis C direct acting antivirals.

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

- a. The MCP shall designate both a primary and alternate point of contact who will perform the following functions: be available 24 hours a day, 7 days a week during the time of an emergency; be responsible for monitoring news, alerts and warnings about disaster/emergency events; have decision-making authority on behalf of the MCP; respond to directives issued by ODM; and cooperate with the local- and state-level Emergency Management Agencies. The MCP shall communicate any changes to the primary and alternate point of contact to the Contract Administrator at least one business day prior to the effective date of the change.

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- b. The MCP shall participate in ODM sanctioned workgroups and processes to establish a state-level emergency response plan which will include a provision for Medicaid recipients, and will comply with the resulting procedures.
  - c. During the time of an emergency or a natural, technological, or man-made disaster, the MCP shall be able to generate a current list of members for whom an individual disaster plan, according to the specifications below, has been developed, including the risk and the individual-level plan, and distribute to local and state emergency management authorities according to the protocol established by ODM.
  - d. The MCP shall identify members who are at risk for harm, loss, or injury during any potential natural, technological, or manmade disaster. The MCP shall ensure every member who is technology and/or service dependent, with no known reasonable means to access services, is known and documented as part of the plan's Comprehensive Disaster/Emergency Response Plan. For these members, the MCP shall develop an individual-level plan with the member when appropriate. The MCP shall ensure staff, including care managers, are prepared to respond to and implement the plans in the event of an emergency or disaster. The member-level plan shall:
    - i. 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;
    - ii. Identify how and when the plan will be activated;
    - iii. Be documented in the member record maintained by the MCP; and
    - iv. Be provided to the member.
58. **MCP Portfolio Expansion.** The MCP shall immediately report to ODM all arrangements wherein services or contracts may overlap with Medicaid plans when plans are seeking to expand their portfolios through contracts with other entities.
59. **Subcontractual Relationships and Delegation.** If the MCP delegates to any first tier, downstream and related entity (FDR), they shall ensure it has an arrangement with the FDR to perform administrative services as defined below on the MCP's behalf.
- a. Unless otherwise specified by ODM, administrative services include: care management, marketing, utilization management, quality improvement, enrollment, disenrollment, membership functions, claims administration, licensing and credentialing, provider network management, and coordination of benefits.
  - b. Parties to administrative services arrangements are defined as:
    - i. First tier entity: any party that enters into a written arrangement, acceptable to ODM, with the MCP to provide administrative services for Ohio Medicaid eligible individuals.

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- ii. 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.
  - iii. Related entity: any party related to the MCP by common ownership or control, and under an oral or written arrangement performs some of the administrative services under the MCP's contract with ODM.
- c. Before the MCP enters into an arrangement with an FDR to perform an administrative function not listed above that could impact a member's health, safety, welfare or access to Medicaid covered services, the MCP shall contact ODM to request a determination of whether or not the function should be included as an administrative service that complies with the provisions listed herein.
- d. **Pharmacy Benefit Manager (PBM) Agreements.** If the MCP enters into a contract or agreement (hereinafter referred to as "PBM agreement") with a PBM for the provision and administration of pharmacy services, the agreement shall be developed as a pass-through pricing model as defined below. For the purposes of this Agreement, all requirements applicable to a PBM shall also apply to any contract or agreement the MCP has with a Pharmacy Benefit Administrator (PBA).
- i. For the purposes of this Agreement, a pass-through pricing model is defined as a PBM agreement type where:
    - 1. All monies related to services provided for the MCP are passed through to the MCP, including but not limited to: dispensing fees and ingredient costs paid to pharmacies, and all revenue received, including but not limited to pricing discounts paid to the PBM, rebates<sup>1</sup>, inflationary payments<sup>2</sup>, and supplemental rebates;
    - 2. All payment streams, including any financial benefits such as rebates, discounts, credits, clawbacks, fees, grants, chargebacks, reimbursements, or other payments that the PBM receives related to services provided for the MCP are fully disclosed to the MCP, and provided to ODM upon request; and
    - 3. The PBM is paid an administrative fee which covers their cost of providing the PBM services as described in the PBM contract as well as margin.
  - ii. The payment model for the PBM's administrative fee shall be made available to ODM. If concerns are identified, ODM reserves the right to request any changes be made to the

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<sup>1</sup> Rebates include manufacturer fees and administration fees for rebating.

<sup>2</sup> Inflationary payments refers to any agreement a PBM may have with a manufacturer where the manufacturer agrees to a payment back to the PBM if a drug has inflation above an agreed upon level.

payment model.

- iii. The PBM agreement shall allow for the MCP to perform a competitive market check every three years or allow the MCP to annually renegotiate its terms.
- iv. The MCP shall work with ODM throughout calendar year 2019 to establish a value-based payment model to be effective July 1, 2019 or another timeline as established by ODM.
- v. **PBM Agreement Language.**
  1. The following provisions shall be included in any agreement between the MCP and their PBM:
    1. At least annually, the PBM shall hire an independent third party to complete a Service Organization Controls report (SOC-1) audit over the PBM's services and activities. This report shall be provided to the MCP, and information from this audit shall be made available to ODM upon request.
    2. The PBM shall not steer or require any providers or members to use a specific pharmacy in which the PBM has an ownership interest or that has an ownership interest in the PBM, if for the primary purpose of reducing competition or financially benefitting the PBM's associated businesses. Arrangements between MCPs and PBMs to promote value-based reimbursement and purchasing or enhancing health outcomes are permitted.
    3. The PBM shall load eligibility information into their system within 24 hours of receipt of the 834C file from the MCP.
    4. The PBM shall report semi-annually to the MCP their list of specialty drugs by National Drug Code, including a report on any drugs that have moved between specialty and non-specialty designation.
    5. The PBM shall submit a report containing data from the prior calendar year to the MCP. The report shall be made available to ODM upon request and contain the following information:
      - i. The aggregate amount of all rebates that the PBM negotiated from all pharmaceutical manufacturers on behalf of the MCP; and
      - ii. The aggregate administrative fees that the PBM negotiated from all pharmaceutical manufacturers on behalf of the MCP.

2. The following provisions shall be addressed in any agreement between the MCP and their PBM:
  - a. The ability for the MCP, or its designee that has no ownership or control interest with the PBM, to audit and review contracts or agreements between the PBM and their pharmacies at least annually to ensure correct pricing has been applied. This includes, but is not limited to, prescription drug claim data, billing records, and other records to ensure the PBM's compliance with the terms and conditions of their agreement.
  - b. If there is not a provision in the agreement to restrict the PBM from selling pharmacy data, the MCP shall require a secure process to be included and followed. If any Ohio Medicaid MCP pharmacy data is sold, aggregate total amount received by the PBM for the MCP's data shall be reported to the MCP at least semi-annually.
  - c. The ability for the MCP, at its discretion, to enter into non-exclusive specialty pharmacy network arrangements when a specialty pharmacy can provide a better price on a drug.
  - d. A clause that allows the MCP to terminate the agreement for cause, including conduct that is likely to mislead, deceive, or defraud the public, as well as unfair or deceptive business practices.
- e. Upon request, the MCP shall disclose to ODM all financial terms and arrangements for payment of any kind that apply between the MCP, or the MCP's FDR, and any provider of a Medicaid service. If the FDR is a PBM or PBA, this disclosure shall include financial terms and payment arrangements for formulary management, drug-switch programs, educational support, claims processing, pharmacy network fees, data sales fees, and all other fees. ODM acknowledges that such information may be considered confidential and proprietary and thus shall be held strictly confidential by ODM as specified in Article VII of this Agreement.
- f. The MCP that enters into a written arrangement with an FDR shall include the following enforceable provisions:
  - i. A description of the administrative services to be provided by the FDR and any requirements for the FDR to report information to the MCP.
  - ii. The beginning date and expiration date or automatic renewal clause for the arrangement, as well as applicable methods of extension, renegotiation and termination.
  - iii. Identification of the service area and Medicaid population, either "non-dual" or "non-dual and dual" the FDR will serve.



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Appendix C  
Plan Responsibilities

- iv. A provision stating that the FDR shall release to the MCP and ODM any information necessary for the MCP to perform any of its obligations under the MCP's provider agreement with ODM, including but not limited to compliance with reporting and quality assurance requirements.
- v. A provision that the FDR's applicable facilities and records will be open to inspection by the MCP, ODM, its designee or other entities as specified in OAC rule.
- vi. A provision that the arrangement is governed by and construed in accordance with all applicable state or federal laws, regulations and contractual obligations of the MCP. The arrangement shall be automatically amended to conform to any changes in laws, regulations and contractual obligations without the necessity for written amendment.
- vii. A provision that Medicaid eligible individuals and ODM are not liable for any cost, payment, copayment, cost-sharing, down payment, or similar charge, refundable or otherwise for services performed, including in the event the FDR or the MCP cannot or will not pay for the administrative services. This provision does not prohibit waiver entities from collecting patient liability payments from MCP members as specified in OAC rule 5160:1-6-05.1.
- viii. The procedures to be employed upon the ending, nonrenewal or termination of the arrangement including at a minimum to promptly supply any documentation necessary for the settlement of any outstanding claims or services.
- ix. A provision that the FDR will abide by the MCP's written policies regarding the False Claims Act and the detection and prevention of fraud, waste and abuse.
- x. A provision that the FDR, and all employees of the FDR, are subject to the applicable provider qualifications in OAC rule 5160-26-05.
- xi. For an FDR providing administrative services that result in direct contact with a Medicaid eligible individual, a provision that the FDR will identify, and where indicated, arrange pursuant to the mutually agreed upon policies and procedures between the MCP and FDR for the following at no cost to the individual or ODM:
  - 1. Sign language services; and
  - 2. Oral interpretation and oral translation services.
- xii. For an FDR providing licensing and credentialing services of medical providers, a provision that:
  - 1. The credentials of medical professionals affiliated with the party or parties will be reviewed by the MCP; or

2. The credentialing process will be reviewed and approved by the MCP and the MCP will audit the credentialing process on an ongoing basis.
- xiii. For an FDR providing administrative services that result in the selection of providers, a provision that the MCP retains the right to approve, suspend, or terminate any such selection.
- xiv. A provision that permits ODM or the MCP to seek revocation or other remedies, as applicable, if ODM or the MCP determines that the FDR has not performed satisfactorily, or the arrangement is not in the best interest of the MCP's members.
- g. The MCP is ultimately responsible for meeting all contractual obligations under the MCP's provider agreement with ODM. The MCP shall:
  - i. Ensure the performance of the FDR is monitored on an ongoing basis to identify any deficiencies or areas for improvement;
  - ii. Impose corrective action on the FDR as necessary; and
  - iii. Maintain policies and procedures that ensure there is no disruption in meeting its contractual obligations to ODM, if the FDR or the MCP terminates the arrangement between the FDR and the MCP.
- h. Unless otherwise specified by ODM, all information required to be submitted to ODM shall be submitted directly by the MCP.
- i. Information regarding new, changes to, or termination of FDR arrangements shall be reported to ODM no less than 15 calendar days prior to it taking effect.
- j. Delegation requirements do not apply to care management arrangements between the MCP and a Comprehensive Primary Care Practice or Patient Centered Medical Home as cited in Appendix K.
- k. In accordance with 42 CFR 438.602, the MCP shall post on its website the name and title of individuals included in 42 CFR 438.604(a)(6). For the purposes of this requirement, the term "subcontractor" is defined as any individual or entity that has a contract with the MCP that relates directly or indirectly to the performance of the MCP's obligations under this Agreement, not including a network provider.

**60. Appeals and Grievances.** The MCP shall have written policies and procedures for an appeal and grievance system for members, in compliance with the requirements of OAC rule 5160-26-08.4 and 42 CFR 438 Subpart F, and shall include the participation of individuals authorized by the MCP to require corrective action. The MCP is prohibited from delegating the appeal or grievance process to another entity unless approved by ODM. These policies and procedures shall include a process by which members may file grievances and appeals with the MCP, and a process by which members may access the state's fair hearing system through the Ohio Department of Job and Family Services (ODJFS) Bureau

of State Hearings (BSH).

- a. **State Hearing Process.** The MCP shall develop and implement written policies and procedures that ensure the MCP's compliance with the state hearing provisions specified in division 5101:6 of the Administrative Code. Upon request, the MCP's state hearing policies and procedures shall be made available for review by ODM. When the MCP is notified by BSH that a member has requested a state hearing, the MCP shall review the state hearing request and within two business days of receipt of the BSH notice, confirm via email to [State\\_Hearings\\_Scheduling@jfs.ohio.gov](mailto:State_Hearings_Scheduling@jfs.ohio.gov) one of the following:
- i. The MCP has no record that the member has requested a plan appeal pertaining to the state hearing request;
  - ii. The MCP 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;
  - iii. The MCP 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; or
  - iv. The MCP has not yet made a decision on the appeal request pertaining to the state hearing request and identify the date the MCP received the appeal request and the date the MCP is currently required to decide an appeal resolution.

Unless the timeframe for a member to file an appeal with the MCP is exhausted in accordance with OAC rule 5160-26-08.4, if the MCP confirms to BSH that there is no record of the member requesting a plan appeal, the MCP shall attempt to contact the member to initiate the plan appeal process.

- b. **Logging and Reporting of Appeals and Grievances.** The MCP shall maintain records of all appeals and grievances, including resolutions, for a period of ten years. Upon request, the records shall be made available to ODM and the Medicaid Fraud Control Unit.
- i. The record of each grievance or appeal shall contain, at a minimum:
    1. The name of the member for whom the appeal or grievance was filed;
    2. The date the appeal or grievance was received;
    3. A general description of the reason for the appeal or grievance;
    4. The date of each review or, if applicable, review of meeting;
    5. If applicable, the resolution of the appeal or grievance; and

6. If applicable, the date of the resolution.

- ii. The MCP shall identify a key staff person responsible for the logging and reporting of appeals and grievances and ensuring the grievance and appeals system is in accordance with this rule.
- iii. The MCP shall submit information regarding appeal and grievance activity as directed by ODM.

61. **Ohio Equity Institute Data.** The MCP shall submit data files for ODM-sanctioned improvement efforts involving infant mortality in priority communities as specified by ODM.

62. **Ventilator Program.** The MCP shall 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 ventilator dependent individuals.

63. **Utilization Management Programs.** The MCP shall implement clearly defined structures and processes to maximize the effectiveness of the care provided to members pursuant to OAC rule 5160-26-03.1.

Pursuant to the criteria in ORC section 5160.34(C), the MCP is prohibited from retroactively denying a prior authorization (PA) request as a utilization management strategy. In addition, the MCP shall permit the retrospective review of a claim submitted for a service where PA was required, but not obtained, pursuant to the criteria in ORC section 5160.34(B)(9). Also ORC section 5160.34 requires the MCPs establish a streamlined provider appeal process relating to adverse PA determinations.

- a. **Drug Utilization Management.** Pursuant to ORC section 5167.12, the MCP may implement strategies for the management of drug utilization. ODM may request details of drug utilization management programs, such as prior authorization, step therapy, partial fills, specialty pharmacy, pill-splitting, etc. and require changes to such programs, if they cause barriers to care. The MCP may, subject to ODM prior-approval, require PA of certain drug classes and place limitations on the type of provider and locations where certain drugs may be administered; however, the MCP cannot require PA for drugs used to prevent preterm birth nor can they require PA for the location of administration. The MCP shall establish their PA system so that it does not unnecessarily impede member access to medically-necessary Medicaid-covered services as follows:
  - i. As outlined in this appendix, the MCP shall adhere to specific PA limitations to assist with the transition of new members from FFS Medicaid.
  - ii. As outlined in ORC section 5167.12 and Appendix G, the MCP shall allow members to receive without PA certain antidepressant and antipsychotic drugs and to take into consideration if the member is stabilized on a specific antidepressant or antipsychotic drug when PA is permitted.
  - iii. The MCP shall comply with the provisions of 1927(d)(5) of the Social Security Act, 42 USC 1396r-8(d)(5), 42 CFR 438.3(s)(6), and OAC rule 5160-26-03.1 regarding the

timeframes for prior authorization of covered outpatient drugs.

- iv. **Coordinated Services Program (CSP).** The MCP shall develop and submit for prior approval, a CSP as defined in OAC rule 5160-20-01 to address the overuse or misuse of all services. The MCP shall, at a minimum, follow all provisions set forth in OAC rule 5160-20-01 for initial and continued enrollment. The MCP shall offer to provide care management services to any member who is enrolled in the CSP.
  - v. The MCP shall develop prospective and retrospective drug utilization review programs designed to promote the appropriate clinical prescribing of covered drugs as outlined in Appendix G.
- b. **Medication Therapy Management (MTM) Program.** MTM is a process that promotes safe and effective use of medications, including prescription and over the counter drugs, vitamins, and herbal supplements.
- i. The MCP shall develop an MTM program that shall be submitted and approved annually as directed by ODM. The MCP's MTM program shall detail the MTM triggering events, activity that occurs after a triggering event, how each MTM interaction is documented and reimbursed, and how an action plan will be initiated and monitored.
  - ii. The MCP's MTM program shall utilize community pharmacists or other qualified providers to render MTM services.
  - iii. The MCP shall report quarterly to ODM the key utilization and financial metrics for their MTM program.
- c. **Behavioral Health Expedited Prior Authorization.** 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) shall be prior authorized as expeditiously as the member's health condition requires but no later than 48 hours after receipt of the request in accordance with OAC rule 5160-26-03.1.

The sanctions for noncompliance with requirements in this appendix are listed in Appendix N of this Agreement.

## APPENDIX D

### ODM RESPONSIBILITIES

The following are the Ohio Department of Medicaid (ODM) responsibilities not otherwise specifically stated in Ohio Administrative Code (OAC) Chapter 5160-26 or elsewhere in this Agreement.

1. ODM will provide the MCP with an opportunity to review and comment on the rate-setting time line, proposed rates, proposed changes to the OAC program rules and the amended provider agreement.
2. ODM will notify the MCP of managed care program policy and procedural changes and, whenever possible, offer sufficient time for comment and implementation.
3. ODM will provide regular opportunities for the MCP to receive program updates and discuss program issues with ODM staff.
4. ODM will provide technical assistance sessions where MCP attendance and participation is required. ODM will also provide optional technical assistance sessions to the MCP.
5. ODM will provide the MCP linkages to organizations that can provide guidance on the development of effective strategies to eliminate health disparities.
6. ODM will conduct an annual analysis of Medicaid eligible individuals to identify whether there are prevalent common primary languages other than English in the MCP service areas. ODM will notify the MCP of any languages identified as prevalent for the purpose of translating marketing and member materials outlined in Appendix F.
7. ODM will provide the MCP with an annual MCP Calendar of Submissions outlining major submissions and due dates.
8. ODM will identify contact staff, including the Contract Administrator (CA), selected for the MCP.
9. ODM will provide the MCP with an electronic Provider Master File containing all Ohio Medicaid fee-for-service (FFS) providers, which includes their Medicaid Provider Number, as well as all providers who have been assigned a provider reporting number for current encounter data purposes. This file also includes NPI information when available.
10. **Service Area Designation.** ODM will implement a mandatory managed care program in service areas wherever choice and capacity allow and the criteria in 42 CFR 438.50(a) are met.
11. **Member Information.**
  - a. ODM, or its designee, will provide membership notices, informational materials, and instructional materials to members and eligible individuals in a manner and format that may be easily understood. At least annually, ODM or its designee will provide current MCP members with an open enrollment notice which describes the managed care program and includes

information on the MCP options in the service area and other information regarding the managed care program as specified in 42 CFR 438.10.

- b. ODM will notify members or ask the MCP to notify members about significant changes affecting contractual requirements, member services or access to providers.
- c. If the MCP elects not to provide, reimburse, or cover a counseling service or referral service due to an objection to the service on moral or religious grounds, ODM will provide coverage and reimbursement for these services for the MCP's members.
- d. As applicable, ODM will provide information to MCP members on what services the MCP will not cover and how and where the MCP's members may obtain these services.

**12. Membership Selection.**

- a. The Ohio Medicaid Consumer Hotline (henceforth referred to as the "Hotline") is responsible for providing unbiased education and selection services for the Medicaid managed care program. The Hotline operates a statewide toll-free telephone center to assist eligible individuals in selecting an MCP or choosing a health care delivery option.
- b. Eligible individuals will be auto-assigned to an MCP at the discretion of ODM in accordance with 42 CFR 438.54.
- c. ODM or their designated entity shall provide Consumer Contact Records (CCRs) to the MCP on no less than a weekly basis. The CCRs are a record of each consumer initiated MCP enrollment, change, or termination, and each Hotline initiated MCP assignment processed through the Hotline.
- d. ODM verifies MCP enrollment via a membership roster. ODM or its designated entity provides HIPAA compliant 834 daily and monthly transactions.

**13. Monthly Premium Payment.** ODM will remit payment to the MCP via an electronic funds transfer (EFT), or at the discretion of ODM, by paper warrant.

- a. ODM will confirm all premium payments paid to the MCP during the month via a monthly remittance advice (RA).
- b. ODM or its designated entity will provide a record of each recipient detail level payment via HIPAA compliant 820 transactions. ODM or its designee will keep a record of the MCP's Accounts Payable (i.e. Pay 4 Performance, Primary Care Rate Increase, and Health Insurance Provider Fee) and Accounts Receivable (i.e. Penalty, Credit Balance) transaction on the MITS Provider Portal Report Tab.

**14.** ODM will make available a website which includes current program information.

**15.** ODM will regularly provide information to the MCP regarding different aspects of the MCP's performance including, but not limited to, information on MCP-specific and statewide external quality

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Appendix D

ODM Responsibilities

review organization surveys, focused clinical quality of care studies, consumer satisfaction surveys and provider profiles.

16. ODM or its designee reserves the right to review and audit the Pharmacy Benefit Manager (PBM) or Pharmacy Benefit Administrator (PBA) agreements between the MCP and a PBM or PBA to ensure the PBM or PBA is fulfilling its contractual obligations. The MCP shall be responsible for ensuring that any findings from these audits are corrected within the timeframe specified by ODM.
17. ODM or its designee, at least annually, will conduct a pricing analysis to identify trends in payment to chain pharmacies and non-chain pharmacies, including but not limited to, identifying cost trends and payments to chain pharmacies and non-chain pharmacies.
18. The Office of Managed Care (OMC) is responsible for the oversight of the MCPs' provider agreements with ODM. Within the OMC, a specific Contract Administrator (CA) has been assigned to the MCP. Unless expressly directed otherwise, the MCP shall first contact its designated CA for questions/assistance related to Medicaid and/or the MCP's program requirements /responsibilities. If its CA is not available and the MCP needs immediate assistance, MCP staff should request to speak to a supervisor within the Bureau of Managed Care Compliance and Oversight.



**APPENDIX E**  
**RATE METHODOLOGY**

MILLIMAN CLIENT REPORT

# Calendar Year 2019 Medicaid Managed Care Provider Agreement Rate Certification Summary

January 1, 2019 through December 31, 2019

## Ohio Department of Medicaid

December 10, 2018

[Jeremy D. Palmer](#), FSA, MAAA  
Principal and Consulting Actuary

[Jason A. Clarkson](#), FSA, MAAA  
Principal and Consulting Actuary





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## Introduction & Executive Summary

***This document is an abridged version of the file titled “CY 2019 Medicaid Managed Care Certification” dated December 10, 2018. Please refer to the certification report for a complete version of the calendar year 2019 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, 2019. This letter provides documentation for the development of the actuarially sound capitation rates.

## Section I. Medicaid managed care rates

### 1. General information

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

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

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

- Actuarial standards of practice applicable to Medicaid managed care rate setting which have been enacted as of the capitation rate certification date, including: ASOP 1 (Introductory Actuarial Standard of Practice); ASOP 5 (Incurred Health and Disability Claims); ASOP 23 (Data Quality); ASOP 25 (Credibility Procedures); ASOP 41 (Actuarial Communications); ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies); and ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification).
- Actuarial soundness and rate development requirements in the Medicaid and CHIP Managed Care Final Rule (CMS 2390-F) for the provisions effective for the CY 2019 managed care program rating period.
- The most recent *Medicaid Managed Care Rate Development Guide* published by CMS.
- Throughout this document and consistent with the requirements under 42 CFR 438.4(a), the term “actuarially sound” will be defined as in ASOP 49:

*“Medicaid capitation rates are “actuarially sound” if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits; health benefit settlement expenses; administrative expenses; the cost of capital, and government-mandated assessments, fees, and taxes.”<sup>1</sup>*

<sup>1</sup> <http://www.actuarialstandardsboard.org/asops/medicaid-managed-care-capitation-rate-development-and-certification/>

## A. RATE DEVELOPMENT STANDARDS

### i. Annual basis

The capitation rates are for the one year rate period from January 1, 2019 through December 31, 2019.

### ii. 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 associated with the covered populations.

### iii. Cross-subsidization of rate cell payment

The capitation rates were developed at the rate cell level and neither cross-subsidize nor are cross-subsidized by payments from any other rate cell.

## B. APPROPRIATE DOCUMENTATION

### i. Documentation of required elements

This report contains appropriate documentation of key elements, including data used, assumptions made, and methods for analyzing data and developing assumptions and adjustments.

## 2. Data

This section provides information regarding the base data used to develop the capitation rates.

### 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 on a monthly basis 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 2019 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 MCPs;
- Annual cost report data submitted by the MCPs;
- Re-priced inpatient and outpatient hospital claims experience provided by ODM;
- Historical FFS data for behavioral health carve-in services provided by ODM;
- Historical FFS data provided by ODM for the new populations;
- CY 2017 MCP Survey completed by each MCP; and,
- Statutory financial statement data.

##### (ii) Age of the data

The data serving as the base experience in the capitation rate development process was incurred during CY 2017. The annual cost report data reflects claims paid through March 31, 2018. The encounter data used in our

rate development process reflected encounters paid through March 31, 2018, consistent with the basis of the annual cost report data.

For the purposes of trend development and analyzing emerging population enrollment patterns and claims experience, we also reviewed encounter and cost report experience from CY 2015 through the first half of CY 2018. Cost report and encounter data was provided by ODM.

For the purpose of analyzing inpatient and outpatient hospital reimbursement changes, we received hospital encounter data (re-priced to ODM's fee schedule) for inpatient and outpatient hospital services incurred during CY 2017 from ODM. We also summarized statutory financial statement data from calendar years 2016 and 2017, and the second quarter of CY 2018. Financial statement data was summarized using MCP annual cost report data and subsequently reconciled using S&P Global.

### **(iii) Data sources**

The historical encounter data used for this certification is submitted by the five MCPs on an ongoing basis. This data is stored in ODM's Medicaid Information Technology System (MITS). Medicaid enrollment and encounter data stored in MITS was provided to us for the purposes of developing the CY 2019 capitation rates.

CY 2017 annual cost report data was also provided to us. The cost report data is contained in Microsoft Excel files that the MCPs submit to ODM.

### **(iv) Sub-capitation**

Sub-capitated data is identified separately in both the encounter and cost report experience.

**Encounter Data:** MCPs 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 MCPs provided additional information related to sub-capitated services through their CY 2017 MCP 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 MCP encounter data.

**Cost Report:** We relied on the separate reporting of non-sub-capitated and sub-capitated experience by the MCPs in the medical cube worksheets of the CY 2017 cost reports. In the MCP cost reports, sub-capitated expenditures represent the amounts paid by MCPs for sub-capitated services, rather than "shadow priced" claims as illustrated in the CY 2017 encounter data.

## **(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 MCPs. Managed care eligibility is maintained in MITS by ODM. The actuary, the MCPs, 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 MCPs 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 MCP performance measurement, with measures focused on completeness, accuracy, and comparison between data sources. Appendix L of ODM's contract with the MCPs 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 MCP-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 MCP'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 MCP'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 per member per month (PMPM) by MCP and high level service categories;
- MCP distribution of members by annual encounter-reported expenditures; and,
- MCP 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 2017 encounter data used in the development of the rates was paid through March 31, 2018. As noted in this report, claims completion is applied to the encounter data for estimated CY 2017 claims paid after March 31, 2018.

#### *Cost Report Data*

MCPs submit quarterly and year-end annual cost report data to ODM. We reviewed each MCP's quarterly and annual cost reports to identify large data variances, incomplete data, and other reporting issues. These issues are provided to each MCP 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 MCP and reconciled to the MCP's audited NAIC financial statement information. The year-end annual cost report is completed by the MCPs 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 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 MCP Cost Report submissions along with NAIC financial statement information. We also review the encounter data to ensure each claim is related to a covered individual and a covered service. We summarize the encounter data into an actuarial cost model format. Annual base period data summaries are created to ensure that the data for each service is consistent across the MCPs 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 MCP and service category combinations that may have unreasonable reported data.

#### *Cost Report Data*

As stated in the Completeness section, MCPs 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 MCPs 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 MCP 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 capitation rates effective January 1, 2019. Assessing the encounter data for consistency with the MCP cost reports was a vital part of the rate development process. We reviewed utilization and cost metrics by rate cell and region for CY 2017 encounter data and cost reports. Experience was reviewed for non-sub-capitated services, sub-capitated services, and in aggregate. Aggregate expenditures in the encounter data were approximately 6% less than aggregate 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 that have been 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 website.
- Re-priced inpatient claims experience – To support our analysis of the impact of the APR-DRG changes during the historical experience period and rate period, we received re-priced inpatient encounter records from ODM. The claims experience included the actual MCP paid amount, along with claims re-priced to ODM's fee schedule. We confirmed the MCP paid amount was consistent with the encounter experience we had previously received, and confirmed the re-priced amounts were consistent with ODM's published inpatient hospital fee schedule.
- Re-priced outpatient claims experience – To support our analysis of the impact of EAPG implementation, we received re-priced outpatient encounter records from ODM. The claims experience included the actual MCP paid amount, along with claims re-priced to ODM's fee schedule. We confirmed the MCP paid amount was consistent with the encounter experience we had previously received, and confirmed the re-priced amounts were 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 MCPs. The values presented in this letter are dependent upon this reliance.

While there are areas for data improvement, we found the encounter data to be of appropriate quality for developing the CY 2019 capitation rates. After applying a series of data quality adjustments to both the encounter and cost report data, aggregate claims in the encounter data were within 0.1% of aggregate claims in the cost report data on a PMPM basis.

#### (iii) Data concerns

Through discussions with ODM and various data analyses, we were made aware of and confirmed encounter data quality concerns.

### (c) Appropriate data

#### (i) Use of encounter and fee-for-service data

FFS data was used as the base experience to develop the impact of behavioral health carve-in. We reviewed and shared data summaries of the behavioral health FFS data with ODM to validate that it was appropriate for use. FFS experience was also used to estimate the potential impact of ODM's policy decision to move certain periods of retro-active FFS eligibility into the managed care delivery system. Additionally, FFS data was used to estimate the impact of moving previously-FFS populations into managed care. Managed care encounter data was used in the development of the capitation rates for all other 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 2017 encounter data, which were shared with ODM and participating MCPs.

**iii. Data adjustments**

Capitation rates were developed primarily from CY 2017 encounter data. Adjustments were made to the base experience for data quality, completion, reimbursement changes, managed care efficiencies, and other program adjustments.

**(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 capitation rates are based on CY 2017 experience. Encounter data is paid through March 31, 2018. Completion factors were developed by summarizing encounter data and applying traditional actuarial techniques to develop estimates of incurred but not paid (IBNP) liability, through the use of Milliman's Robust Time-Series Analysis System (RTS)<sup>2</sup>.

First, we stratified the data by category of service and 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 through the use of encounter data were compared to MCP reported IBNP liability estimates in the CY 2017 MCP Cost Reports for reasonableness.

The monthly completion factors were applied to CY 2017 experience to estimate the remaining claims liability for the calendar year. Results were aggregated into annual completion factors for each calendar year.

**(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 since January 1, 2017, the beginning of the base experience period used in the capitation rate development.

**Hepatitis C Fibrosis Level 2 Protocol.** Effective July 1, 2017, MCPs were required to modify prior authorization criteria for hepatitis C medications to allow for individuals with an F2 fibrosis score. Hepatitis C utilization was increased by approximately 18% in aggregate to account for the change in fibrosis level protocol. This increase was calculated based on a review of hepatitis C utilization in the first half of 2017 relative to the second half of 2017, with consideration for delayed utilization increases observed in other states when modifying hepatitis C prior authorization criteria.

<sup>2</sup> 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 runoff using time series forecasting which employs the interrelationship between claim payments during the first three months of claim payments for each incurred month.

**IMD as an “In Lieu of” Service.** 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. In addition, we applied adjustments to the calendar year 2017 base data to reflect observed utilization increases following the implementation of IMDs as an in-lieu-of service following July 1, 2017.

**Respite Service Expansion.** Effective January 1, 2017, eligibility for respite services was expanded so that more children may access the benefit. This service expansion included both SSI and non-SSI children. Eligibility is based on severe emotional disturbance (SED) and substance-use disorder (SUD) diagnosis criteria established by ODM. Consistent with the CY 2018 capitation rates, the CY 2019 capitation rates include approximately \$2 million for respite services.

**Behavioral Health Carve-In and Redesign.** Effective July 1, 2018, outpatient and professional behavioral health (BH) services are covered benefits in the MMC program. These benefits were previously provided to MMC members under the fee-for-service (FFS) program. FFS claims from CY 2017 served as the base data for estimating the impact to MMC capitation rates associated with BH carve-in. In addition, ODM implemented comprehensive reforms to mental health and substance abuse treatment services, known as behavioral health redesign. These redesign initiatives were not effective during the CY 2017 FFS base data period utilized for rate setting activities, and include the following:

- Expanding Medicaid rehabilitation options for individuals with the highest intensity needs through assertive community treatment programs, intensive home based treatment for youth, and residential treatment for substance abuse disorders;
- Recoding Medicaid BH services to align with current health care payment standards which support the coordination of benefits and integration of behavioral and physical care; and,
- Adjusting the Medicaid BH fee schedule, including any changes in the utilization base.

ODM provided a utilization mapping from current BH services to the expanded BH services offered under BH redesign. We repriced the existing costs to the BH redesign fee schedule using the utilization mapping to reflect the expanded BH procedures. We also repriced claims that will be receiving an increase in the fees due to BH redesign. We relied on CY 2017 FFS data to determine the impact of each component of BH redesign impact.

In addition to BH redesign, we evaluated the impact of other prospective adjustments and program changes in our development of BH service costs. This includes the following items:

- Prospective Trend. We trended the CY 2017 FFS BH base data to the CY 2019 rate period. Trend assumptions were developed through a review of historical BH service trends, and were applied separately to child and adult rate cells.
- Managed Care Efficiencies. ODM provided us with information from the MCP provider agreements related to transition requirements associated with BH carve-in. MCPs are required to follow FFS BH coverage policies, prior authorizations, and coverage of out-of-network providers for specified durations. As a result of these requirements, we have not applied managed care efficiencies on BH carve-in expenditures.
- Serious Mental Illness (SMI) Health Home. Effective July 1, 2018, ODM’s existing SMI Health Home program was sunset. We observed total expenditures of approximately \$28.7 million for this program in the CY 2017 FFS base data. Approximately 78% of these expenditures occurred in the North Central region, where we also observed materially lower utilization of Community Psychiatric Support and Treatment (CPST) services. We estimated the impact of increased CPST utilization associated with the removal of SMI Medical Home.
- Population Morbidity Changes. We evaluated the impact of population morbidity changes as they related to BH services. This includes the population morbidity changes discussed later in this certification, such as enrollment associated with the Developmental Disabilities (DD) waiver populations.

**Full Coverage of IMD Under Age 21 and Over Age 64.** Effective January 1, 2018, MCPs are required to cover both the professional and facility component of IMD stays for members under 21 and over 64 years of age. MCPs

were previously responsible for professional services only for the under 21 and over 64 populations. We estimated the impact of this program change through the use of fee-for-service IMD experience during CY 2017.

#### **Inpatient Reimbursement Changes.**

ODM will rebase its inpatient hospital base rates through the continued use of All Patients Refined Diagnosis Related Groups (APR DRG). This includes hospital base rates, along with APR DRG relative weights which were last updated September 1, 2018. In addition, cost-to-charge ratios (CCR) and capital add-on updates were applied when modeling January 1, 2019 inpatient reimbursement. To estimate the impact of this reimbursement change, we received re-priced CY 2017 inpatient hospital encounter experience to reflect reimbursement rates that will be effective on January 1, 2019 from ODM. The aggregate percentage change in ODM reimbursement was calculated by rate cell. This percentage change was applied to the inpatient paid claims experience, weighted by the proportion of total inpatient encounter data expenditures subject to reimbursement based on APR DRG pricing. The adjustment does not reflect hospital charge inflation impacting outlier payments. The impact of outlier payments is addressed in the development of prospective unit cost trends. Separate adjustments were developed for maternity delivery and non-maternity delivery inpatient services. We did not apply adjustments to nursing facility utilization.

#### **Outpatient EAPG Rebasing.**

ODM will rebase its outpatient hospital payments through the continued use of the Enhanced Ambulatory Patient Grouping System (EAPG). This includes EAPG relative weights and base rates by hospital, which were last updated April 1, 2018. In addition, CCR updates were applied in situations where CRRs are still used in the payment formula when modeling January 1, 2019 outpatient reimbursement. The impact of outpatient reimbursement changes was calculated by region and rate cell. Adjustments were calculated through the use of data provided by ODM, which we reviewed for reasonableness.

#### **Nursing Facility Reimbursement Changes.**

ODM updates nursing facility (NF) payment rates and acuity scores on a semi-annual basis. We applied adjustments to reflect the impact of the semi-annual per diem update. Adjustments were applied to the nursing facility category of service, and vary based on differences in base nursing facility experience by rate cell and region.

#### **Other Fee Schedule Changes.**

We reviewed other known fee schedule changes. Effective January 1, 2018, ODM set professional rates for certain neonatal and newborn services at 75% of the Medicare rates for these services. Because of this increase, clinical laboratory, molecular pathology, and other pathology services were reduced to prevent an increase in aggregate Medicaid expenditures. Additionally, ODM reduced the maximum Medicaid payment for radiology, clinical laboratory, molecular pathology, and other pathology services by five percent, effective January 1, 2018. Through the use of 5160-1-60 Appendix DD and 5160-11-09, we estimated the impact of these and other fee schedule changes effective January 1, 2019, and applied rating adjustments to impacted categories of service.

**Pharmacy Benefit Changes.** We evaluated the impact associated with pharmacy benefit changes in the MMC program. This included consideration for the following:

- Hepatitis C Fibrosis Level 0 Protocol. Effective January 1, 2019, MCPs will be required to modify prior authorization criteria for hepatitis C medications to allow for individuals with an F0 fibrosis score. Hepatitis C utilization was increased by 50% to account for the change in fibrosis level protocol. This increase was calculated based on a review of hepatitis C fibrosis score distribution information, experience in other programs, and actuarial judgement.
- Pharmacy Pass-Through Pricing. Effective January 1, 2019, ODM will require that MCP contracting arrangements with pharmacy benefit managers (PBM) be structured as a pass-through pricing model, consistent with the definition included in Appendix C of the Provider Agreement. Prior to January 1, 2019, MCP PBM contracts were structured as a spread-pricing arrangement. In aggregate, we estimate that this change will be neutral to the capitation rates. We reduced pharmacy expenditures by \$3 per script as a result

of this program change. The total amount removed from pharmacy expenditures was added to non-benefit expense amounts to account for pass-through pricing PBM admin fees.

- **Medication Assisted Treatment Program Changes.** Effective January 1, 2019, ODM will require consistent utilization management and prior authorization be applied to Central Nervous System (CNS) Agents, or Medication Assisted Treatment (MAT). Based on data provided by ODM, information collected from the MCPs, and actuarial judgment, we assumed an increase in MAT utilization of 40%.

In addition, to assist in addressing the opioid crisis ODM will standardize drug dispensing for the CNS Agents therapeutic class. We modeled drug market share shifting and supplemental rebate changes that are anticipated to occur as a result of these efforts. Encounter claims data provided by ODM was used for determining current utilization and reimbursement levels by National Drug Code (NDC). In completing this analysis, we relied on market share shifting assumptions along with MCP supplemental rebate data provided by ODM. As a result of these program changes, we did not apply generic dispensing rate (GDR) or cost per script managed care efficiency adjustments to the CNS Agents therapeutic class.

**Population Morbidity Changes.** We applied adjustments to account for estimated population morbidity differences between calendar year 2017 and calendar year 2019. Adjustments were applied to account for known population changes based on data provided by ODM. Items considered when developing these adjustments are outlined below.

- **Disenrolled Members.** We received a list of member IDs that were involuntarily disenrolled during the summer of 2017. In developing the CY 2019 capitation rates, we removed historical claims and member months for these members.
- **Duplicate Member IDs.** We were informed of the potential for duplicate member IDs in the vendor file eligibility information we received. We removed member months associated with duplicate member IDs.
- **Enrollment Decline.** In December 2017, we observed a material decline in enrollment for the HST 19-64 F rate cell. This enrollment decline was a result of ODM efforts to evaluate eligibility status for currently-enrolled individuals. We identified potential enrollment and claims for removal based on the existence of eligibility more than two months following a member's delivery month. The resulting impact was an approximately 17% increase to the benefit expense of the HST 19-64 F rate cell.

In addition, we observed material enrollment decreases in the CFC and EXT populations during 2018. MMC enrollment in the CFC and EXT populations is approximately 3% lower in September 2018 relative to March 2018. We reviewed CY 2017 encounter data for members that disenrolled during this time period, and determined that leaving members had medical and pharmacy claims PMPM approximately 20% lower than average. We applied morbidity adjustments to impacted rate cells based on net enrollment decrease projections for CY 2019 we received from ODM, along with an assumed morbidity impact of 20% for leaving members.

- **Managed Care Day One.** Effective January 1, 2018, MMC members are enrolled in a MCP the first of the month *coinciding* with the date of Medicaid eligibility approval. Prior to this program adjustment, MMC members were enrolled in a MCP *following* the date of approval (either the beginning of the next month or the month after next, depending on approval date). Managed Care Day One is estimated to result in one additional month of MCP enrollment for many new MMC members. Morbidity adjustments were developed based on our review of historical claims experience associated with this additional month of enrollment.
- **Medicaid Buy-in for Workers with Disabilities (MBIWD).** Effective July 1, 2018, the non-Dual MBIWD population was enrolled in mandatory managed care under ABD rate cells. MBIWD members also included in the DD waiver population are eligible for voluntary enrollment in managed care. The morbidity of the MBIWD population is anticipated to have an immaterial impact to ABD rate cells.
- **Spenddown Population.** Effective July 1, 2018, certain populations previously held out of managed care were enrolled in the MMC program. This includes non-Dual members that were formerly Medicaid Spenddown prior to ODM's 1634 eligibility conversion. We estimated the morbidity impact associated with this population based on enrollment information provided by ODM.

- Specialized Recovery Services (SRS) Population. Effective January 1, 2019, members eligible for Medicaid under the 1915(i) waiver will be enrolled in mandatory managed care. We received a listing of SRS recipient IDs from ODM, and utilized this information to develop enrollment and morbidity impacts associated with the introduction of this population.
- Voluntary Enrollment of DD Waiver Population. Effective January 1, 2017, the Developmental Disabilities (DD) waiver population was eligible for voluntary enrollment in managed care. Waiver services continue to be provided on a FFS basis. We estimated the morbidity impact associated with this population based on enrollment information through July 2018.

### Targeted Reimbursement.

We reviewed MCP provider reimbursement levels in CY 2017 in relation to ODM's FFS reimbursement methodologies. The 2017 MCP Survey required each participating MCP to report its provider reimbursement methodologies by population (CFC, ABD, Extension, and AFK), region, and service category. Additionally, reimbursement levels in relation to Ohio Medicaid's fee-for-service reimbursement schedule were required to be reported at the same level of granularity. This information was provided for the following service categories:

- Inpatient Hospital;
- Outpatient Hospital Emergency Room;
- Outpatient Hospital Other;
- Professional;
- Radiology / Pathology / Laboratory;
- Pharmacy; and,
- Other.

Additionally, we received inpatient and outpatient encounter data from ODM that was re-priced to the FFS fee schedule. In discussion with ODM, we adjusted the base experience to reflect a targeted reimbursement ratio between the composite base experience MCP reimbursement and fee-for-service reimbursement. The targeted reimbursement ratios are inclusive of 2019 fee-for-service reimbursement changes.

### 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 CY 2019 that are not fully reflected in the CY 2017 base experience. 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 MCPs. *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 program, are considered material. The following is a list of program adjustments deemed immaterial based on our review of the experience data and policy change.

- **Acupuncture Coverage.** Effective January 1, 2018, acupuncture services were expanded to include new provider types along with electrical stimulation. We do not anticipate making a service coverage adjustment for this program change as projected expenditures are estimated to be immaterial.
- **APRN Prescribing.** There was a provision in MCD49 allowing an Advanced Practice Registered Nurse (APRN) who is certified in psychiatric mental health by a national certifying organization to prescribe atypical antipsychotics and antidepressant drugs without going through prior authorization. This provision already exists for psychiatrists. Given the existing high rate of prescribing for "preferred" agents, we do not anticipate a material shift in volume to more expensive agents.
- **Comprehensive Primary Care (CPC).** A portion of the MMC population is enrolled in the Ohio CPC program, and the MCPs may be required to pay gain sharing payments to participating providers. To receive a gain sharing payment, a provider would need to achieve a cost of care level lower than historical levels. For this reason, no adjustment is applied in the CY 2019 rate setting process for CPC, as gain sharing payments are assumed to be offset by the cost of care savings achieved by the CPC providers.

- **Dental Program Changes.** Effective July 1, 2018, Silver Diamine Fluoride (SDF) was included as a covered dental benefit in the MMC program for all ages. In addition, effective January 1, 2018, coverage for tobacco cessation and counseling services are a covered dental benefit. Based on information provided by ODM, we estimated coverage of SDF and tobacco cessation to be budget neutral.
- **ESRD Dialysis Clinic Reimbursement Changes.** Effective July 1, 2017, reimbursement for End-Stage Renal Disease (ESRD) clinics are based on the calendar year 2016 prospective payment system (PPS) base rate published by the Centers for Medicare and Medicaid Services (CMS). Reimbursement for services were established as follows:
  - Chronic maintenance dialysis performed in an ESRD dialysis clinic: 58.75% of PPS base rate;
  - Chronic maintenance dialysis performed in a home setting: 25.18% of PPS base rate;
  - Dialysis support services: 33.75% of PPS base rate; and,
  - Dialysis with self-care training: 67.75% of PPS base rate.

We reviewed experience data for applicable services and believe that this program change is not material to the rate development process.

- **Laboratory Contract and Community SUD Treatment Providers.** Effective January 1, 2019, substance use disorder (SUD) providers (provider type 95) with appropriate CLIA certifications will be able to perform on-site laboratory services. Based on information provided by ODM, we do not anticipate that this program adjustment will result in a material increase in laboratory service expenditures.
- **Podiatry Program Change.** Under Ohio Medicaid Rule 5160-7-03, changes were proposed to covered podiatric services to remove the program limit of one LTCF visit per month by a podiatrist, effective November 1, 2018. Based on feedback from ODM, projected expenditures are assumed to be immaterial.
- **Third Party Liability (TPL) Collections.** ODM will contract with HMS for the purpose of pursuing third party liability (TPL) recoveries for MMC claims experience. This collection will occur 12 months after claim payment, at which point the MCP will be unable to obtain these recoveries. We believe this program change will be immaterial to the capitation rate development process.
- **Ventilator Dependent Nursing Facility Rate.** Effective February 1, 2017, ODM began reimbursing nursing facilities for the higher costs associated with caring for individuals who are ventilator-dependent at an elevated per diem rate equal to 60% of the statewide average of the Medicaid per day payment rate for long-term acute care hospital services. We believe that the majority of this program adjustment is reflected in the base data for the MMC program, and the impact associated with January 2017 is estimated to be immaterial.

Each of the program adjustments listed above were determined to be immaterial on a stand-alone basis (i.e., impacted the rates by less than 0.1%). We evaluated the composite impact of all of the immaterial items listed above to assess whether an aggregate impact should be applied in the CY 2019 rate development process. Based on this analysis, the impact of immaterial program adjustments is immaterial on a composite basis (i.e., impacted the rates by less than 0.1%), so no further adjustments were applied.

#### (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 encounter 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 for enrollees aged 21 to 64 associated with an 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 MCPs in 2017. Co-pay amounts were estimated by applying ODM's co-pay policies to the MCP encounter data. Separate adjustments were made for emergency room, dental, vision, and pharmacy categories of service based on the uncollected co-pay amounts as a percentage of CY 2017 expenditures. Co-pay adjustments were not applied to children or pregnant women populations, with the exception of co-pays for vision services for pregnant women. Adjustments to account for uncollected co-pays reduced the base experience data by approximately 0.3%.

### ***Pharmacy Rebates***

Based on an analysis of CY 2017 annual cost report data, retail pharmacy expenditures were reduced by supplemental rebates assumed to be collected by the MCPs. We reviewed CY 2017 historical experience period to assess a reasonably attainable level of supplemental pharmacy rebates. No adjustment for pharmacy rebates was made to the MAT therapeutic class due to ODM's efforts to standardize drug dispensing for this therapeutic class. Supplemental rebates are assumed to vary by population from approximately 3.0% to 6.0% of total pharmacy expenditures.

### ***Third Party Liability/Fraud and Abuse***

In addition to actual cost avoidance reflected in the encounter data, we estimated additional third party liability (TPL) and fraud recoveries based on data available in CY 2017 cost reports and MCP surveys. These data sources indicated that approximately 0.3% of total claims were recovered and not reflected in the baseline experience data. We adjusted encounter baseline data by region to reflect an estimated amount of TPL and fraud recoveries using data reported by the MCPs.

### ***Non-encounter Claims Payment***

We made an adjustment to 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. These adjustments were completed when developing the base encounter data summaries.

### ***Net Reinsurance***

Ohio Administrative Code requires MCPs contracted with ODM for the MMC program to carry reinsurance for high cost inpatient claims. We have adjusted inpatient expenses in the historical period by the net cost of reinsurance (reinsurance premiums less reinsurance recoveries) as reported in the CY 2017 annual cost reports.

The aggregate statewide reinsurance loss ratio for MCPs in CY 2017 was approximately 83% (reinsurance recoveries / reinsurance premiums). A statewide estimated reinsurance premium by rate cell was developed by taking statewide reinsurance recoveries for each rate cell and dividing by the 83% loss ratio. 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 MCP 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. In aggregate, net reinsurance increased projected benefit expenses by approximately 0.1%.

## 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 MCPs 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. Basis for Variation in Assumptions

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

### iii. 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.

### iv. In Lieu Of Services

As noted earlier, ODM began permitting the use of IMDs as an in-lieu-of service 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.

### v. Benefit expenses associated with members residing in an IMD

We reviewed benefit costs for enrollees aged 21 to 64 during the base experience period to identify costs associated with an Institution for Mental Diseases (IMD) stay of more than 15 days in a month and any other MCP costs for services delivered in a month when an enrollee had an IMD stay of more than 15 days. These costs were identified and removed from the encounter data. 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.

### vi. IMDs as an in lieu of service provider

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.

#### (a) Number of Unique Enrollees

We observed a total of approximately 2,225 unique enrollees ages 21-64 who received treatment in an IMD during the CY 2017 base data period.

#### (b) Average Length of Stay

The average length of stay for enrollees ages 21-64 who received treatment in an IMD during CY 2017 was approximately 6 days. The minimum length of stay was 1 day and the maximum length of stay was 24 days. Note that as described above, costs were identified and removed from the encounter data for members with an IMD stay of more than 15 days in a month.

#### (c) IMD Treatment Impact on Capitation Rates

The CY 2019 capitation rates for the MMC program include approximately \$32.5 million in IMD expenditures for enrollees ages 21-64. This estimate reflects the unit cost of Inpatient Psychiatric/SA services for non-teaching hospitals, along with adjustments to reflect observed utilization levels following the implementation of IMDs as an in-lieu-of service during the CY 2017 base data period.

## B. APPROPRIATE DOCUMENTATION

### i. Projected Benefit Costs

This section provides the 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 per member per month (PMPM) cost summaries**

The capitation rates were developed from historical claims and enrollment data from the MMC enrolled populations. This data consisted of CY 2017 incurred encounter data that has been submitted by the MCPs. We relied upon CY 2017 Fee-for-Service (FFS) claims data to develop behavioral health carve-in benefit expenses.

##### **Step 2: Apply data quality adjustments**

We applied data quality adjustments to the CY 2017 incurred encounter data submitted by the MCPs. This process included adjustments for known missing claims reported in CY 2017 MCP Survey submissions. In situations where there are known discrepancies with MCP encounter data, we applied adjustments using CY 2017 annual cost reports submitted by each MCP.

##### **Step 3: Rate cell reassignment**

Effective August 1, 2016, Ohio converted from the status of a 209(b) to a 1634 state for disability determination. As a 209(b) state, Ohio's eligibility determination standard was more restrictive than the criteria used by the Social Security Administration (SSA). Under the 1634 conversion, Ohio has adopted the SSA definition of disability and extended Medicaid eligibility to all individuals who receive Supplemental Security Income (SSI). Individuals with SSI are automatically enrolled in Medicaid.

In developing the adjusted base data for the CY 2019 capitation rates, member rate cells were reassigned based on each member's rate cell as of July 1, 2018. For members included in the CY 2017 encounter data but not enrolled as of July 1, 2018, we reassigned member rate cells based on state data exchange (SDX) files for the state of Ohio. The SDX files contain information related to which MMC enrollees receive SSI. This process produced total benefit expense equal to the CY 2017 incurred encounter data, while reflecting post-1634 member rate cell assignment along with other historical population movement.

##### **Step 4: Apply historical and other adjustments to cost summaries**

As documented in the previous section, utilization and cost per service rates from the base experience period were adjusted for a number of items, including but not limited to: incomplete data adjustments, uncollected co-pays, pharmacy rebates, TPL, and policy and program changes that occurred during CY 2017.

##### **Step 5: Adjust for prospective program and policy changes and trend to calendar year 2019**

We adjusted the CY 2017 base experience for known policy and program changes that have occurred or are expected to be implemented between the base period and the end of the CY 2019 rate period. In the previous section, we documented these items and the adjustment factors for each covered population. Assumed trend factors were applied for 24 months to the adjusted utilization and unit cost values, or per member per month (PMPM) values, as appropriate, from the midpoint of the base experience period (July 1, 2017) to the midpoint of the rate period (July 1, 2019).

As described later in this section, further adjustments were applied to the CY 2017 base experience to reflect targeted improvements in managed care efficiency for specific rate cells and service categories that are estimated to impact projected 2019 benefit expense. The PMPMs resulting from the application of these adjustments established the adjusted benefit expense by population rate cell for the rating period.

## Other material adjustments - managed care efficiency

We calculated percentage adjustments to the experience data 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
- Generic drug dispensing rates by therapeutic class
- Mix of vaginal and cesarean section deliveries in the CY 2017 base period utilization

### Emergency Room

For the outpatient hospital 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. Additionally, potentially avoidable outpatient hospital emergency room visits were summarized by rate cell. Target utilization levels were developed by assuming a 20% decrease in potentially avoidable services.

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. In coordination with determination of the managed care adjustments for hospital outpatient emergency room services, we assumed that 95% of emergency room visits reduced would be replaced with an office visit. Additionally, 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 base year utilization to reflect higher levels of care management relative to the CY 2017 experience period. We identified potentially avoidable admissions using the AHRQ prevention quality indicators (PQI). We also analyzed the frequency of re-admissions for the same DRG. Inpatient hospital managed care adjustments were developed by applying assumed reductions to potentially avoidable inpatient admissions and same-DRG readmissions. This analysis was completed at the population and regional level.

Our analysis was completed at the regional level by first reducing readmissions within 30 days, and then reducing non-readmissions for select PQIs. Inpatient hospital managed care adjustments were developed by applying a 10% reduction to same-DRG readmissions and a 5% reduction to potentially avoidable inpatient admissions. In completing our analysis, we estimated inpatient hospital unit cost changes based on the utilization reductions outlined above. No adjustments were made to corresponding inpatient physician charges to account for the potential shift of these services to an ambulatory setting. Additionally, nursing facility claims were excluded from this analysis.

### Pharmacy Services

We reviewed historical pharmacy experience by therapeutic class for each MCP to estimate achievable generic drug dispensing rates (GDR), generic drug cost per script, and brand drug cost per script. For each therapeutic class, we estimated the impact of improvements in GDR and cost per script amounts by repricing MCP historical experience to levels achieved by other MCPs during the same time period. In addition, our review of historical pharmacy experience for managed care efficiencies included a review of the number of prescriptions that each member was taking during the CY 2017 base experience period. The goal of this efficiency adjustment is to identify users with excessive prescriptions and identify opportunities for reduction. We separated the experience into two categories: 10-14 scripts per month and 15+ scripts per month. Based on clinical evaluation of this adjustment, we established thresholds of reduction of 2 scripts per month for those over 15 scripts per month and removal of 1 script for those in the 10-14 category. We developed pharmacy managed care efficiency adjustments by rate cell to reflect mix differences by therapeutic class due to the age, gender, and morbidity of the applicable rate cell.

### Maternity Delivery Kick Payment

We reviewed the mix of vaginal and cesarean section deliveries by MCP 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 MCP and region. Vaginal delivery percentages were adjusted to levels achieved by MCPs with at least 1,000 deliveries in a region, with a minimum assumed percentage of 70%. This analysis resulted in shifting approximately 1.0% of CY 2017 deliveries from cesarean to vaginal. 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 this rate certification report and the overall methodology utilized to develop the capitation rates is consistent with the prior rate-setting analysis.

### 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 historical base period (CY 2017) to the CY 2019 rating period of this certification. 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 three years of cost and utilization experience, from CY 2015 through the base experience data period (CY 2017).

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<sup>3</sup>, 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 this certification, we are interested only in unit cost and utilization trends, so in general, our combinations of unit cost and utilization trends should be lower than NHE trends.
- *Express Scripts 2017 Drug Trend Report (February 2018)*<sup>4</sup>.
- *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 morbidity changes. We used linear regression to project experience during the contract period. Contract period projections were compared to base period experience to determine an appropriate annualized trend. For BH carve-in services, we relied on historical FFS data for these services. Additional details related to key aspects of the trend development process are outlined below.

#### **Inpatient Unit Cost Trends**

As previously mentioned, an explicit adjustment has been made for changes in ODM's inpatient APR-DRG fee schedule from the CY 2017 base experience period to the fee schedule that will be in place during CY 2019. This adjustment did not include the impact of outlier payment inflation.

<sup>3</sup> <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsprojected.html>

<sup>4</sup> <http://lab.express-scripts.com/lab/drug-trend-report/2017-dtr>

For inpatient unit cost trends, we used CY 2017 inpatient encounter data experience adjusted to the fee schedule that will be in place during CY 2019 to evaluate the impact of cost inflation due to outlier payments. We trended reported costs from the admission date to the midpoint of the rate period (July 1, 2019) at an annualized trend rate of six percent. The 6% annualized trend was applied to project the billed charges component of inpatient outlier payments to the midpoint of the rate period. This annualized trend rate was not utilized for any other purposes. We developed this assumption based on information from the Milliman Health Cost Guidelines™. The estimated change in inpatient cost as a result of outlier inflation was used in the development of inpatient unit cost trend assumptions.

### ***Pharmacy trends***

We developed a Medicaid Pharmacy model (trend model) for the purposes of studying and projecting detailed pharmacy trend information. The trend model summarizes pharmacy claims data by month, drug type (brand, generic, specialty brand, and specialty generic), covered population, and therapeutic class (according to GPI-4 assignments). Projected values were estimated using the base period data as a starting point and applying anticipated shifts and trends. There are several areas for consideration.

#### *Brand patent loss*

When a brand drug loses patent, the utilization often shifts from the brand drug to the new generic alternatives. Our model assumes effective dates of patent expirations and a shifts in utilization as a result of patent loss.

#### *Cost per script trends*

Projected costs per script in the first month of the projection period are based on the average costs per script in the most recent three months of the experience period, adjusted for any anomalies in the data. These costs are trended forward using separate cost trend assumptions by therapeutic class for brand, generic, and specialty products.

In developing cost trends, we relied on a combination of Milliman research, publicly available industry trend reports, and the historical average wholesale price (AWP) trends using MMC encounter data. Generic drugs, which historically had modest price increases, have experienced more significant price increases in recent years, due to ingredient shortages, changes to legislation, and consolidation of generic manufacturers resulting in reduced competition. However, this pattern has begun to slow, and generic trends are expected by the industry to return to more typical levels over the next few years. As a result, generic cost trends were dampened for therapeutic classes that experienced significant price increases in recent years.

#### *Changes in utilization*

Utilization levels for the first month of the projection period are based on the average utilization in the most recent six months of the experience period, adjusted for any anomalies in the data. We applied monthly utilization trends to this starting point to estimate the projection period utilization. To develop utilization trend assumptions, we relied on a combination of Milliman research, publicly available industry trend reports, and the historical utilization trends developed using MMC encounter data. Monthly seasonality is accounted for in our trend development.

#### *Hepatitis C Virus (HCV) Trends*

We examined detailed HCV claims data separately from our typical trend work. As discussed previously, we considered the impact of changes to the Hepatitis C Fibrosis Level Protocol. In addition, we assumed continued unit cost savings for hepatitis C drugs based on achieving the average unit cost of Mavyret, or approximately \$12,000 per script.

### **(iii) Comparisons**

Historical trends should not be used in a simple formulaic manner to determine future trends; a great deal of actuarial judgment is also needed. We did not explicitly rely on the historical MCP encounter data trend experience due to anomalies observed in the historical trend data. We referred to the sources listed in the prior

section as well as considered changing practice patterns, the impact of reimbursement changes on utilization in the MMC population, and shifting population mix.

Explicit adjustments were made outside of trend to reflect all recent or planned changes in reimbursement from the base period to the rating period.

#### iv. Mental Health Parity and Addiction Equity Act Service Adjustment

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 final results, we have not made any rating adjustments to accommodate parity compliance.

#### v. In Lieu of Services

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. IMD as an in-lieu-of service represents approximately 15% of the "Inpatient Psychiatric/SA" service category, and is not included in any other service categories.

#### vi. Retrospective Eligibility Periods

##### (a) MCO responsibility

Under the ODM contract, beginning April 1, 2016, the MCPs became responsible for retrospective eligibility periods when the beneficiary was previously enrolled with an MCP in the MMC program less than 90 days prior to re-enrolling with an MCP. ODM will provide capitation payments to the MCPs for beneficiaries meeting this criteria. We reviewed historical eligibility meeting the MCP retro-active eligibility criteria, as well as associated FFS expenses, and did not observe material or consistent cost differences between retro-active eligibility member months (meeting the specific 90 day criteria) and managed care member months. We have not adjusted the estimated benefit expense included in the rates for the retrospective eligibility policy change. FFS claims incurred during retrospective eligibility periods have been excluded from the base data.

##### (b) Claims treatment

As noted earlier, claims for retrospective eligibility periods are not reflected in the base data.

##### (c) Enrollment treatment

Enrollment is treated consistently with claims. We have not included retrospective eligibility in the base experience period.

##### (d) Adjustments

As previously mentioned, no explicit adjustment was applied for the CY 2019 rate setting.

## 4. Special Contract Provisions Related to Payment

### A. INCENTIVE ARRANGEMENTS

#### i. Rate Development Standards

This section provides documentation of the incentive payment structure in the MMC program.

## ii. Appropriate Documentation

Incentive payments under this plan are below 105% of the certified capitation rates paid under the contract. Effective April 1, 2018, an incentive pool is determined by the portion of withhold that is not returned to the MCPs after a first pass review. By design, the incentive amount represented by the bonus pool is significantly less than 5% of the certified rates.

## 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 and purpose

Effective April 1, 2018, ODM implemented a quality withhold arrangement for the MMC program. The withhold arrangement is measured on a calendar year basis. The withhold measures are primarily based on Healthcare Effectiveness Data and Information Set (HEDIS) metric benchmarks.

##### (ii) Description of total percentage withheld

Effective April 1, 2018, ODM established a quality withhold of 2.0% of the capitation, and will determine the return of the withhold based on review of each MCP's data relative to the applicable HEDIS benchmarks. The capitation rates shown in this letter are illustrated before offset for the withhold amount; however, the CY 2019 capitation rates documented in this report are actuarially sound while considering the amount of the withhold not expected to be earned.

##### (iii) Estimate of percent to be returned

Based on our review of MCPs' historical performance relative to the applicable HEDIS metric benchmarks, along with information provided by ODM, we believe that a full withhold return is attainable by the MCPs.

##### (iv) Reasonableness of withhold arrangement

Our review of the total withhold percentage of 2.0% 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 MCP's financial operating needs and capital reserves. Our interpretation of financial operating needs relates to cash flow needs for the MCP to pay claims and administer benefits for its covered population. We evaluated the reasonableness of the withhold within this context by reviewing the MCP's cash available to cover operating expenses, as well as the capitation rate payment mechanism utilized by ODM.

##### (v) Effect on the capitation rates

The rate is certified as actuarially sound after adjustment for the amount of the withhold not expected to be earned back.

## 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

ODM maintains a cost-neutral risk pool for high cost Hepatitis C drugs. The risk pool was introduced for the CY 2015 MMC rates to address the high cost nature of Hepatitis C treatment and the potential for the prevalence of treated Hepatitis C beneficiaries to vary between MCPs. To the extent an MCP receives a higher proportion of Hepatitis C drug expenditures in relation to other MCPs, the MCP will receive additional reimbursement from the risk sharing pool. Conversely, an MCP receiving a lower portion of Hepatitis C drug expenditures will be required to pay into the risk sharing pool. The development of the risk pool does not impact the capitation rate development process.

#### (i) Methodology

The CY 2019 Hepatitis C drug risk pool aggregate amounts will be developed using the estimated CY 2019 Hepatitis C drug benefit expense PMPM included in the CY 2019 capitation rates, multiplied by the actual CY 2019 membership on a region and rate cell basis. The estimated CY 2019 Hepatitis C drug PMPM is developed on a prospective basis and is based on a review of historical Hepatitis C drug expenditures through June 2018. Program and policy changes developed for the CY 2019 MMC rates impacting Hepatitis C expenditures were applied to the base experience.

Consistent with the prior capitation rates, the estimated CY 2019 Hepatitis C drug PMPM is based on the historical Hepatitis C drug expenditures, with no smoothing adjustment across region or rate cell. Therefore, certain region and rate cell combinations may have estimated CY 2019 Hepatitis C drug expenditures while other similar region and rate cell combinations may have zero or significantly lower estimated CY 2019 Hepatitis C drug expenditures.

Please note that the estimated CY 2019 Hepatitis C drug PMPM will not be updated with actual CY 2019 Hepatitis C drug experience, but the actual CY 2019 membership will be used to develop the aggregate expenditures to be redistributed as part of the Hepatitis C drug risk pool reconciliation.

#### (ii) Schedule of risk pool submissions

The following table illustrates the expected timeline for implementation of the CY 2019 Hepatitis C drug risk pools:

Ohio Department of Medicaid Medicaid Managed Care Program Capitation Rates Effective January 1, 2019 Timeline for Hepatitis C Drug Risk Pools		
Function	Interim	Final
Prescription Dates of Service	January – June 2019	January – December 2019
Prescription Paid Date	September 30, 2019	March 31, 2020
Prescription Submission Date	October 2019 cut-off	April 2020 cut-off
MCP Distribution Calculation	December 15, 2019	June 15, 2020
MCP Payment and Recoupment	December 30, 2019	June 30, 2020

#### (iii) Attestation of the use of generally accepted actuarial principles and practices

The CY 2019 Hepatitis C risk pools were developed in accordance with generally accepted actuarial principles and practices.

### (b) Medical Loss Ratio

#### **Description**

ODM's provider agreement indicates that ODM will perform medical loss ratio (MLR) calculations for the MMC program. This includes the ABD, CFC, AFK, and Extension populations.

#### **Financial consequences**

There are no financial consequences associated with MLR requirements.



### (c) Reinsurance Requirements and Effect on Capitation Rates

Ohio Administrative Code requires MCPs contracted with ODM for the MMC program to carry reinsurance for high cost inpatient claims.<sup>5</sup> We have adjusted inpatient expenses in the historical period by the net cost of reinsurance (reinsurance premiums less reinsurance recoveries) as reported in the 2017 annual cost report data. Reinsurance recoveries were based on amounts reported in MCP cost report data.

## D. DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

### i. Rate Development Standards

Consistent with guidance in 42 CFR §438.6(c), the CY 2019 MMC capitation rates reflect consideration of the Care Innovation and Community Improvement Program (CICIP).

### ii. Appropriate Documentation

#### (a) Description of Delivery System and Provider Payment Initiatives

##### (i) Description of delivery system and provider payment Initiatives included in the capitation rates

Effective July 1, 2018, the Care Innovation and Community Improvement Program (CICIP) was developed to increase alignment of quality improvement strategies and goals between ODM, MCPs, 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 per member per month (PMPM) payments are made to eligible hospital agencies from the MCPs. 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.

##### (ii) Amount of delivery system and provider payment Initiatives included in the capitation rates

We estimated total payments for CICIP through the use of historical utilization and cost data provided by ODM for calendar year 2017. The difference between MCP payments and the average commercial rate (ACR) of 308.57% was used to establish CICIP payments. The total CICIP payment amounts were converted to a PMPM basis for application in the capitation rates. After the PMPM payment amounts were determined, they were reduced by 10% prior to inclusion in the CY 2019 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 calculation of the incentive pool 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. The CY 2019 capitation rates include PMPM amounts for CICIP, which vary by region and rate cell.

<sup>5</sup> <http://codes.ohio.gov/oac/5160-26-09>

### **(iii) Providers receiving delivery system and provider payment initiatives**

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.

### **(iv) Description of consistency with 438.6(c) preprint**

We confirm that CICIP as described in this certification is consistent with the final approved 438.6(c) pre-print.

## **E. PASS-THROUGH PAYMENTS**

*MCP Hospital Incentive Payments:* The MCP Hospital Incentive program was developed to incentivize hospitals to contract with the MCPs, as the State’s approved hospital supplemental upper payment limit program appeared to be creating an incentive for hospitals to want their payments delivered under the FFS program. Hospitals that have an active MCP contract are eligible to receive a payment.

### **i. Rate Development Standards**

This section provides information on the pass-through payments reflected in the CY 2019 capitation rates.

### **ii. Appropriate Documentation**

#### **(a) Description of Pass-Through Payments**

##### **(i) Description**

The total computable funding for the program is appropriated by Ohio’s General Assembly from the State’s General Revenue Fund. The MCP/Hospital Incentive program was developed to incentivize hospitals to contract with the MCPs, as the State’s approved hospital supplemental upper limit payment program appeared to be creating an incentive for hospitals to want their payments delivered under the FFS program. Hospitals that have an active MCP contract and provide inpatient services are eligible to receive a payment. The basis for the distribution of the MCP/Hospital Incentive payment in the capitation rates is an allocation based on the non-nursing home inpatient costs associated with each rate group/rating region combination exclusive of Extension, AFK, and maternity delivery kick payment rate cells.

##### **(ii) Amount**

The total computable funding for the program is appropriated by Ohio’s General Assembly from the State’s General Revenue Fund. For CY 2019, the amount is assumed to be \$162 million, excluding additional taxes and fees that are applied to the appropriation amount.

##### **(iii) Providers receiving the payment**

Hospitals that have an active MCP contract are eligible to receive a payment.

##### **(iv) Financing mechanism**

As referenced above, the total computable funding for the program is appropriated by Ohio’s General Assembly from the State’s General Revenue Fund.

##### **(v) Pass-through payments for previous rating period**

Appropriated amounts for the MCP/Hospital Incentive program were set at \$162 million in aggregate for each of calendar years 2014 through 2018.

**(vi) Pass-through payments for rating period in effect on July 5, 2016**

The rating period in effect on July 5, 2016 was the CY 2016 rating period. Appropriated amounts for the MCP/Hospital Incentive program were set at \$162 million in aggregate.

**(b) Hospital Pass-Through Payments**

Based on information provided by ODM, the \$162 million associated with the MCP/Hospital Incentive will result in total inpatient hospital expenditures materially below the amount Medicare FFS would have paid for the services. To determine the phasing out of the MCP Hospital Incentive payment in accordance with the Final Medicaid managed care regulations, ODM requested that we estimate the hospital upper payment limit (UPL) for the MMC program. To support this request, ODM provided us with the state fiscal year (SFY) 2017 FFS hospital UPL demonstration. We estimated the hospital UPL for the MMC program by calculating a UPL factor based on the FFS UPL demonstration. This UPL factor was then applied to managed care expenditures, repriced to Medicaid FFS reimbursement, for the purpose of estimating the managed care UPL. The MMC hospital UPL estimate developed under this approach produced a base amount for the MMC program of approximately \$2.1 billion (based on CY 2016 MMC program experience).

Based on this information, we believe that the \$162 million associated with the MCP Hospital Incentive will result in total hospital expenditures materially below the maximum amount allowable under the Final Medicaid managed care regulations.

**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 MCP 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.

**iii. Basis for variation in assumptions**

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

**iv. Health insurance providers fee**

Detail regarding the health insurance providers fee is provided in a later section of this letter.

**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 2019 non-benefit costs are listed below:

- Annual cost report data submitted by the MCPs.
- CY 2017 MCP Survey completed by each MCP.
- Statutory financial statement data for each of the MCPs.

- Average costs from the financial statements of Medicaid health plans nationally, as summarized by Palmer, Pettit, and McCulla. These reports date from 2012 through 2018, analyzing financial results from 2011 through 2017.<sup>6</sup>

### ***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.

Historical reported administrative expenses were reconciled between the available data sources for the purpose of evaluating the quality of the data provided. CY 2017 cost report administrative expenses were analyzed by MCP for reasonableness and completeness of the data provided. This data formed the baseline for projected 2019 administrative expense amounts. There is a significant amount of variation in the reporting of administrative expenses between the five MCPs, both in the magnitude of administrative expenses and in the rate cell allocation methodology utilized. We summarized historical reported values for each MCP and reallocated these values using a percent of revenue before taxes allocation methodology. Separate administrative expense amounts were developed for CFC Children, ABD <21, ABD 21+, Delivery, AFK, and the adult CFC/EXT populations.

Effective January 1, 2019, ODM will require that MCP contracting arrangements with pharmacy benefit managers (PBM) be structured as a pass-through pricing model, consistent with the definition included in Appendix C of the Provider Agreement. Prior to January 1, 2019, MCP PBM contracts were structured as a spread-pricing arrangement. As a result of this program adjustment, an amount equal to \$3 per script was added to non-benefit expense amounts to account for PBM admin previously included in spread-pricing. In addition, non-benefit expense amounts were developed with consideration for sub capitated administrative expense amounts included in MCP cost report submissions.

### **(b) Material changes**

Projected non-benefit costs for CY 2019 include consideration for PBM administrative expenses previously included in pharmacy spread-pricing; estimated to be \$3 per script on average. There are no other material changes to the data, assumptions, or methodology used to develop the projected non-benefit cost.

### **(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 MCP cost reports and financial statement data. The CY 2019 non-benefit cost allowance is determined as a percentage of the capitation rates before fees and taxes.

In addition, CY 2019 capitation rates include amounts for the following non-benefit expense:

- **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 MCPs for the purposes of developing strategies and systems that will provide enhanced maternal case management and reduce infant mortality rates. Funding to support MCP initiatives for the program is included in the applicable regions and female rate cells. A total of \$13.4 million was added to four female CFC 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.

<sup>6</sup> The 2018 report analyzing administrative costs for 2017 can be found at: <http://www.milliman.com/insight/2018/Medicaid-managed-care-financial-results-for-2017/>

- **MCP Hospital Incentive:** A total of \$162 million was added to CFC and ABD non-delivery rate cells, before fees and taxes, for the MCP Hospital Incentive payment. This amount was allocated based on total projected inpatient claims by region and rate cell.
- **HUB Contracting Requirements:** We included care management amounts under the delivery kick payment in five regions to account for the Pathways Community HUB (HUB) contracting requirements (North Central, Northwest, Southwest, Northeast Central, and Northeast). Care management to account for HUB contracting requirements is 2.5% of the delivery kick payment, consistent with the prior rate-setting.

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 MCP based on projected Medicaid member months for January through June 2019, and then weighted based on regional enrollment by MCP. As the HIC Franchise Fee is assessed on a state fiscal year basis, we anticipate amending the CY 2019 capitation rates to reflect HIC Franchise Fee amounts applicable to July through December 2019. The HIC tax will remain at 1% of total capitation.

### iii. Health insurance providers fee

#### (a) Whether the fee is incorporated in the rates

Consistent with ODM's payment of the Health Insurer Fee (HIF) in prior years, CY 2019 rates will be amended based on the calculated HIF attributable to ODM premium revenue. To the extent the actual paid HIF is less than the calculated HIF, the rates for the MCP will be amended based on actual paid HIF.

#### (b) Fee year or data year

The HIF for each insurer is calculated based on the data year. The adjusted CY 2019 rates will be based on the 2020 HIF attributable to the 2019 data year.

#### (c) Determination of fee impact to rates

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

#### (d) Timing of adjustment for health insurance providers fee

The 2019 capitation rates will be amended based on the 2020 HIF attributable to the 2019 data year. We anticipate developing the rate adjustment in the last quarter of CY 2020.

#### (e) Identification of long-term care benefits

An estimated percentage of each capitation rate cell that is attributable to long-term care services as described in 26 CFR 57.2(h)(2)(ix) will be estimated for the purposes of the HIF payment.

#### (f) Application of health insurance providers fee in 2014, 2015, and 2016 capitation rates

The MCPs were required to pay the HIF in 2014, 2015, and 2016. For each year, the initially certified capitation rates were adjusted to include the HIF and associated income tax impacts to reflect the non-tax-deductibility of the HIF.

## 6. Risk Adjustment and Acuity Adjustments

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 CFC, ABD, Extension, and AFK populations will be prospectively risk adjusted by MCP on a regional basis to reflect estimated prospective morbidity differences in the underlying population enrolling with each MCP.

### ii. Risk adjustment model

Risk adjustment will be performed using CDPS + Rx version 6.3. Risk adjustment will be performed on a budget neutral basis at the region and rate cell level. Newborns, one year olds, and delivery kick payments will be excluded from the risk adjustment process.

### iii. Acuity adjustments

Acuity adjustments are not applicable to the CY 2019 capitation rates.

## B. APPROPRIATE DOCUMENTATION

### i. Prospective risk adjustment

#### (a) Data and adjustments

The January 1, 2019 through June 30, 2019 rate period will be risk adjusted based on a diagnosis and prescription drug collection period including incurred (dispensed) dates from January 1, 2017 through December 31, 2017, paid through June 30, 2018. The risk adjustment diagnosis base data will exclude diagnosis codes associated with diagnostic testing and certain medical supply codes.

The risk adjustment process will account for the variation in HIC Franchise Fee payments by MCP. Prospective risk scores will be applied to the CY 2019 capitation rates less CICIP, HIC Franchise Fee, and HIC tax amounts. We will then apply CICIP amounts along with MCP-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 MCP. This includes the newborn and one-year-old rate cells.

#### (b) Risk adjustment model

Populations will be risk-adjusted using CDPS+Rx risk scoring models. We will provide full documentation of the results and methodology for the risk adjustment analysis in a separate correspondence.

#### (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 MCPs. The risk adjustment methodology uses generally accepted actuarial principles and practices.

## Section II. New adult group capitation rates

ODM implemented the Affordable Care Act's Medicaid expansion on January 1, 2014. As of July 2018, approximately 600,000 individuals receive Medicaid benefits through MCPs under ODM's expansion population, known as the 'Extension' population.

### 1. Data

#### A. DATA USED IN CERTIFICATION

The source of data used to develop the Extension capitation rates for CY 2019 was identical to the source of data used in the development of rates for the ABD, CFC, and AFK populations: encounter data submitted by the contracted MCPs.

#### B. 2017 EXPERIENCE VS. ASSUMPTIONS

ODM has monitored enrollment and costs in the Extension population on an on-going 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 MCPs on a quarterly basis. Actual MCP-covered member months were approximately 2.1% above values estimated in the development of the 2017 rates. On an aggregate basis, actual benefit expense was approximately 1.0% lower than estimated benefit expense included in the rates.

### 2. Projected Benefit Costs

#### A. DESCRIPTION OF PROJECTED BENEFIT COST ISSUES

CY 2017 Extension population experience, in the form of adjusted encounter data, is used as the underlying data source for the development of the CY 2019 capitation rates. In developing the adjusted base data for the CY 2019 capitation rates, rate cells were reassigned based on each member's rate cell as of July 1, 2018. This process is consistent with the methodology used in developing the CY 2018 capitation rates for the Extension population. The data sources, assumptions, and methodologies are generally consistent with the CY 2018 certification and the July amendment to the CY 2018 certification.

Discussion of other assumption changes is provided in the next section.

#### B. DESCRIPTION OF KEY ASSUMPTION

**Adjustments for pent-up demand** – Consistent with the CY 2018 rate setting, it was assumed that the baseline experience data did not require these adjustments.

**Adjustment for adverse selection** – Consistent with the CY 2018 rate setting, it was assumed that the baseline experience data did not require these adjustments.

**Adjustment for demographics of the new adult group** – The current rate cell structure of the Extension population appropriately adjusts capitation payments to the MCPs to the extent the demographic mix of the Extension population changes significantly during the CY 2019 rate period.

**Differences in provider reimbursement rates or provider networks** – MCPs were required to report provider reimbursement relative to ODM's reimbursement schedule by population group (CFC, ABD <21, ABD 21+, Extension, and AFK) and major service category in the 2017 MCP Survey. Additionally, we received re-priced inpatient and outpatient claims experience from ODM that allowed us to evaluate MCP hospital reimbursement relative to ODM's reimbursement schedule. We are not aware of any provider network differences between the Extension 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.

## C. CHANGES TO BENEFIT PLAN

As outlined in the July 2018 amendment to the certified CY 2018 capitation rates, behavioral health services were carved-in to the MMC program on July 1, 2018. No other benefit changes have been made to the Extension 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 Extension rate development process other than those previously outlined in the 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 2017. We used this information to evaluate the reasonableness of our non-benefit expense assumptions for the Extension population. The non-benefit expense percentage loads have been set equal for the CFC Adult and Extension populations in the development of the CY 2019 rates. This assumption is consistent with the prior certification.

Effective January 1, 2019, ODM will require that MCP contracting arrangements with pharmacy benefit managers (PBM) be structured as a pass-through pricing model, consistent with the definition included in Appendix C of the Provider Agreement. Prior to January 1, 2019, MCP PBM contracts were structured as a spread-pricing arrangement. As a result of this program adjustment, an amount equal to \$3 per script was added to non-benefit expense amounts to account for PBM administrative expenses previously included in spread-pricing.

### B. ASSUMPTION DIFFERENCES RELATIVE TO OTHER MEDICAID POPULATIONS

As stated previously, non-benefit expense assumptions for the Extension population were set equal to the CFC Adult population.

## 4. Final Certified Rates or Rate Ranges

### A. COMPARISON TO PREVIOUS CERTIFICATION

On an aggregate basis, the July 2018 Extension rates are estimated to decrease by 0.5%.

### B. DESCRIPTION OF OTHER MATERIAL CHANGES TO THE CAPITATION RATES

We have addressed all material changes to the Extension rate development methodology.

## 5. Risk Mitigation Strategies

### A. DESCRIPTION OF RISK MITIGATION STRATEGY

ODM's provider agreement indicates that ODM will perform MLR calculations for the MMC program. This includes the ABD, CFC, AFK, and Extension populations. There are no financial consequences associated with MLR requirements.

### B. CHANGES TO RISK MITIGATION STRATEGY RELATIVE TO PRIOR YEARS

The MLR calculation for CY 2018 will be performed in early 2019; however, consistent with the prior certification there will be no MLR rebate requirements for the Extension program in CY 2019.



## Limitations

The information contained in this report has been prepared for the Ohio Department of Medicaid (ODM) to provide documentation of the development of the calendar year 2019 actuarially sound capitation rates for the Medicaid Managed Care Program (MMC). The data and information presented may not be appropriate for any other purpose.

The information contained in this letter, including the enclosures, has been prepared for ODM and their consultants and advisors. It is our understanding that the information contained in this letter will be shared with CMS and may be utilized in a public document. Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter 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 letter must rely upon their own experts in drawing conclusions about the capitation rates, assumptions, and trends.

Milliman has relied upon certain data and information provided by ODM and the participating Medicaid MCPs in the development of the calendar year 2019 capitation rates. Milliman has relied upon ODM and the MCPs for the accuracy of the data and accept it without audit. To the extent that the data provided is not accurate, the capitation rate development would need to be modified to reflect revised information.

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

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

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The 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: 2019 Rate Change Summaries

**Ohio Department of Medicaid  
Medicaid Managed Care Program  
Capitation Rates Effective January 1, 2019  
Calendar Year 2019 Rate Change Summary**

**Region: North Central**

<b>Rate Cell</b>	<b>Projected Member Months / Deliveries</b>	<b>July 2018 Capitation Rate</b>	<b>Calendar Year 2019 Capitation Rate</b>	<b>% Change</b>
<b>CFC</b>				
HF/HST <1 M+F	57,617	\$ 842.78	\$ 915.19	8.59%
HF/HST 1 M+F	51,098	174.92	153.67	(12.15%)
HF/HST 2-13 M+F	549,995	175.87	163.95	(6.78%)
HF/HST 14-18 M	87,474	237.38	217.39	(8.42%)
HF/HST 14-18 F	89,089	293.69	273.21	(6.97%)
HF 19-44 M	56,367	323.02	340.84	5.52%
HF 19-44 F	231,316	444.98	439.34	(1.27%)
HF 45+ M+F	33,983	652.45	615.94	(5.60%)
HST 19-64 F	17,979	562.72	605.49	7.60%
<b>Subtotal CFC</b>	<b>1,174,918</b>	<b>\$ 301.79</b>	<b>\$ 295.14</b>	<b>(2.20%)</b>
<b>Extension</b>				
EXT 19-34 M	87,191	\$ 393.68	\$ 409.38	3.99%
EXT 19-34 F	87,510	430.90	444.13	3.07%
EXT 35-44 M	44,928	585.86	573.71	(2.07%)
EXT 35-44 F	39,360	667.38	712.04	6.69%
EXT 45-54 M	42,819	784.29	757.17	(3.46%)
EXT 45-54 F	46,810	850.46	827.60	(2.69%)
EXT 55-64 M	37,224	936.58	867.62	(7.36%)
EXT 55-64 F	42,482	912.11	854.86	(6.28%)
<b>Subtotal EXT</b>	<b>428,324</b>	<b>\$ 634.16</b>	<b>\$ 626.01</b>	<b>(1.29%)</b>
<b>ABD</b>				
ABD <21	50,718	\$ 905.62	\$ 823.12	(9.11%)
ABD 21+	132,833	1,759.32	1,655.48	(5.90%)
<b>Subtotal ABD</b>	<b>183,551</b>	<b>\$ 1,523.43</b>	<b>\$ 1,425.49</b>	<b>(6.43%)</b>
<b>AFK</b>	<b>28,937</b>	<b>\$ 487.49</b>	<b>\$ 456.74</b>	<b>(6.31%)</b>
<b>CFC &amp; EXT Delivery</b>	<b>3,635</b>	<b>\$ 5,797.37</b>	<b>\$ 5,631.01</b>	<b>(2.87%)</b>
<b>Total</b>	<b>1,815,730</b>	<b>\$ 518.26</b>	<b>\$ 501.31</b>	<b>(3.27%)</b>

**Ohio Department of Medicaid  
Medicaid Managed Care Program  
Capitation Rates Effective January 1, 2019  
Calendar Year 2019 Rate Change Summary**

**Region: Northwest**

<b>Rate Cell</b>	<b>Projected Member Months / Deliveries</b>	<b>July 2018 Capitation Rate</b>	<b>Calendar Year 2019 Capitation Rate</b>	<b>% Change</b>
<b>CFC</b>				
HF/HST <1 M+F	40,459	\$ 821.86	\$ 913.10	11.10%
HF/HST 1 M+F	34,814	159.79	167.18	4.62%
HF/HST 2-13 M+F	368,478	152.15	141.88	(6.75%)
HF/HST 14-18 M	59,660	224.40	221.44	(1.32%)
HF/HST 14-18 F	62,251	242.34	236.65	(2.35%)
HF 19-44 M	35,659	312.62	325.82	4.22%
HF 19-44 F	134,004	426.30	427.44	0.27%
HF 45+ M+F	19,342	645.81	591.37	(8.43%)
HST 19-64 F	13,519	520.50	519.65	(0.16%)
<b>Subtotal - CFC</b>	<b>768,186</b>	<b>\$ 274.87</b>	<b>\$ 273.82</b>	<b>(0.38%)</b>
<b>Extension</b>				
EXT 19-34 M	42,298	\$ 394.67	\$ 407.47	3.24%
EXT 19-34 F	49,094	415.85	440.31	5.88%
EXT 35-44 M	22,626	590.74	558.32	(5.49%)
EXT 35-44 F	24,526	675.44	673.67	(0.26%)
EXT 45-54 M	21,694	863.90	812.95	(5.90%)
EXT 45-54 F	27,800	904.78	917.93	1.45%
EXT 55-64 M	20,692	922.09	978.81	6.15%
EXT 55-64 F	26,385	878.11	882.20	0.47%
<b>Subtotal - Extension</b>	<b>235,115</b>	<b>\$ 651.53</b>	<b>\$ 657.94</b>	<b>0.98%</b>
<b>ABD</b>				
ABD <21	21,206	\$ 840.72	\$ 845.44	0.56%
ABD 21+	56,358	1,527.93	1,466.43	(4.03%)
<b>Subtotal - ABD</b>	<b>77,564</b>	<b>\$ 1,340.05</b>	<b>\$ 1,296.65</b>	<b>(3.24%)</b>
<b>AFK</b>	<b>11,782</b>	<b>\$ 470.02</b>	<b>\$ 483.39</b>	<b>2.84%</b>
<b>CFC &amp; EXT Delivery</b>	<b>2,344</b>	<b>\$ 4,976.46</b>	<b>\$ 5,317.38</b>	<b>6.85%</b>
<b>Total</b>	<b>1,092,647</b>	<b>\$ 444.32</b>	<b>\$ 442.75</b>	<b>(0.35%)</b>

**Ohio Department of Medicaid**  
**Medicaid Managed Care Program**  
**Capitation Rates Effective January 1, 2019**  
**Calendar Year 2019 Rate Change Summary**

**Region: Southwest**

<b>Rate Cell</b>	<b>Projected Member Months / Deliveries</b>	<b>July 2018 Capitation Rate</b>	<b>Calendar Year 2019 Capitation Rate</b>	<b>% Change</b>
<b>CFC</b>				
HF/HST <1 M+F	216,363	\$ 921.57	\$ 1,016.37	10.29%
HF/HST 1 M+F	195,793	199.90	194.66	(2.62%)
HF/HST 2-13 M+F	2,125,364	178.39	175.70	(1.51%)
HF/HST 14-18 M	339,931	245.92	240.20	(2.33%)
HF/HST 14-18 F	348,824	288.01	280.85	(2.49%)
HF 19-44 M	202,122	296.59	317.86	7.17%
HF 19-44 F	815,887	416.77	417.41	0.15%
HF 45+ M+F	128,285	641.04	608.71	(5.04%)
HST 19-64 F	70,131	498.31	522.97	4.95%
<b>Subtotal - CFC</b>	<b>4,442,700</b>	<b>\$ 296.87</b>	<b>\$ 299.51</b>	<b>0.89%</b>
<b>Extension</b>				
EXT 19-34 M	317,238	\$ 372.02	\$ 397.64	6.89%
EXT 19-34 F	313,243	419.41	430.22	2.58%
EXT 35-44 M	170,921	559.90	589.01	5.20%
EXT 35-44 F	151,799	661.46	670.97	1.44%
EXT 45-54 M	164,780	773.38	755.77	(2.28%)
EXT 45-54 F	175,209	846.05	830.88	(1.79%)
EXT 55-64 M	140,075	888.76	849.74	(4.39%)
EXT 55-64 F	162,811	854.31	872.10	2.08%
<b>Subtotal - Extension</b>	<b>1,596,076</b>	<b>\$ 616.99</b>	<b>\$ 623.13</b>	<b>1.00%</b>
<b>ABD</b>				
ABD <21	156,428	\$ 1,269.49	\$ 1,146.33	(9.70%)
ABD 21+	407,003	1,633.32	1,617.97	(0.94%)
<b>Subtotal - ABD</b>	<b>563,431</b>	<b>\$ 1,532.31</b>	<b>\$ 1,487.03</b>	<b>(2.96%)</b>
<b>AFK</b>	<b>110,387</b>	<b>\$ 527.98</b>	<b>\$ 615.81</b>	<b>16.64%</b>
<b>CFC &amp; EXT Delivery</b>	<b>12,843</b>	<b>\$ 5,434.81</b>	<b>\$ 5,339.38</b>	<b>(1.76%)</b>
<b>Total</b>	<b>6,712,594</b>	<b>\$ 490.88</b>	<b>\$ 491.55</b>	<b>0.14%</b>

**Ohio Department of Medicaid  
Medicaid Managed Care Program  
Capitation Rates Effective January 1, 2019  
Calendar Year 2019 Rate Change Summary**

**Region: South Central**

<b>Rate Cell</b>	<b>Projected Member Months / Deliveries</b>	<b>July 2018 Capitation Rate</b>	<b>Calendar Year 2019 Capitation Rate</b>	<b>% Change</b>
<b>CFC</b>				
HF/HST <1 M+F	188,260	\$ 1,126.97	\$ 1,244.81	10.46%
HF/HST 1 M+F	177,571	245.60	215.61	(12.21%)
HF/HST 2-13 M+F	1,836,014	179.34	183.89	2.54%
HF/HST 14-18 M	290,569	226.12	269.22	19.06%
HF/HST 14-18 F	292,333	273.57	307.26	12.31%
HF 19-44 M	201,705	308.16	327.41	6.25%
HF 19-44 F	661,988	468.91	481.11	2.60%
HF 45+ M+F	124,398	629.79	609.10	(3.29%)
HST 19-64 F	60,614	549.88	532.18	(3.22%)
<b>Subtotal - CFC</b>	<b>3,833,452</b>	<b>\$ 316.94</b>	<b>\$ 331.52</b>	<b>4.60%</b>
<b>Extension</b>				
EXT 19-34 M	250,110	\$ 438.07	\$ 451.60	3.09%
EXT 19-34 F	253,291	468.20	488.61	4.36%
EXT 35-44 M	130,825	626.87	657.01	4.81%
EXT 35-44 F	122,723	699.71	712.83	1.88%
EXT 45-54 M	122,575	883.14	845.55	(4.26%)
EXT 45-54 F	138,127	878.39	897.80	2.21%
EXT 55-64 M	100,753	1,008.75	940.47	(6.77%)
EXT 55-64 F	118,468	929.07	939.69	1.14%
<b>Subtotal - Extension</b>	<b>1,236,872</b>	<b>\$ 676.96</b>	<b>\$ 682.27</b>	<b>0.78%</b>
<b>ABD</b>				
ABD <21	121,041	\$ 1,343.92	\$ 1,250.84	(6.93%)
ABD 21+	384,064	1,620.33	1,643.59	1.44%
<b>Subtotal - ABD</b>	<b>505,105</b>	<b>\$ 1,554.09</b>	<b>\$ 1,549.47</b>	<b>(0.30%)</b>
<b>AFK</b>	<b>81,587</b>	<b>\$ 517.32</b>	<b>\$ 617.40</b>	<b>19.35%</b>
<b>CFC &amp; EXT Delivery</b>	<b>11,320</b>	<b>\$ 4,877.72</b>	<b>\$ 4,916.66</b>	<b>0.80%</b>
<b>Total</b>	<b>5,657,016</b>	<b>\$ 518.77</b>	<b>\$ 530.92</b>	<b>2.34%</b>

**Ohio Department of Medicaid  
Medicaid Managed Care Program  
Capitation Rates Effective January 1, 2019  
Calendar Year 2019 Rate Change Summary**

**Region: Southeast**

<b>Rate Cell</b>	<b>Projected Member Months / Deliveries</b>	<b>July 2018 Capitation Rate</b>	<b>Calendar Year 2019 Capitation Rate</b>	<b>% Change</b>
<b>CFC</b>				
HF/HST <1 M+F	60,767	\$ 1,038.80	\$ 925.12	(10.94%)
HF/HST 1 M+F	53,465	181.82	166.66	(8.34%)
HF/HST 2-13 M+F	609,721	168.88	166.55	(1.38%)
HF/HST 14-18 M	107,112	228.81	236.62	3.41%
HF/HST 14-18 F	108,143	276.61	271.40	(1.88%)
HF 19-44 M	83,160	315.56	328.99	4.26%
HF 19-44 F	250,688	426.92	442.21	3.58%
HF 45+ M+F	42,823	603.59	580.85	(3.77%)
HST 19-64 F	23,156	597.65	544.77	(8.85%)
<b>Subtotal - CFC</b>	<b>1,339,035</b>	<b>\$ 301.10</b>	<b>\$ 296.54</b>	<b>(1.52%)</b>
<b>Extension</b>				
EXT 19-34 M	100,886	\$ 376.24	\$ 379.14	0.77%
EXT 19-34 F	97,288	433.45	449.85	3.78%
EXT 35-44 M	52,507	562.83	592.41	5.26%
EXT 35-44 F	49,053	621.11	668.64	7.65%
EXT 45-54 M	52,966	763.67	766.29	0.34%
EXT 45-54 F	61,764	816.93	791.18	(3.15%)
EXT 55-64 M	46,741	847.56	865.54	2.12%
EXT 55-64 F	55,531	874.61	869.53	(0.58%)
<b>Subtotal - Extension</b>	<b>516,736</b>	<b>\$ 617.79</b>	<b>\$ 627.24</b>	<b>1.53%</b>
<b>ABD</b>				
ABD <21	40,652	\$ 1,114.99	\$ 986.56	(11.52%)
ABD 21+	149,195	1,428.96	1,394.95	(2.38%)
<b>Subtotal - ABD</b>	<b>189,847</b>	<b>\$ 1,361.73</b>	<b>\$ 1,307.50</b>	<b>(3.98%)</b>
<b>AFK</b>	<b>34,849</b>	<b>\$ 504.47</b>	<b>\$ 569.69</b>	<b>12.93%</b>
<b>CFC &amp; EXT Delivery</b>	<b>3,750</b>	<b>\$ 4,441.83</b>	<b>\$ 4,687.10</b>	<b>5.52%</b>
<b>Total</b>	<b>2,080,467</b>	<b>\$ 487.96</b>	<b>\$ 483.95</b>	<b>(0.82%)</b>

**Ohio Department of Medicaid  
Medicaid Managed Care Program  
Capitation Rates Effective January 1, 2019  
Calendar Year 2019 Rate Change Summary**

**Region: Northeast**

<b>Rate Cell</b>	<b>Projected Member Months / Deliveries</b>	<b>July 2018 Capitation Rate</b>	<b>Calendar Year 2019 Capitation Rate</b>	<b>% Change</b>
<b>CFC</b>				
HF/HST <1 M+F	252,007	\$ 1,132.79	\$ 1,159.51	2.36%
HF/HST 1 M+F	231,454	226.16	195.41	(13.60%)
HF/HST 2-13 M+F	2,504,180	187.90	176.27	(6.19%)
HF/HST 14-18 M	424,343	238.53	232.72	(2.44%)
HF/HST 14-18 F	439,680	276.11	268.05	(2.92%)
HF 19-44 M	275,639	283.28	280.38	(1.02%)
HF 19-44 F	1,089,718	416.57	404.79	(2.83%)
HF 45+ M+F	188,294	606.31	572.31	(5.61%)
HST 19-64 F	72,284	628.87	599.88	(4.61%)
<b>Subtotal - CFC</b>	<b>5,477,599</b>	<b>\$ 314.48</b>	<b>\$ 303.96</b>	<b>(3.35%)</b>
<b>Extension</b>				
EXT 19-34 M	470,475	\$ 364.38	\$ 377.24	3.53%
EXT 19-34 F	446,059	398.79	392.96	(1.46%)
EXT 35-44 M	237,107	521.15	507.29	(2.66%)
EXT 35-44 F	200,510	604.04	580.06	(3.97%)
EXT 45-54 M	237,039	744.23	715.84	(3.81%)
EXT 45-54 F	256,396	779.97	755.80	(3.10%)
EXT 55-64 M	224,284	853.93	797.33	(6.63%)
EXT 55-64 F	253,860	819.71	784.42	(4.31%)
<b>Subtotal - Extension</b>	<b>2,325,730</b>	<b>\$ 589.07</b>	<b>\$ 572.20</b>	<b>(2.86%)</b>
<b>ABD</b>				
ABD <21	227,448	\$ 1,036.09	\$ 981.60	(5.26%)
ABD 21+	619,046	1,617.89	1,534.38	(5.16%)
<b>Subtotal - ABD</b>	<b>846,494</b>	<b>\$ 1,461.56</b>	<b>\$ 1,385.85</b>	<b>(5.18%)</b>
<b>AFK</b>	<b>105,627</b>	<b>\$ 527.82</b>	<b>\$ 599.26</b>	<b>13.53%</b>
<b>CFC &amp; EXT Delivery</b>	<b>15,205</b>	<b>\$ 5,331.46</b>	<b>\$ 5,320.79</b>	<b>(0.20%)</b>
<b>Total</b>	<b>8,755,450</b>	<b>\$ 510.16</b>	<b>\$ 492.62</b>	<b>(3.44%)</b>



**Ohio Department of Medicaid  
Medicaid Managed Care Program  
Capitation Rates Effective January 1, 2019  
Calendar Year 2019 Rate Change Summary**

**Region: Northeast Central**

<b>Rate Cell</b>	<b>Projected Member Months / Deliveries</b>	<b>July 2018 Capitation Rate</b>	<b>Calendar Year 2019 Capitation Rate</b>	<b>% Change</b>
<b>CFC</b>				
HF/HST <1 M+F	61,527	\$ 873.44	\$ 826.75	(5.35%)
HF/HST 1 M+F	54,403	163.07	164.61	0.94%
HF/HST 2-13 M+F	597,973	165.69	164.21	(0.89%)
HF/HST 14-18 M	98,049	226.39	229.80	1.51%
HF/HST 14-18 F	99,819	269.55	251.18	(6.82%)
HF 19-44 M	62,803	285.84	288.93	1.08%
HF 19-44 F	239,738	401.01	389.01	(2.99%)
HF 45+ M+F	37,125	535.38	583.87	9.06%
HST 19-64 F	21,361	528.97	502.27	(5.05%)
<b>Subtotal - CFC</b>	<b>1,272,798</b>	<b>\$ 279.74</b>	<b>\$ 274.54</b>	<b>(1.86%)</b>
<b>Extension</b>				
EXT 19-34 M	84,116	\$ 341.09	\$ 375.73	10.16%
EXT 19-34 F	86,566	404.05	391.72	(3.05%)
EXT 35-44 M	44,233	508.73	532.29	4.63%
EXT 35-44 F	44,662	611.63	583.87	(4.54%)
EXT 45-54 M	45,708	689.45	658.29	(4.52%)
EXT 45-54 F	53,422	762.86	764.82	0.26%
EXT 55-64 M	41,214	823.15	863.98	4.96%
EXT 55-64 F	50,321	784.31	793.55	1.18%
<b>Subtotal - Extension</b>	<b>450,242</b>	<b>\$ 575.57</b>	<b>\$ 581.07</b>	<b>0.96%</b>
<b>ABD</b>				
ABD <21	40,970	\$ 1,091.77	\$ 1,056.77	(3.21%)
ABD 21+	108,589	1,458.00	1,402.94	(3.78%)
<b>Subtotal - ABD</b>	<b>149,559</b>	<b>\$ 1,357.68</b>	<b>\$ 1,308.11</b>	<b>(3.65%)</b>
<b>AFK</b>	<b>29,117</b>	<b>\$ 496.34</b>	<b>\$ 499.02</b>	<b>0.54%</b>
<b>CFC &amp; EXT Delivery</b>	<b>3,742</b>	<b>\$ 4,480.21</b>	<b>\$ 4,409.94</b>	<b>(1.57%)</b>
<b>Total</b>	<b>1,901,716</b>	<b>\$ 446.69</b>	<b>\$ 440.51</b>	<b>(1.38%)</b>

**Ohio Department of Medicaid  
Medicaid Managed Care Program  
Capitation Rates Effective January 1, 2019  
Calendar Year 2019 Rate Change Summary**

**Region: Statewide**

<b>Rate Cell</b>	<b>Projected Member Months / Deliveries</b>	<b>July 2018 Capitation Rate</b>	<b>Calendar Year 2019 Capitation Rate</b>	<b>% Change</b>
<b>CFC</b>				
HF/HST <1 M+F	877,000	\$ 1,021.33	\$ 1,075.50	5.30%
HF/HST 1 M+F	798,598	210.61	191.79	(8.93%)
HF/HST 2-13 M+F	8,591,725	178.52	173.96	(2.55%)
HF/HST 14-18 M	1,407,138	235.50	240.73	2.22%
HF/HST 14-18 F	1,440,139	277.69	277.15	(0.19%)
HF 19-44 M	917,455	298.37	309.45	3.71%
HF 19-44 F	3,423,339	428.71	427.41	(0.30%)
HF 45+ M+F	574,250	618.43	593.02	(4.11%)
HST 19-64 F	279,044	559.15	550.27	(1.59%)
<b>Subtotal - CFC</b>	<b>18,308,688</b>	<b>\$ 304.85</b>	<b>\$ 304.23</b>	<b>(0.20%)</b>
<b>Extension</b>				
EXT 19-34 M	1,352,314	\$ 382.07	\$ 398.84	4.39%
EXT 19-34 F	1,333,051	422.43	429.06	1.57%
EXT 35-44 M	703,147	558.94	568.83	1.77%
EXT 35-44 F	632,633	644.94	646.61	0.26%
EXT 45-54 M	687,581	780.11	754.23	(3.32%)
EXT 45-54 F	759,528	823.83	812.81	(1.34%)
EXT 55-64 M	610,983	892.23	853.09	(4.39%)
EXT 55-64 F	709,858	855.38	845.60	(1.14%)
<b>Subtotal - Extension</b>	<b>6,789,095</b>	<b>\$ 617.94</b>	<b>\$ 615.37</b>	<b>(0.42%)</b>
<b>ABD</b>				
ABD <21	658,463	\$ 1,140.12	\$ 1,058.62	(7.15%)
ABD 21+	1,857,088	1,604.63	1,563.00	(2.59%)
<b>Subtotal - ABD</b>	<b>2,515,551</b>	<b>\$ 1,483.04</b>	<b>\$ 1,430.97</b>	<b>(3.51%)</b>
<b>AFK</b>	<b>402,286</b>	<b>\$ 516.84</b>	<b>\$ 584.02</b>	<b>13.00%</b>
<b>CFC &amp; EXT Delivery</b>	<b>52,839</b>	<b>\$ 5,152.25</b>	<b>\$ 5,150.44</b>	<b>(0.04%)</b>
<b>Total</b>	<b>28,015,620</b>	<b>\$ 499.28</b>	<b>\$ 494.53</b>	<b>(0.95%)</b>

## APPENDIX F

### MARKETING AND MEMBER COMMUNICATIONS

The following are the MCP responsibilities related to communicating with eligible individuals pre-enrollment and MCP members post-enrollment. Upon request, the MCP shall provide both members and eligible individuals with a copy of their practice guidelines.

1. **Marketing Activities.** Marketing means any communication from the MCP to an eligible individual who is not a member of the MCP that can reasonably be interpreted as intended to influence the individual to select membership in the MCP, or to not select membership in or to terminate membership from another MCP. When marketing, the MCP shall:
  - a. Ensure representatives, as well as materials and plans, represent the MCP in an honest and forthright manner, and do not make statements which are inaccurate, misleading, confusing, or otherwise misrepresentative, or which defraud the eligible individuals or ODM.
  - b. Ensure no marketing activity directed specifically toward the Medicaid population begins prior to approval by ODM.
  - c. Not engage directly or indirectly with cold-call marketing activities including, door-to-door or telephone contact. Cold-call marketing means any unsolicited personal contact by the MCP with an eligible individual for the purpose of marketing.
  - d. Receive prior approval for any event or location where the MCP plans to provide information to eligible individuals.
  - e. 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 MCP membership.
  - f. Not offer inducements to any county department of job and family services (CDJFS) or Ohio Medicaid Consumer Hotline staff or to others who may influence an individual's decision to select MCP membership.
  - g. The MCP may offer nominal gifts prior-approved by ODM to an eligible individual as long as these gifts are offered whether or not the individual selects membership in the MCP.
  - h. The MCP may reference member incentive/appreciation items in marketing presentations and materials; however, such member items shall not be made available to non-members.
  - i. Not make marketing presentations, defined as a direct interaction between the MCP's marketing representative and an eligible individual, in any setting unless requested by the eligible individual.
  - j. MCP marketing representatives shall offer the ODM-approved solicitation brochure to the eligible individual at the time of the marketing presentation and shall provide:

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- i. An explanation of the importance of reviewing the information in the ODM-approved solicitation brochure, how the individual can receive additional information about the MCP prior to making an MCP membership selection, and the process for contacting ODM to select an MCP.
    - ii. Information that membership in the particular MCP is voluntary and that a decision to select or not select the MCP will not affect eligibility for Medicaid or other public assistance benefits.
    - iii. Information that each member shall choose a PCP and shall access providers and services as directed in the MCP's member handbook and provider directory. Upon request, the MCP shall provide eligible individuals with a provider directory.
    - iv. Information that all medically necessary Medicaid covered services, as well as any additional services provided by the MCP, will be available to all members.
  - k. MCP marketing representatives and other MCP staff are prohibited from offering eligible individuals the use of a portable device (laptop computer, cellular phone, etc.) to assist with the completion of an online application to select and/or change MCPs, as all enrollment activities shall be completed by the Hotline.
2. **Marketing Representatives and Training.** An MCP that utilizes marketing representatives for marketing presentations requested by eligible individuals shall comply with the following:
- a. All marketing representatives shall be employees of the MCP. A copy of the representative's job description shall be submitted to ODM.
  - b. 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 rule, any performance-based compensation would be considered a form of commission. Upon ODM request, the MCP shall make available for inspection, the compensation packages of marketing representatives.
  - c. Marketing representatives shall be trained and duly licensed by the Ohio Department of Insurance to perform such activities.
  - d. The MCP shall develop and submit to ODM for prior approval (at initial development and at the time of revision) a marketing representative training program which shall include:
    - i. A training curriculum including:
      - 1. A full review of the MCP's solicitation brochure, provider directory and all other marketing materials including all video, electronic and print.
      - 2. An overview of the applicable public assistance benefits, designed to familiarize and impart a working knowledge of these programs.

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3. The MCP's process for providing sign language, oral interpretation and oral translation services to an eligible individual to whom a marketing presentation is being made, including a review of the MCP's written marketing materials.
  4. 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.
  5. An overview of the ramifications to the MCP and the marketing representatives if ODM rules are violated.
  6. Review of the MCP's code of conduct or ethics.
- ii. Methods that the MCP will utilize to determine initial and ongoing competency with the training curriculum.
- e. Any MCP staff person providing MCP information or making marketing presentations to an eligible individual shall:
- i. Visibly wear an identification tag and offer a business card when speaking to an eligible individual and provide information which ensures that the staff person is not mistaken for an Ohio Medicaid Consumer Hotline, federal, state or county employee.
  - ii. Inform eligible individuals that the following MCP information or services are available and how to access the information or services:
    1. Sign language, oral interpretation, and oral translation services at no cost to the member.
    2. Written information in the prevalent non-English languages of eligible individuals or members residing in the MCP's service area.
    3. Written information in alternative formats.
  - iii. Not discriminate on the basis of age, gender, gender identity, sexual orientation, race, color, religion, national origin, military status, ancestry, disability, genetic information, health status, or the need for health services.
  - iv. Not ask eligible individuals questions related to health status or the need for health services.
- f. Only ODM approved MCP 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 he or she select MCP membership in a particular MCP. As provided in ORC Chapter 1751 and ORC section 3905.01, all non-licensed agents, including providers, are prohibited from

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advising or recommending to an eligible individual that he or she select MCP membership in a particular MCP as this would constitute the unlicensed practice of marketing.

- g. MCP informational displays do not require the presence of a marketing representative if no marketing presentation will be made.

3. **Marketing Materials.** Marketing materials are those items produced in any medium, by or on behalf of the MCP, including gifts of nominal value (i.e., items worth no more than \$15.00), which can reasonably be interpreted as intended to market to eligible individuals as defined in OAC rule 5160-26-01.

a. Marketing materials shall comply with the following requirements:

- i. Be available in a manner and format that may be easily understood.
  - ii. Written materials developed to promote membership selection in the MCP shall be available in the prevalent non-English languages of eligible individuals in the service area and in alternative formats in an appropriate manner that takes into consideration the special needs of eligible individuals including but not limited to visually-impaired and LRP eligible individuals.
  - iii. Oral interpretation and oral translation services shall be available for the review of marketing materials at no cost to eligible individuals.
  - iv. Be distributed to the MCP's entire service area.
  - v. The mailing and distribution of all MCP marketing materials shall be prior-approved by ODM and may contain no information or text on the outside of the mailing that identifies the addressee as a Medicaid recipient.
  - vi. Not contain any assertion or statement (whether written or oral) that the MCP is endorsed by the Centers for Medicare and Medicaid Services (CMS), the Federal or state government or similar entity.
- b. ODM or its designee may, at the MCP's request, mail MCP marketing materials to the eligible individuals. Postage and handling for each mailing will be charged to the requesting MCP. The MCP address shall not be used as the return address in mailings to eligible individuals processed by ODM.
- c. **Solicitation Brochure.** The MCP shall have a solicitation brochure available to eligible individuals which contains, at a minimum:
- i. Identification of the Medicaid recipients eligible for the MCP's coverage.
  - ii. Information that the MCP's ID card replaces the member's monthly Medicaid card.

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- iii. A statement that all medically-necessary Medicaid-covered services will be available to all members, including Healthchek services for those individuals under age 21.
- iv. A description of any additional services available to all members.
- v. Information that membership selection in a particular MCP is voluntary, that a decision to select MCP membership or to not select MCP membership in the MCP will not affect eligibility for Medicaid or other public assistance benefits, and that individuals may change MCPs under certain circumstances.
- vi. Information on how the individual can request or access additional MCP information or services, including clarification on how this information can be requested or accessed through:
  - 1. Sign language, oral interpretation and oral translation services at no cost to the eligible individual;
  - 2. Written information in the prevalent non-English languages of eligible individuals or members in the MCP's service area; or
  - 3. Written information in alternative formats.
- vii. Clear identification of corporate or parent company identity when a trade name or DBA is used for the Medicaid product.
- viii. 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 MCP operates will be provided upon request.
- ix. Information that the individual shall choose a PCP from the MCP's provider panel and that the PCP will coordinate the member's health care.
- x. Information that a member may change PCPs at least monthly.
- xi. A statement that all medically necessary health care services shall be obtained in or through the MCP's providers except emergency care, behavioral health services provided through facilities and any other services or provider types designated by ODM.
- xii. A description of how to access emergency services including information that access to emergency services is available within and outside the service area.
- xiii. A description of the MCP's policies regarding access to providers outside the service area.
- xiv. Information on member-initiated termination options in accordance with OAC rule 5160-26-02.1.

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- xv. Information on the procedures an eligible individual shall follow to select membership in an MCP including any applicable ODM selection requirements.
  - xvi. If applicable, information on any member co-payments the MCP has elected to implement in accordance with OAC rule 5160-26-12.
4. **Marketing Plan.** The MCP shall submit an annual marketing plan to ODM that includes all planned activities for promoting membership in or increasing awareness of the MCP. The marketing plan submission shall include an attestation by the MCP that the plan is accurate is not intended to mislead, confuse or defraud the eligible individuals or ODM.
5. **ODM Approval.** The MCP is responsible for ensuring all new and revised marketing materials (including materials used for marketing presentations) and member materials (including mailing and distribution) are approved by ODM prior to distribution to eligible individuals or members. The MCP shall include with each marketing submission an attestation that the material is accurate and is not intended to mislead, confuse or defraud the eligible individuals or ODM. In accordance with 42 CFR 438.104(c), ODM will consult with the Medical Care Advisory Committee in reviewing all MCP submitted marketing materials.
6. **Alleged Marketing Violations.** The MCP shall immediately notify ODM in writing of its discovery of an alleged or suspected marketing violation. ODM will forward information pertaining to alleged marketing violations to the Ohio Department of Insurance and the Medicaid Fraud Control Unit as appropriate.
7. Upon ODM's request, the MCP may be required to provide written notice to members of any significant change affecting contractual requirements, member services or access to providers.
8. **Member Materials.** Member materials are those items developed by or on behalf of the MCP to fulfill MCP 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 MCP and which do not include any reference to the MCP are not considered to be member materials.
- a. Member materials shall be:
    - i. Available in written format and alternative formats in an appropriate manner that takes into consideration the special needs of the member including, but not limited to, visually-limited and LRP members.
    - ii. Provided in a manner and format that may be easily understood;
    - iii. Printed in the prevalent non-English languages of members in the service area upon request; and
    - iv. Consistent with the practice guidelines specified in OAC rule 5160-26-05.1.



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- b. MCP member materials shall not include statements that are inaccurate, misleading, confusing, or otherwise misrepresentative, or which defraud eligible individuals or ODM.
9. **New Member Materials.** The MCP shall provide to each member or assistance group that selects or changes MCPs an MCP identification (ID) card, a new member letter, notice of advanced directives, provider directory postcard and post card providing the link to the member handbook, if sent in lieu of the full member handbook.
- a. **ID Card.** The MCP ID card shall contain:
    - i. The MCP's name as stated in its article of incorporation and any other trade or DBA name used;
    - ii. The name of the member(s) enrolled in the MCP and each member's medical management information system billing number;
    - iii. The name and telephone numbers of the PCPs assigned to the members;
    - iv. Information on how to obtain the current eligibility status of the members;
    - v. Coordinated Services Program (CSP) information as specified by ODM;
    - vi. Pharmacy information; and
    - vii. The MCP's emergency procedures including the toll-free call-in system phone numbers.
  - b. **New Member Letter.** The MCP shall use the model language specified by ODM for the new member letter and member handbooks. The MCP New Member Letter shall inform each member of the following:
    - i. The new member materials issued by the MCP, what action to take if he or she did not receive those materials, and how to access the MCP's provider directory;
    - ii. How to access MCP-provided transportation services;
    - iii. How to change primary care providers;
    - iv. The population groups not required to select MCP membership and what action to take if a member believes he or she meets this criteria and does not want to be an MCP member;
    - v. The need and time frame for a member to contact the MCP if he or she has a health condition that the MCP should be aware of in order to most appropriately manage or transition the member's care; and

- vi. The need and how to access information on medications that require prior authorization.
- c. **Member Handbook.** The MCP Member Handbook shall be clearly labeled as such and shall include:
- i. The rights of members including all rights found in OAC rule 5160-26-08.3 and any member responsibilities specified by the MCP. With the exception of any prior authorization (PA) requirements the MCP describes in the member handbook, the MCP cannot establish any member responsibility that would preclude the MCP's coverage of a Medicaid-covered service.
  - ii. Information regarding services excluded from MCP coverage and the services and benefits available through the MCP and how to obtain them, including at a minimum:
    - 1. All services and benefits requiring PA or referral by the MCP or the member's PCP;
    - 2. Self-referral services, including Title X services, and women's routine and preventative health care services provided by a woman's health specialist as specified in OAC rule 5160-26-03;
    - 3. FQHC, RHC and certified nurse practitioner services specified in OAC rule 5160-26-03; and
    - 4. Any applicable pharmacy utilization management strategies prior-approved by ODM.
  - iii. Information regarding available emergency services, the procedures for accessing emergency services and directives as to the appropriate utilization, including:
    - 1. An explanation of the terms "emergency medical condition," "emergency services," and "post-stabilization services," as defined in OAC rule 5160-26-01;
    - 2. A statement that PA is not required for emergency services;
    - 3. An explanation of the availability of the 911 telephone system or its local equivalent;
    - 4. A statement that members have the right to use any hospital or other appropriate setting for emergency services; and
    - 5. An explanation of the post-stabilization care services requirements specified in OAC rule 5160-26-03.
  - iv. The procedure for members to express their recommendations for change to the MCP;

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- v. Identification of the categories of Medicaid recipients eligible for MCP membership;
- vi. Information stating that the MCP's ID card replaces the member's monthly Medicaid card, how often the card is issued and how to use it;
- vii. A statement that medically necessary health care services shall be obtained through the providers in the MCP's provider network with any exceptions that apply such as emergency care;
- viii. Information related to the selection of a PCP from the MCP provider directory, how to change PCPs no less often than monthly, the MCP's procedures for processing PCP change requests after the initial month of MCP membership, and how the MCP will provide written confirmation to the member of any new PCP selection prior to or on the effective date of the change;
- ix. A description of Healthchek services including who is eligible and how to obtain Healthchek services through the MCP;
- x. Information on additional services available to members including care management;
- xi. A description of the MCP'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;
- xii. Information on member-initiated termination options in accordance with OAC rule 5160-26-02.1;
- xiii. Information about MCP-initiated terminations;
- xiv. An explanation of automatic MCP membership renewal in accordance with OAC rule 5160-26-02;
- xv. The procedure for members to file an appeal, a grievance, or state hearing request as specified in OAC rule 5160-26-08.4, the MCP's mailing address and a copy of the optional form(s) that members may use to file an appeal or grievance with the MCP. Copies of the form(s) to file an appeal or grievance shall also be made available through the MCP's member services program;
- xvi. The standard and expedited state hearing resolution time frames as outlined in 42 CFR 431.244;
- xvii. The member handbook issuance date;
- xviii. A statement that the MCP 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

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- receipt of health services;
  - xix. An explanation of subrogation and coordination of benefits;
  - xx. A clear identification of corporate or parent identity when a trade name or DBA is used for the Medicaid product;
  - xxi. Information on the procedures for members to access behavioral health services;
  - xxii. Information on the MCP's advance directives policies, including a member's right to formulate advance directives, a description of applicable state law, and a statement of any limitation regarding the implementation of advance directives as a matter of conscience;
  - xxiii. A statement that the MCP provides covered services to members through a provider agreement with ODM, and how members can contact ODM;
  - xxiv. The toll-free call-in system phone numbers;
  - xxv. A statement that additional information is available from the MCP upon request including, at a minimum, the structure and operation of the MCP and any physician incentive plans the MCP operates;
  - xxvi. Process for requesting or accessing additional MCP information or services including at a minimum:
    - 1. Oral interpretation or translation services;
    - 2. Written information in the prevalent non-English languages in the MCP's service areas; and
    - 3. Written information in alternative formats.
  - xxvii. If applicable, detailed information on any member co-payments the MCP has elected to implement in accordance with OAC rule 5160-26-12;
  - xxviii. How to access the MCP's provider directory; and
  - xxix. The MCP shall provide access to provider panel information to members via the MCP's website and printed provider directories.
- d. In addition to an MCP identification (ID) card, a new member letter, and a member handbook, the MCP shall provide to each member or assistance group, as applicable, provider panel information, Notice of Nondiscrimination, and information on advance directives, as specified by ODM.

10. If a member's MCP membership is automatically renewed as specified in OAC rule 5160-26-02, the MCP shall issue an ID card prior to the new effective date of coverage. The MCP shall also issue a new member handbook postcard to the member if the member handbook has been revised since the initial MCP membership date.
11. **Issuance of Member Materials.** The ID card, new member letter and request postcard shall be mailed within 10 business days of receiving the 834C enrollment file, except during state cutoff when plans have the option to follow the 834 file loading process as specified by ODM.
  - a. The MCP may mail ODM prior-approved postcards to new members in lieu of mailing printed advance directives, directories, and member handbooks. At a minimum, the postcards shall advise members to call the MCP or return the postcards to request a printed advance directive, provider directory, and/or member handbook.
  - b. If the MCP does not use an ODM prior-approved postcard, the MCP shall mail printed advance directives, provider directories, and member handbooks to all new members, within 5 calendar days of receiving the 834C.
  - c. If requested, a printed advance directive, provider directory, and member handbook shall be sent to a member within seven calendar days of the request.
  - d. The MCP shall designate two MCP staff members to receive a copy of the new member materials on a monthly basis in order to monitor the timely receipt of these materials. At least one of the staff members shall receive the materials at their home address.
  - e. The MCP ID card shall contain pharmacy information, as prescribed by ODM.

12. **Information Required for MCP Websites.**

- a. **On-line Provider Directory.** The MCP shall have an internet-based provider directory or link to the Medicaid Consumer Hotline's online provider directory available in the same format as its ODM-approved provider directory, that allows members to electronically search for the MCP panel providers based on name, provider type and geographic proximity (as specified in Appendix H). MCP provider directories shall include all MCP-contracted providers (except as specified by ODM) as well as certain ODM non-contracted providers.
- b. **On-line Member Website.** The MCP shall have a secure internet-based website which provides members the ability to submit questions, comments, grievances, and appeals, and receive a response. Members shall be given the option of a response by return e-mail or phone call. The MCP's responses to questions or comments shall be made within one business day of receipt. The MCP's responses to grievances and appeals shall adhere to the timeframes specified in OAC rule 5160-26-08.4. The member website shall be regularly updated to include the most current ODM-approved materials, although this website shall not be the only means for notifying members of new and/or revised MCP information (e.g., change in holiday closures, changes in additional benefits, and revisions to approved member materials). The MCP shall make a copy of its Authorized Representative request form available to members through its online member

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portal located on the MCP's website.

- c. The MCP member website shall also include, at a minimum, the following information which shall be accessible to members and the general public without any log-in restriction:
  - i. MCP contact information, including the MCP's toll-free member services phone number, service hours, and closure dates;
  - ii. A listing of the counties the MCP serves or an indication that the MCP serves the entire state;
  - iii. The ODM-approved MCP member handbook, recent newsletters and announcements;
  - iv. The MCP's on-line provider directory as referenced this appendix;
  - v. Current version of the Member Handbook;
  - vi. A list of services requiring prior authorization (PA);
  - vii. The MCP's preferred drug list (PDL), including an explanation of the list and identification of any preferred drugs that require PA, the MCP's list of drugs that require PA, including an explanation of the list, identification of first line drugs for drugs that require PA for step therapy, how to initiate a PA, and the MCP's policy for coverage of generic versus brand name drugs.
  - viii. A 30-calendar day's advance notice of changes to the list of all services requiring prior authorization, as well as the MCP's PDL and list of drugs requiring prior authorization via their website. The MCP shall provide a hard copy of the notification of any PA changes upon request;
  - ix. The toll-free telephone number for the 24/7 medical advice call-in system specified in Appendix C;
  - x. Contact information to schedule non-emergency transportation assistance, including an explanation of the available services and to contact member services for transportation services complaints.
  - xi. The toll-free member services, 24/7 call-in systems and transportation scheduling telephone numbers shall be easily identified on either the MCP's website home page or a page that is a direct link from a contact button on the home page. ODM may require the MCP to include additional information on the member website as needed; and
  - xii. All Healthchek information as specified Appendix C.
13. The MCP shall receive prior written approval from ODM before adding any information to its website that would require ODM prior approval in hard copy form (e.g., provider listings, member handbook

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information).

14. The MCP shall provide members with a printed version of its Preferred Drug List (PDL) and Prior Authorization (PA) lists upon request.

The sanctions for noncompliance with requirements in this appendix are listed in Appendix N of this Agreement.

## APPENDIX G

### COVERAGE AND SERVICES

1. **Basic Benefit Package.** The MCP shall ensure members have timely access to all services outlined in OAC rule 5160-26-03, with limited exclusions, limitations and clarifications (specified in this appendix), including emergency and post-stabilization services pursuant to 42 CFR 438.114. For information on Medicaid-covered services, the MCP shall refer to the Ohio Department of Medicaid (ODM) website. Services covered by the MCP benefit package shall include:
  - a. Inpatient hospital services;
  - b. Outpatient hospital services;
  - c. Services provided by rural health clinics (RHCs) and federally qualified health centers (FQHCs);
  - d. Physician services whether furnished in the physician's office, the member's home, a hospital, or elsewhere;
  - e. Laboratory and x-ray services;
  - f. Screening, diagnosis, and treatment services to children under the age of 21 under Healthchek, Ohio's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. These services include all mandatory and optional medically necessary services (including treatment) and items listed in 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and mental illness and conditions discovered by a screening described in 42 U.S.C. 1396d(r). Such services and items, if approved through prior authorization, include those services and items listed at 42 U.S.C. 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. An EPSDT screening is an examination and evaluation of the general physical and mental health, growth, development, and nutritional status of an individual under age 21. It includes the components set forth in 42 U.S.C. 1396d(r) and shall also be provided by plans to children under the age of 21;
  - g. Family planning services and supplies;
  - h. Home health and private duty nursing services in accordance with OAC Chapter 5160-12. State plan home health and private duty nursing services shall be accessed prior to using the same or similar waiver funded services;
  - i. Podiatry;
  - j. Chiropractic services;
  - k. Physical therapy, occupational therapy, developmental therapy, and speech therapy;
  - l. Nurse-midwife, certified family nurse practitioner, and certified pediatric nurse practitioner services;



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- m. Free-standing birth center services in free-standing birth centers as defined in OAC rule 5160-18-01;
- n. Prescribed drugs;
- o. Ambulance and ambulette services;
- p. Dental services;
- q. Durable medical equipment and medical supplies;
- r. Vision care services, including eyeglasses;
- s. Nursing facility stays as specified in OAC rule 5160-26-03 for ABD and MAGI members. For Adult Extension members, nursing facility stays are covered for the length of time medically necessary;
- t. Hospice care;
- u. 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;
- v. Immunizations, following the coverage requirements provided by ODM for any newly approved vaccine under the Vaccines for Children (VFC) program;
- w. Preventive services covered by Ohio Medicaid in accordance with Section 4106 of the Affordable Care Act and 42 CFR 440.130(c);
- x. All U.S. Preventive Services Task Force (USPSTF) grade A and grade B preventive services and approved vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) and their administration, without cost-sharing, as provided in Section 4106 of the Affordable Care Act. Additionally, the MCP shall cover without cost-sharing, services specified under Public Health Service Act Section 2713 in alignment with the Alternative Benefit Plan;
- y. Screening and counseling for obesity provided during an evaluation and management or preventive medicine visit, as described in OAC rule 5160-1-16.;
- z. Respite services for Supplemental Security Income (SSI) members under the age of 21 with long-term care or behavioral health needs, as approved by CMS within the applicable 1915(b) waiver;
- aa. Telemedicine; and
- bb. Services for members with a primary diagnosis of Autism Spectrum Disorder (ASD) including coverage mandated by ORC section 1751.84.

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2. **Exclusions.** The MCP is not required to pay for services not covered by the Medicaid program, except as specified in OAC rule 5160-26-03 or this Agreement. Information regarding non-covered services can be found on the ODM website. Services not covered by the Medicaid program include:
- a. Services or supplies not medically necessary;
  - b. Treatment of obesity unless medically necessary;
  - c. Experimental services and procedures, including drugs and equipment, not in accordance with customary standards of practice;
  - d. Abortions, except in the case of a reported rape, incest, or when medically necessary to save the life of the mother;
  - e. Infertility services;
  - f. Voluntary sterilization if under 21 years of age or legally incapable of consenting to the procedure;
  - g. Reversal of voluntary sterilization procedures;
  - h. Plastic or cosmetic surgery not medically necessary (These services could be deemed medically necessary if medical complications or conditions in addition to the physical imperfection are present);
  - i. Sexual or marriage counseling;
  - j. Biofeedback services;
  - k. Services to find cause of death (autopsy) or services related to forensic studies;
  - l. Paternity testing;
  - m. Services determined by another third-party payer as not medically necessary;
  - n. Drugs not covered by the Ohio Medicaid pharmacy program as specified in OAC rule 5160-9-03;
  - o. Assisted suicide services, defined as services for the purpose of causing, or assisting to cause, the death of an individual. This does not pertain to withholding or withdrawing medical treatment, nutrition or hydration or to the provision of a service for the purpose of alleviating pain or discomfort, even if the use may increase the risk of death, so long as the service is not furnished for the specific purpose of causing death;
  - p. Medical services if the service was caused by a provider-preventable condition as defined in 42 CFR 447.26. The prohibition on payment for provider-preventable conditions shall not result in a loss of access to care or services for Medicaid consumers; and

- q. Non-emergency services or supplies provided by out-of-network providers, unless the member has followed the instructions in the MCP member handbook for seeking coverage of such services, or unless otherwise directed by ODM.

### 3. Clarifications.

- a. **Member Cost-Sharing.** As specified in OAC rules 5160-26-05 and 5160-26-12, the MCP is permitted to impose the applicable member co-payment amount for dental services, vision services, non-emergency emergency department services, or prescribed drugs, the MCP shall notify ODM if they intend to impose a co-payment. ODM shall approve the notice to be sent to the MCP's members and the timing of when the co-payments will begin to be imposed. If ODM determines the MCP's decision to impose a particular co-payment on their 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.

Notwithstanding the preceding paragraph, the MCP shall provide an ODM-approved notice to all their members 90 calendar days in advance of the date that the MCP will impose the co-payment. With the exception of member co-payments the MCP has elected to implement in accordance with OAC rules 5160-26-05 and 5160-26-12, the MCP's payment constitutes payment in full for any covered services and their subcontractors shall not charge members or ODM any additional co-payment, cost sharing, down-payment, or similar charge, refundable or otherwise.

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

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

- c. **Help Me Grow.** In accordance with ORC section 5167.16, upon request and in coordination with the Help Me Grow program, the MCP shall arrange depression screening and cognitive behavioral health therapies for members enrolled in the Help Me Grow program and who are either pregnant or the birth mother of an infant or toddler under three years of age. Screening shall be provided in the home and therapy services shall be provided in the home when requested by the member.

- d. **Boards of Alcohol, Drug Addiction and Mental Health Services.** Pursuant to ORC Chapter 340, boards of alcohol, drug addiction and mental health services serve as the community addiction and mental health planning agencies for the county or counties under their jurisdiction. These boards may advocate on behalf of Medicaid recipients enrolled in managed care whom have been identified as needing behavioral health services and are required to:
  - i. Evaluate the need for facility services, addiction services, mental health services and recovery supports; and
  - ii. Establish a unified system of treatment for mentally ill persons and persons with addictions.
- e. **Institutions for Mental Disease (IMDs).**
  - i. **Mental Health Stays.** In accordance with 42 CFR 438.6(e), the MCP may provide mental health services to members ages 21 through 64 for up to 15 days per calendar month while receiving inpatient treatment in an IMD as defined in Section 1905(i) of the Social Security Act. The MCP is not prohibited from contracting with an IMD to provide mental health services to members' ages 21 through 64, but Medicaid will not compensate the MCP for the provision of such services beyond 15 days per calendar month either through direct payment or considering any associated costs in Medicaid rate setting. MCP payments to the IMD are established in the plan's contractual agreement with the provider. The MCP is required to report quarterly on IMD stays that exceed 15 days per calendar month per ODM's specifications.
  - ii. **Substance Use Disorder (SUD) Treatment.** The MCP will continue to work with ODM in development of the 1115 SUD demonstration waiver to provide services to individuals with an SUD diagnosis. This work includes the MCP utilizing the American Society of Addiction Medicine (ASAM) level of care criteria, increasing care coordination efforts and monitoring IMD network adequacy.
- f. **Respite Services.** The MCP will provide access to and payment for respite services in accordance with OAC rule 5160-26-03. The MCP of may elect to cover additional respite services as a value added benefit in accordance with the terms of this agreement. The MCP will submit a quarterly report as designated by ODM.
- g. **Organ Transplants.**
  - i. The MCP shall ensure coverage for organ transplants and related services in accordance with OAC rule 5160-2-07.1. Coverage for all organ transplant services, except kidney transplants, is contingent upon review and recommendation by the "Ohio Solid Organ Transplant Consortium" based on criteria established by Ohio organ transplant surgeons and authorization from the ODM prior authorization unit. Reimbursement for bone marrow transplant and hematopoietic stem cell transplant services, as defined in OAC rule 3701:84-01, is contingent upon review and recommendation by the "Ohio Hematopoietic Stem Cell Transplant Consortium" based on criteria established by Ohio experts in the field of bone marrow transplant and authorization from the ODM prior

authorization unit. While the MCP may require prior authorization for these transplant services, the approval criteria shall be limited to confirming the member has been recommended to and approved for a transplant by either consortium and authorized by ODM. In accordance with OAC rule 5160-2-03, all services related to covered organ donations are covered for the donor recipient when the member is Medicaid eligible.

- ii. **Prior Authorizations for Transplant Evaluations (Pre-Transplants).** The MCP 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 shall be able to access pre-transplant services required for consortium review). The MCP may require providers to submit prior information for the purposes of assisting members with identifying available providers, initiating care management services, and addressing any compensation issues. However, when identifying available providers that could ultimately impact where the transplant is performed, the MCP shall not solely consider a provider’s panel status but also consider the proximity to a member’s residence, support system and the network of providers who have coordinated the member’s care.
  
- h. **Acupuncture.** Ohio Medicaid acupuncture coverage is limited to the pain management of migraine headaches and lower back pain.
  
- i. **Gender Transition.** Pursuant to 45 CFR 92.207(b)(4), the MCP is prohibited from having or implementing a categorical coverage exclusion or limitation for all health services related to gender transition. However, 45 CFR 92.207(d) clarifies that this does not prevent the MCP from determining whether a particular health service is medically necessary or otherwise meets applicable coverage requirements in individual cases.
  
- j. **Prescribed Drugs.**
  - i. In providing the Medicaid pharmacy benefit to their members, the MCP shall cover:
    1. The same drugs covered by the FFS program, in accordance with OAC rules 5160-26-03 and 5160-9-03;
    2. All Covered Outpatient Drugs, as defined in in Section 1927(k) of the Social Security Act, 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; and
    3. Central Nervous System (CNS) Agents (Medication Assisted Treatment of Opioid Addiction) as specified by ODM.
  
  - ii. The MCP shall pay an administration fee at the point-of-sale to pharmacists administering drugs by injection as allowed per OAC rule 4729-5-40.

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- iii. The MCP shall continue to work with ODM to create a consistent utilization management and prior authorization approach for all opioids and Medication Assisted Treatment (MAT).
- iv. The MCP may limit prescribed drugs, subject to ODM review and approval. The MCP shall use the Limitations of Coverage and Drug Use Programs as set forth in 1927(d) and (g) of the Social Security Act, as well as other pharmacy benefit management strategies. Such strategies may include but are not limited to:
  1. A Preferred Drug list (PDL) which must be reviewed at least annually by the MCPs' Pharmacy and Therapeutics (P&T) Committee, meet the clinical needs of the MCPs' population, and include a range of drugs in each therapeutic class represented. If requested by ODM, MCPs must provide a satisfactory written explanation of the reasons for the designation of a drug in any category;
  2. Limits on quantity, age, clinical requirements and/or step therapy;
  3. Prior authorization programs that comply with the requirements of Section 1927(d)(5) of the Social Security Act as well as:
    - a. ORC section 5160.34(B)(6) through (B)(8) that specify the requirements to: honor prior authorization requests; permit a retrospective review of a claim; disclose any new prior authorizations; and list prior authorization requirements;
    - b. ORC section 5164.7511 with respect to medication synchronization; and
    - c. ORC section 5167.12(B) that prohibits the MCP from requiring prior authorization (PA) in the case of a drug to which all of the following apply:
      - i. The drug is an antidepressant or antipsychotic;
      - ii. The drug is administered or dispensed in a standard tablet or capsule form, except that in the case of an antipsychotic, the drug also may be administered or dispensed in a long-acting injectable form;

national certifying organization;

- iv. The drug is prescribed for a use indicated on the drug's labeling, as approved by the federal food and drug administration.
- v. The MCP may require PA for antidepressant or antipsychotic drugs that do not meet the criteria outlined above. The MCP shall consider the prescribing provider's verification that the member is stable on the specific medication when making the PA decision.
- v. The MCP shall participate in a consensus list process with ODM. Participation shall include quarterly meetings to obtain prior ODM approval of changes to the MCP's list of drugs requiring PA. Unless otherwise authorized by ODM, the quarterly meeting process will ensure that the combined list of drugs requiring PA for the MCP results in a combined percentage agreement that is no less than seventy percent.
- vi. The MCPs shall receive permission from ODM 90 calendar days in advance of making a change to drug coverage that will add prior authorization requirements to a drug or drug class that will affect more than 1,000 plan members, or greater than 1% of the MCP's total ODM enrollment, whichever is less.
- vii. The MCP shall operate a drug utilization review program 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 MCP shall submit information to fulfill the requirements of the annual report detailed in 42 CFR 456.712 of subpart K, including a detailed description of the program as required by 42 CFR 438.3(s)(5).
- viii. The MCP may block all payments to pharmacies for drugs prescribed by a particular non-panel provider, if the MCP has done all of the following:
  - 1. Referred the prescriber to ODM Program Integrity for suspicion of fraud, waste, or abuse.
  - 2. Determined that the prescriber is not an employee of a Federally Qualified Health Center, Rural Health Clinic, Qualified Family Planning Provider, emergency department, or Ohio MHAS-certified Community Mental Health Center or Substance Use Disorder provider.
  - 3. Notified members who received prescriptions, within the previous 90 calendar days, from that provider, that prescriptions from the prescriber will no longer be covered and ensured members have future access to a prescriber of the same specialty.
- ix. The MCP shall, at a minimum, ensure same day coverage of the first dose of the long-acting injectable opioid antagonist for substance use disorders, if the administering

provider:

1. Stocks the medication, or
  2. Has an agreement with a pharmacy to act as a prescription pick-up station, as described in OAC rule 4729-5-10.
- x. The MCP shall report the following information to ODM upon request:
1. The top 25 drugs by total net cost after any discount and rebates are applied; and
  2. The top 25 drugs by highest percent increase in price paid per unity to the MCP's pharmacies based upon average price in the quarter being reported compared to the previous quarter.
4. **Information Sharing with Non-Panel Providers.** To assist members in accessing medically-necessary Medicaid covered services, the MCP is required to share specific information with certain non-panel providers. The information is to assist non-panel providers to recognize MCP membership, access information needed to provide services and if applicable successfully submit claims to the MCP.
- a. **ODM-Designated Providers.** The MCP shall share specific information with MHA-certified CMHCs, MHA-certified Medicaid providers, FQHCs/RHCs, qualified family planning providers (QFPPs), hospitals and if applicable, certified nurse midwives (CNMs), certified nurse practitioners (CNPs), and free-standing birth centers (FBCs) as defined in OAC rule 5160-18-01 within the MCP's service area and in bordering regions if appropriate based on member utilization information. The information shall be shared within the first month after the MCP has been awarded a Medicaid provider agreement for a specific region and annually thereafter.

At a minimum, the information shall include the following:

- i. The information's purpose;
- ii. Claims submission information including the MCP's Medicaid provider number for each region (this information is only required to be provided to non-panel FQHCs/RHCs, QFPPs, CNMs, CNPs and hospitals);
- iii. The MCP's prior authorization and referral procedures;
- iv. A picture of the MCP's member ID card (front and back);
- v. Contact numbers for obtaining information for eligibility verification, claims processing, referrals, PA, post-stabilization care services and if applicable information regarding the MCP's behavioral health administrator; and
- vi. A listing of the MCP's laboratories and radiology providers.



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- b. **MCP-authorized Providers.** The MCP authorizing the delivery of services from a non-panel provider shall ensure they have a mutually agreed upon compensation amount for the authorized service and notify the provider of the applicable provisions of OAC rule 5160-26-05. This notice is provided when the MCP authorizes a non-panel provider to furnish services on a one-time or infrequent basis to the MCP member and shall include required ODM-model language and information. This notice shall also be included with the transition of services form sent to providers as outlined in Appendix C.
  - c. Upon request, the MCP shall provide information to ODM to document the non-contracting providers identified by the MCP and the information provided to each provider. If the MCP requires referrals to specialists, they shall ensure information on referral approvals and denials is made available to ODM upon request.
5. **Mental Health Parity and Addiction Equity Act (MHPAEA) Requirements.** The MCP shall comply with MHPAEA 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 to all populations included under the terms of this Agreement and include:
- a. The MCP shall demonstrate to ODM that all covered services are being delivered in compliance with the MHPAEA regulation.
  - b. The MCP shall 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 might impact compliance.
  - c. The MCP shall conduct an analysis each calendar year to determine compliance with MHPAEA and provide results of the analysis to ODM. If no changes have been made to the MCP's covered services, the MCP may attest to compliance with MHPAEA. The analysis or attestation will be due to ODM during the month of December, no later than December 31<sup>st</sup>.
  - d. The MCP shall 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 MCP.

The sanctions for noncompliance with requirements in this appendix are listed in Appendix N of this Agreement.

## APPENDIX H

### PROVIDER PANEL SPECIFICATIONS

1. **Federal Access Standards.** The MCP shall provide or arrange for the delivery of all medically necessary, Medicaid-covered health services in a timely manner, and ensure compliance with federally defined provider panel access standards as required by 42 CFR 438.206.
  - a. In establishing and maintaining its provider panel, the MCP shall consider the following:
    - i. The anticipated Medicaid membership.
    - ii. The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the MCP.
    - iii. The number and types (in terms of training, experience, and specialization) of panel providers required to deliver the contracted Medicaid services.
    - iv. The geographic location of panel providers and Medicaid members, considering distance, travel time, the means of transportation ordinarily used by Medicaid members, and whether the location provides physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities.
    - v. The MCP shall adequately and timely cover services provided by an out-of-network provider if the MCP's contracted provider panel is unable to provide the services covered under this Agreement. The MCP shall cover the out-of-network services for as long as the MCP network is unable to provide the services. The MCP shall coordinate with the out- of-network provider with respect to payment and ensure the provider agrees with the applicable requirements.
  - b. Contracting providers shall offer hours of operation no less than the hours of operation offered to commercial members or comparable to Medicaid FFS, if the provider serves only Medicaid members. The MCP shall ensure services are available 24 hours a day, 7 days a week, when medically necessary. The MCP shall establish mechanisms to ensure panel providers comply with timely access requirements, and shall take corrective action if there is failure to comply.
  - c. In order to demonstrate adequate provider panel capacity and services, 42 CFR 438.206 and 438.207 stipulates that the MCP shall submit documentation to the Ohio Department of Medicaid (ODM), in a format specified by ODM, that demonstrates it offers an appropriate range of preventive, primary care, behavioral health, family planning and specialty services adequate for the anticipated number of members in the service area, while maintaining a provider panel sufficient in number, mix, and geographic distribution to meet the needs of the number of members in the service area. This documentation of assurance of adequate capacity and services shall be submitted to ODM no less frequently than at the time the MCP enters into a contract with ODM; at any time there is a significant change (as defined by ODM) in the MCP's operations that would affect adequate capacity and services (including changes in services,

benefits, geographic service or payments); on an annual basis; and at any time there is enrollment of a new population in the MCP.

2. **General Provisions.** The ODM provider panel requirements are specified in the charts included with this appendix and shall be met prior to the MCP receiving a provider agreement with ODM. The MCP shall remain in compliance with these requirements for the duration of the provider agreement.
  - a. If the MCP is unable to provide the medically necessary, Medicaid-covered services through their contracted provider panel, the MCP shall ensure access to these services on an as needed basis. For example, if the MCP meets the orthopedist requirement but a member is unable to obtain a timely appointment from an orthopedist on the MCP's provider panel, the MCP will be required to secure an appointment from a panel orthopedist or arrange for an out-of-panel referral to an orthopedist.
  - b. If the MCP offers transportation to their members as an additional benefit and this transportation benefit only covers a limited number of trips, the required transportation listed above may not be counted toward this trip limit as specified in Appendix C.
  - c. In developing the provider panel requirements, ODM considered, on a county-by-county basis, the population size and utilization patterns of the Ohio Medicaid ABD, MAGI, and Adult Extension consumers, as well as the potential availability of the designated provider types. ODM has integrated existing utilization patterns into the provider network requirements to avoid disruption of care. Most provider panel requirements are county-specific but in certain circumstances, ODM requires providers to be located anywhere in the region.
  - d. ODM will recalculate the minimum provider panel specifications if ODM determines that significant changes have occurred in the availability of specific provider types and the number and composition of the eligible population. The Managed Care Provider Network (MCPN) is the tool that will be used for ODM to determine if the MCPs meet all the panel requirements identified within Appendix H; therefore, the plans shall enter all network providers as specified within the file specs.
  - e. On a monthly basis, ODM or its designee will provide the MCP with an electronic file containing the MCP's provider panel as reflected in the ODM Managed Care Provider Network (MCPN) database, or other designated system.
3. **Provider Subcontracting.** Unless otherwise specified in this appendix or OAC rule 5160-26-05, the MCP is required to enter into fully-executed subcontracts with their providers. These subcontracts shall include a baseline contractual agreement, as well as the appropriate ODM-approved Model Medicaid Addendum. The Model Medicaid Addendum incorporates all applicable OAC rule requirements specific to provider subcontracting and therefore cannot be modified except to add personalizing information such as the MCP's name.
  - a. As required by 42 CFR 438.608, all network providers must be enrolled with ODM.
    - i. Except in single case agreements, prior to contracting with a provider and/or listing the provider as a network provider, the MCP shall either:

1. Validate that the provider is:
    - a. Active on the Provider Master File; and
    - b. Enrolled for the service and specialty, as applicable; or
  2. Direct a new provider to the ODM public portal to submit application for screening and enrollment prior to contracting.
    - ii. In accordance with 42 CFR 438.602, an MCP may execute a temporary 120 calendar day network provider agreement pending the outcome of the ODM screening, enrollment and revalidation process. The MCP 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 MCP shall submit the form to ODM for screening and enrollment. The application can be found at: <http://www.medicaid.ohio.gov/Provider/EnrollmentandSupport/ProviderEnrollment>
    - iii. The MCP may only pay a provider who is enrolled, unless the provider is rendering service with a temporary 120-calendar day agreement, a single-case agreement, or for emergency services in accordance with 42 CFR 438.114.
  - b. The MCP may not employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act. Only those providers who meet the applicable criteria specified in this document, and as determined by ODM, will be counted toward meeting minimum panel requirements. The MCP shall credential/re-credential providers in accordance with OAC rule 5160-26-05. The MCP shall ensure the provider has met all applicable credentialing criteria before the provider can be listed as a panel provider. At the direction of ODM, the MCP shall submit documentation verifying that all necessary contract documents have been appropriately completed.
  - c. The MCPN is a centralized database system that maintains information on the status of all MCP-submitted providers. The MCP shall notify ODM of the addition and deletion of their contracting providers as specified in OAC rule 5160-26-05, and shall notify ODM within one business day, in instances where the MCP has identified that they are not in compliance with the provider panel requirements specified in this appendix. For provider deletions, the MCP shall complete and submit an electronic record terminating the provider from the MCPN or other designated system.
4. **Provider Panel Requirements.** The provider network criteria that shall be met by the MCP is as follows:
- a. **Primary Care Providers (PCPs).** PCP means an individual physician (M.D. or D.O.), certain physician group practice/clinic (Primary Care Clinics [PCCs]), physician assistants, or an advanced practice registered nurse (APRN) as defined in ORC section 4723.43 or advanced practice nurse

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group practice within an acceptable specialty, contracting with the MCP to provide services as specified in OAC rule 5160-26-03.1. Acceptable specialty types for PCPs include family/general practice, internal medicine, and pediatrics. Acceptable PCCs include FQHCs, RHCs and the acceptable group practices/clinics specified by ODM. In order for the PCP to count toward minimum provider panel requirement:

- i. Each PCP shall agree to serve at least 50 Medicaid MCP members at each practice site.
- ii. As part of the MCP's subcontract with a PCP, the MCP shall ensure the total Medicaid member capacity is not greater than 2,000 for that individual PCP.

The PCP capacity for a county is the total amount of members that all of the PCPs in the MCP agree to serve in that county. ODM will determine the PCP capacity based on information submitted by the MCP through the MCPN. The PCP capacity shall exceed by at least 5% the total number of members enrolled in the MCP during the preceding month in the same county.

ODM will determine the MCP's compliance with the PCP capacity requirement each quarter using the ODM enrollment report for the previous month. For example, in April, ODM will review the MCP's countable PCP capacity using one of the April MCPN reports. The countable capacity will be compared to the finalized enrollment report for March.

ODM recognizes that some members needing specialized care will use specialty providers as PCPs. In these cases, the MCP will submit the specialist to the MCPN database as a PCP. However, the specialist serving as a PCP will not count toward minimum provider panel PCP requirements, even though they are coded as a PCP. Also, in some situations (e.g., continuity of care) a PCP may only want to serve a very small number of members for the MCP. These PCPs will, however, need to execute a subcontract with the MCP which includes the appropriate Model Medicaid Addendum.

In addition to the PCP capacity requirement, the MCP shall also contract with the specified number of pediatric PCPs for each region. These pediatric PCPs will have their stated capacity counted toward the PCP capacity requirement.

A pediatric PCP shall 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) at a site(s) located within the county/region and be listed as a pediatrician with the Ohio State Medical Board. In addition, half of the required number of pediatric PCPs shall also be certified by the American Board of Pediatrics. The provider panel requirements for pediatricians are included in the practitioner charts in this appendix.

- b. **Non-PCP Provider Network.** Although there are currently no capacity requirements of the non-PCP required provider types, the MCP is required to ensure adequate access is available to members for all required provider types. Additionally, for certain non-PCP required provider types, the MCP shall ensure these providers maintain a full-time practice at a site(s) located in the specified county/region (i.e., the ODM-specified county within the region or anywhere within the region if no particular county is specified). A full-time practice is defined as one where the provider is available to patients at their practice site(s) in the specified county/region for at

least 25 hours a week. ODM will monitor access to services through a variety of data sources, including: consumer satisfaction surveys; member appeals/grievances/complaints and state hearing notifications/requests; clinical quality studies; encounter data volume; provider complaints, and clinical performance measures.

- c. **All Other Provider Network Requirements.** In addition to the PCP capacity requirements, the MCP is also required to maintain adequate access in the remainder of its provider network within the following categories: hospitals, dentists, vision care providers, OB/GYNs, allergists, cardiovascular, gastroenterology, nephrology, neurology, oncology, physical medicine, pediatrician, pediatric dentistry, pediatric behavioral health, behavioral health, podiatry, psychiatry, urology, general surgeons, otolaryngologists, orthopedists. QHCs/RHCs, QFPPs, CNMs, CNPs, FQHCs/RHCs and QFPPs are federally-required provider types.

All Medicaid-contracting MCPs shall provide all medically-necessary Medicaid-covered services to their members and therefore their complete provider network will include many other additional specialists and provider types. The MCP shall ensure all non-PCP network providers follow community standards in the scheduling of routine appointments (i.e., the amount of time members shall wait from the time of their request to the first available time when the visit can occur).

- i. **Hospitals.** The MCP shall contract with the number and type of hospitals specified by ODM for each county/region identified in Table 3. In developing these hospital requirements, ODM considered, on a county-by-county basis, the population size and utilization patterns of the Ohio Medicaid ABD, MAGI, and Adult Extension consumers and integrated the existing utilization patterns into the hospital network requirements to avoid disruption of care. For this reason, ODM may require that the MCP contract with out-of-state hospitals (i.e. Kentucky, West Virginia, etc.). For each Ohio hospital, ODM utilizes the hospital's most current Annual Hospital Registration and Planning Report, as filed with the Ohio Department of Health (ODH), in verifying types of services that hospital provides. Although ODM has the authority, under certain situations, to obligate a non-contracting hospital to provide non-emergency hospital services to the MCP's members, the MCP shall still contract with the specified number and type of hospitals unless ODM approves a provider panel exception (see Provider Panel Exceptions in this appendix).

If the MCP-contracted hospital elects not to provide specific Medicaid-covered hospital services because of an objection on moral or religious grounds, the MCP shall ensure these hospital services are available to its members through another MCP-contracted hospital in the specified county/region.

- ii. **OB/GYNs.** The MCP shall contract with at least the minimum number of OB/GYNs for each county/region, all of whom shall maintain a full-time obstetrical practice at a site(s) located in the specified county/region. Only MCP-contracting OB/GYNs with current hospital privileges at a hospital under contract with the MCP in the region can be submitted to the MCPN, or other system, count towards MCP minimum panel requirements, and be listed in the MCPs' provider directory.

- iii. **Certified Nurse Midwives (CNMs) and Certified Nurse Practitioners (CNPs).** The MCP shall ensure access to CNM and CNP services in the region if such provider types are present within the region. The MCP may contract directly with the CNM or CNP providers, or with a physician or other provider entity which is able to obligate the participation of a CNM or CNP. If the MCP does not contract for CNM or CNP services and such providers are present within the region, the MCP will be required to allow members to receive CNM or CNP services outside of the MCP's provider network.

Only CNMs with hospital delivery privileges at a hospital under contract with the MCP in the region can be submitted to the MCPN, or other system, count towards MCP minimum panel requirements, and be listed in the MCPs' provider directory. The MCP shall ensure a member's access to CNM and CNP services if such providers are practicing within the region.

- iv. **Vision Care Providers.** The MCP shall contract with at least the minimum number of ophthalmologists/ optometrists for each specified county/region, all of whom shall maintain a full-time practice at a site(s) located in the specified county/region to count toward minimum panel requirements. All ODM-approved vision providers shall regularly perform routine eye exams.

The MCP will be expected to contract with an adequate number of ophthalmologists as part of their overall provider panel, but only ophthalmologists who regularly perform routine eye exams can be used to meet the vision care provider panel requirement. If optical dispensing is not sufficiently available in a region through the MCP's contracting ophthalmologists/optometrists, the MCP shall separately contract with an adequate number of optical dispensers located in the region.

- v. **Dental Care Providers.** The MCP shall contract with at least the minimum number of dentists identified in Table 8. Dental providers shall serve adult members and members under the age of 18 to count towards capacity.
- vi. **Other Specialty Types.** Allergists, pediatricians, general surgeons, otolaryngologists, orthopedists for the MAGI population and general surgeons, otolaryngologists, orthopedists, cardiologists, gastroenterologists, nephrologists, neurologists, oncologists, podiatrists, physiatrists, psychiatrists, and urologists for the ABD and Adult Extension populations. The MCP shall contract with at least the minimum number of ODM designated specialty provider types. In order to be counted toward meeting the provider panel requirements, these specialty providers shall maintain a full-time practice at a site(s) located within the specified county/region. Only contracting general surgeons, orthopedists, and otolaryngologists, cardiologists, gastroenterologists, nephrologists, neurologists, oncologists, physiatrists, and urologists with admitting privileges at a hospital under contract with the MCP in the region can be submitted to the MCPN, or other system, count towards MCP minimum panel requirements, and be listed in the MCP's provider directory.

- vii. **FQHCs/RHCs.** The MCP is required to ensure member access to any FQHCs/RHCs, regardless of contracting status. Contracting FQHC/RHC providers shall be submitted for

ODM review via the MCPN process, or other designated process. Even if no FQHC/RHC is available within the region, the MCP shall have mechanisms in place to ensure coverage for FQHC/RHC services in the event that a member accesses these services outside of the region. The MCP shall also educate their staff and providers on the need to ensure member access to FQHC/RHC services.

In order to ensure any FQHC/RHC has the ability to submit a claim to ODM for the state's supplemental payment, the MCP shall offer FQHCs/RHCs reimbursement pursuant to the following:

1. The MCP shall provide expedited reimbursement on a service-specific basis in an amount no less than the payment made to other providers for the same or similar service.
  2. If the MCP has no comparable service-specific rate structure, the MCP shall use the regular Medicaid FFS payment schedule for non-FQHC/RHC providers.
  3. The MCP shall provide FQHCs/RHCs the MCP's Medicaid provider number(s) for each region to enable FQHC/RHC providers to bill for the ODM wraparound payment.
- viii. **Qualified Family Planning Providers (QFPPs).** All MCP members shall be permitted to self-refer for services and supplies allowed under Title X of the Public Health Services Act (Title X services) provided by a QFPP. A QFPP 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 ODH. The MCP shall reimburse all medically-necessary Medicaid-covered Title X services provided to eligible members by a QFPP provider (including on-site pharmacy and diagnostic services) on a patient self-referral basis, regardless of the provider's status as a panel or non-panel provider. A description of Title X services can be found on the ODH website. The MCP will be required to work with QFPPs in the region to develop mutually-agreeable HIPAA compliant policies and procedures to preserve patient/provider confidentiality, and convey pertinent information to the member's PCP and/or MCP.
- ix. **Behavioral Healthcare Providers.** The MCP shall ensure member access to all Medicaid-covered behavioral health (BH) services for members as specified in Appendix G. The MCP must contract with Ohio Department of Mental Health and Addiction Services (OhioMHAS)-certified Community Mental Health Centers (CMHCs) and Substance Use Disorder (SUD) treatment providers for the provision of behavioral health services beginning July 1, 2018 in order to comply with the tables within this appendix.
1. **Community Behavioral Health Center (CBHC) Laboratories.** When the MCP is contracted with a CBHC that is an appropriately credentialed laboratory and meets Medicaid provider-eligibility requirements as a laboratory, the MCP is directed to accept the CBHC laboratory into their panel to allow for continuity of care. (CBHCs include both SUD treatment providers and CMHCs.)



2. **Substance Use Disorder (SUD) Treatment Providers.** The MCP shall contract with at least the minimum number of Ohio Department of Mental Health and Addiction Services (OhioMHAS)-certified SUD treatment facilities identified in Table 5. The MCP shall ensure adequate provider panel capacity exists to provide its members with reasonable and timely access to all state plan SUD treatment services.
  3. **Medication Assisted Treatment (MAT) Prescribers.** The MCP shall contract with at least the minimum number of MAT prescribers identified in Table 7, as well as all willing Opioid Treatment Programs (OTPs) licensed by OhioMHAS and certified by Substance Abuse and Mental Health Services Administration (SAMHSA). Contracted OTPs count towards the MCP's required number of contracted MAT prescribers. Noncompliance with MAT prescriber contracting requirements will be enforced beginning July 1, 2019. The MCP shall report any additional providers prescribing MAT not previously identified by ODM as specified by ODM.
  4. **Community Mental Health Centers (CMHCs).** The MCP shall contract with at least the minimum number of OhioMHAS-certified CMHCs identified in Table 5. In addition, the MCP shall ensure adequate provider panel capacity to provide its members with reasonable and timely access to all state plan mental health services.
  5. **Other Behavioral Health Providers.** The MCP shall contract with at least the minimum number behavioral health providers identified in Table 6. This includes independent marriage and family therapists, licensed independent chemical dependency counselors, licensed independent social workers, psychologists, etc., who do provide services outside of the SUD treatment providers and CMHCs listed above.
- x. **Pharmacies.** The MCP shall provide or arrange for the delivery of all medically necessary Medicaid-covered pharmacy services. When medically necessary, compounding service and same-day home delivery shall also be provided or arranged. The MCP's pharmacy network shall include the minimum required in Table 1 below unless any of the following apply:
1. No retail pharmacies are located in the county;
  2. The MCP has offered the retail pharmacies in the county the opportunity to contract with the MCP at similar rates offered by the Medicaid fee-for-service program so it is anticipated that aggregate payment for dispensed drugs will not be less than the aggregate amount reimbursed by the Medicaid fee-for-service program; or
  3. Available retail pharmacies in a county fail to meet the MCP's quality or program integrity standards.

Irrespective of the requirements and exceptions above, the MCP shall contract with at least one retail pharmacy in one of the adjoining counties.

**Table 1. Pharmacy Network Requirements.**

Adams	2	Fairfield	14	Licking	11	Portage	12
Allen	10	Fayette	3	Logan	5	Preble	2
Ashland	3	Franklin	98	Lorain	20	Putnam	3
Ashtabula	9	Fulton	4	Lucas	43	Richland	11
Athens	6	Gallia	2	Madison	2	Ross	6
Auglaize	3	Geauga	7	Mahoning	22	Sandusky	5
Belmont	8	Greene	12	Marion	6	Scioto	12
Brown	2	Guernsey	2	Medina	12	Seneca	4
Butler	26	Hamilton	69	Meigs	2	Shelby	3
Carroll	1	Hancock	5	Mercer	3	Stark	38
Champaign	3	Hardin	3	Miami	6	Summit	48
Clark	11	Harrison	2	Monroe	1	Trumbull	18
Clermont	15	Henry	1	Montgomery	50	Tuscarawas	8
Clinton	4	Highland	5	Morgan	0	Union	4
Columbiana	8	Hocking	2	Morrow	2	VanWert	1
Coshocton	2	Holmes	1	Muskingum	10	Vinton	0
Crawford	4	Huron	5	Noble	1	Warren	16
Cuyahoga	111	Jackson	3	Ottawa	4	Washington	5
Darke	3	Jefferson	8	Paulding	1	Wayne	7
Defiance	4	Knox	4	Perry	2	Williams	3
Delaware	11	Lake	17	Pickaway	3	Wood	10
Erie	6	Lawrence	5	Pike	3	Wyandot	2

**5. Pharmaceutical Drug Reporting and Pricing Requirements.**

- a. **Drug Rebates.** Section 1927 of the Social Security Act, 42 U.S.C. 1396r-8, mandates that drug companies or labelers shall sign a Medicaid Drug Rebate Agreement with the federal government to provide federal drug rebates to the State in order to have their products covered by the Medicaid Program. Additionally, the Affordable Care Act (ACA) requires ODM to obtain federal drug rebates for drugs paid for by the MCPs. In order to ensure compliance with the provisions of the ACA, the MCP shall:
  - i. Report the necessary encounter data to ODM for the invoicing of manufacturer rebates for all Covered Outpatient Drugs. This includes physician-administered drugs, drugs personally furnished by a physician, drugs provided in clinics and non-institutional settings, drugs dispensed by 340B covered entities, and drugs dispensed to MCP members with private or public pharmacy coverage and the MCP provided secondary coverage.

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- 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 Covered Outpatient Drugs as described above. The MCP shall also assist ODM and its designees with the resolution of drug manufacturer disputes regarding claims for federal drug rebates for drugs dispensed or administered to MCP Members.
  - iii. Establish Medicaid-specific BIN and PCN numbers for point-of-sale pharmacy claims processing, to sure that the MCP's BIN and PCN numbers for Medicaid are not the same as for the MCP's commercial or Medicare part D business lines.
  - iv. Report all outpatient drug information, including National Drug Codes (NDCs) and accurate NDC units for all drug claim types, NCPDP, 837 Professional, 837 Institutional, etc. as designated by ODM. The MCPs may negotiate their own supplemental rebates for pharmaceutical products with drug companies.
  - v. Report all drugs billed to the MCP that were acquired through the 340B drug pricing program using standard modifiers so they can be properly excluded from federal drug rebates.
- b. **Average Wholesale Price (AWP).** If the basis of pricing is determined by AWP, then the MCP shall require the PBM to utilize a nationally recognized AWP source (e.g. Medi-Span). AWP shall mean and refer to a covered prescription service based on pricing files received by the PBM from a nationally recognized source as updated at least every seven days.
- c. **Maximum Allowable Cost (MAC) Pricing.** The MCP shall update maximum allowable cost (MAC) and other pricing benchmarks on a schedule at least as consistent as is required by CMS for Medicare Part D plans found in 42 CFR 423.505(b)(21). The MCP's MAC will have the following characteristics:
- i. The MCP's list of MAC reimbursement is updated a minimum of every 7 calendar days;
  - ii. The MCP will provide, upon request from ODM or a retail community pharmacy in Ohio, at least one source where a non-340B retail community pharmacy in Ohio is able to purchase the drug at the MCP's MAC rate for that drug, or lower; and
  - iii. The MCP will provide a reasonable and direct process for Ohio's retail community pharmacies to communicate with the MCP and report the pharmacy's inability to purchase at the MCP's MAC price and receive instructions from the MCP as to where to purchase at the MAC price.
- d. **MAC Transparency.** If the MCP has an agreement or contract with a pharmacy benefit manager (PBM) or a pharmacy benefit administrator (PBA), the PBM or PBA shall use the same MAC list and pricing schedule to reimburse pharmacies and to charge the MCP. At least semi-annually, the MCP shall review the PBM or PBA's MAC list and pricing structure.

6. **Provider Panel Exceptions.** Failure to contract with, and properly report to the MCPN, all MCP-

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contracted providers will result in sanctions as outlined in Appendix N. ODM will grant an exception to the issuance of a sanction only when an action taken by ODM has adversely impacted a plan's ability to meet the provider panel network standards.

7. **Provider Directories.** MCP provider directories shall include all MCP-contracted providers as well as certain non- contracted providers as specified by ODM. At the time of ODM's review, the information listed in the MCP's provider directory for all MCP-contracted providers shall exactly match the data currently on file in the ODM MCPN, or other designated process.
  - a. MCP provider directories shall utilize a format specified by ODM. Directories may be region-specific or include multiple regions, however, the providers within the directory shall be divided by region, county, and provider type, in that order. The directory shall also specify:
    - i. Provider's name as well as any group affiliation
    - ii. Provider's street address(es)
    - iii. Provider's telephone number(s)
    - iv. Provider's website URL, as appropriate
    - v. Provider's specialty, when applicable
    - vi. Indication of the provider's office/facility accessibility and accommodations (e.g. offices, exam room(s), and equipment), when applicable
    - vii. Indication of whether the provider is accepting new members
    - viii. Indication of the provider's linguistic capabilities, including the specific language(s) offered, including ASL, and whether they are offered by the provider or a skilled medical interpreter at the provider's office.
    - ix. Provider's cultural competence training status, when available.
    - x. How members may obtain directory information in alternate formats that takes into consideration the special needs of eligible individuals including but not limited to, visually-limited, LEP, and LRP eligible individuals.
  - b. **Printed Provider Directory.** Prior to executing a provider agreement with ODM, the MCP shall develop a printed provider directory that shall be prior-approved by ODM. Once approved, in accordance with 42 CFR 438.10, this directory content may be updated with provider additions or deletions by the MCP without ODM prior-approval. Any revisions to the printed provider directory format must be approved by ODM before distribution.
  - c. **Internet Provider Directory.** The MCP is required to have an internet-based provider directory available in a format prior approved by ODM. Any revisions to the internet provider directory format must be approved by ODM before implementation. This internet directory shall allow

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members to electronically search for MCP panel providers based on name, provider type, and geographic proximity. If the MCP has one internet-based directory for multiple populations, each provider shall include a description of which population they serve. If the MCP receives updated provider information, this directory shall be updated in accordance with the timeframes listed in 42 CFR 438.10.

8. **Managed Care Provider Network Performance Measures.** ODM contracts with an External Quality Review Organization (EQRO), to conduct telephone surveys of providers' offices to validate information submitted in the MCPN files. These results will be used to evaluate MCP performance on a biannual basis. Sanctions for these measures are included in Appendix N of this agreement. The following elements have a baseline that shall be met with the statewide results:

- a. **Rate of Primary Care Provider Locations.** Measure 1 (M1) Rate of primary care provider (PCP) locations that were able to be reached. The data updated by the MCPs in ODM's system shall be accurate 70% of the time for the statistically valid statewide sample.

Measure 1 (M1) identifies the proportion of the PCP locations not reached during a biannual audit. The PCP was considered "not reached" if the provider is no longer practicing at the sampled location or the provider did not return phone calls after the EQRO made two attempts at different times during the survey. The measure is an inverse measure such that the higher the percentage of PCP locations not reached, the lower the level of performance.

$$(M1) \text{ Percent of PCP Locations Not Reached} = \frac{\text{Number of PCP Locations Not Reached}}{\text{Total Number of PCP Locations}}$$

- b. **Number of PCP Locations.** Measure 2 (M2) Participating PCP locations still contracted with the MCP.

For Measure 2, the baseline of 92% was established using the previous 2 cycles of data collection. The MCP shall ensure the contracting status of the statistically valid statewide sample is met 92% of the time.

The second measure (M2) reports the proportion of the PCP locations no longer contracted with the identified MCP at the time of the audit. This measure is also inverted such that a higher rate indicates lower performance.

$$(M2) \text{ Percent of PCP Locations Not Contracted with MCP} = \frac{\text{Number of PCP Locations Not With MCP}}{\text{Number of PCP Locations Reached}}$$

- c. ODM collected the first two years of performance measures and additional research to create a baseline for the two measures.
- i. **Measure 1 – PCP Locations Not Reached.** The data updated by the MCPs in ODM's system shall be accurate 70% of the time for the statistically valid statewide sample.
- ii. **Measure 2 – PCP Locations Not Contracted With MCP.** For Measure 2, the baseline of 92% was established using the previous 2 years of collected data of members that were

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reached MCPs shall ensure the contracting status of the statistically valid statewide sample is met 92% of the time.

**Table 2. Network Capacity Minimum Standards.** ODM will be using our internal system, Arc GIS, to determine the time and distance compliance quarterly for the MCPs. The county-based standards will be eliminated for the specialists and then evaluated to determine if other county based standards can be replaced with the time and distance after January 1, 2019.

Allergist	Behavioral Health
Cardiologist	ENT/Otolaryngologist
Gastroenterologist	General Surgeons
Gynecology, OB/GYN	Nephrologist
Neurologist	Oncologist
Orthopedist	Pediatrics
Pediatric Dentistry	Pediatric Behavioral Health
Pharmacy	Podiatrist
Primary Care	Psychiatrist
Urologist	

The above provider types will be measured using the time and distance standards located on the HSD Reference file at <https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html> .

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**Table 3. Hospital Provider Panel.**

County	General Hospital	Hospital System	Inpatient Psych Hospital	County	General Hospital	Hospital System	Inpatient Psych Hospital	County	General Hospital	Hospital System	Inpatient Psych Hospital
ADAMS	-	-	-	HAMILTON	1	2	3	NOBLE	-	-	-
ALLEN	1	-	1	HANCOCK	1	-	1	OTTAWA	-	-	-
ASHLAND	1	-	-	HARDIN	-	-	-	PAULDING	-	-	-
ASHTABULA	1	-	-	HARRISON	-	-	-	PERRY	-	-	-
ATHENS	1	-	-	HENRY	-	-	-	PICKAWAY	1	-	-
AUGLAIZE	-	-	-	HIGHLAND	1	-	1	PIKE	-	-	-
BELMONT	1	-	1	HOCKING	-	-	1	PORTAGE	1	-	-
BROWN	-	-	-	HOLMES	1	-	-	PREBLE	-	-	-
BUTLER	-	-	1	HURON	1	-	-	PUTNAM	-	-	-
CARROLL	-	-	-	JACKSON	-	-	-	RICHLAND	1	-	-
CHAMPAIGN	-	-	-	JEFFERSON	1	-	-	ROSS	1	-	1
CLARK	1	-	-	KNOX	1	-	-	SANDUSKY	1	-	-
CLERMONT	-	-	1	LAKE	1	-	1	SCIOTO	1	-	-
CLINTON	1	-	-	LAWRENCE	-	-	-	SENECA	-	-	-
COLUMBIANA	1	-	-	LICKING	1	-	1	SHELBY	1	-	1
COSHOCTON	1	-	-	LOGAN	1	-	-	STARK	1	-	1
CRAWFORD	1	-	-	LORAIN	1	-	-	SUMMIT	1	1	1
CUYAHOGA	1	1	6	LUCAS	-	1	2	TRUMBULL	1	-	1
DARKE	1	-	1	MADISON	1	-	-	TUSCARAWAS	1	-	1
DEFIANCE	1	-	1	MAHONING	1	-	1	UNION	1	-	-
DELAWARE	-	-	-	MARION	1	-	1	VANWERT	1	-	-
ERIE	1	-	-	MEDINA	1	-	-	VINTON	-	-	-
FAIRFIELD	1	-	1	MEIGS	-	-	-	WARREN	-	-	1
FAYETTE	1	-	-	MERCER	1	-	-	WASHINGTON	1	-	-
FRANKLIN	1	2	3	MIAMI	1	-	1	WAYNE	1	-	-
FULTON	1	-	1	MONROE	-	-	-	WILLIAMS	1	-	-
GALLIA	1	-	1	MONTGOMERY	1	1	1	WOOD	-	-	-
GEAUGA	1	-	1	MORGAN	-	-	-	WYANDOT	1	-	-
GREENE	1	-	-	MORROW	-	-	-				
GUERNSEY	1	-	-	MUSKINGUM	1	-	1				

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**Table 4. Nursing Facility Provider Panel.**

Region	County	Nursing Facility Requirement
W	ADAMS	1
W	ALLEN	2
NE	ASHLAND	1
NE	ASHTABULA	3
CEN/SE	ATHENS	1
W	AUGLAIZE	1
CEN/SE	BELMONT	2
W	BROWN	1
W	BUTLER	5
W	CHAMPAIGN	1
W	CLARK	3
W	CLERMONT	2
W	CLINTON	1
NE	COLUMBIANA	3
CEN/SE	COSHOCTON	1
CEN/SE	CRAWFORD	1
NE	CUYAHOGA	19
W	DARKE	1
W	DEFIANCE	1
CEN/SE	DELAWARE	1
NE	ERIE	2
CEN/SE	FAIRFIELD	2
CEN/SE	FAYETTE	1
CEN/SE	FRANKLIN	11
W	FULTON	1
CEN/SE	GALLIA	1

Region	County	Nursing Facility Requirement
NE	GEAUGA	1
W	GREENE	2
CEN/SE	GUERNSEY	1
W	HAMILTON	14
W	HANCOCK	1
CEN/SE	HARRISON	1
W	HENRY	1
W	HIGHLAND	1
NE	HOLMES	1
NE	HURON	1
CEN/SE	JACKSON	1
CEN/SE	JEFFERSON	2
CEN/SE	KNOX	2
NE	LAKE	2
CEN/SE	LAWRENCE	1
CEN/SE	LICKING	2
CEN/SE	LOGAN	1
NE	LORAIN	4
W	LUCAS	7
NE	MAHONING	5
CEN/SE	MARION	1
NE	MEDINA	2
W	MERCER	1
W	MIAMI	1
W	MONTGOMERY	8
CEN/SE	MORROW	1

Region	County	Nursing Facility Requirement
CEN/SE	MUSKINGUM	1
W	OTTAWA	1
CEN/SE	PERRY	1
CEN/SE	PICKAWAY	1
CEN/SE	PIKE	1
NE	PORTAGE	2
W	PREBLE	1
W	PUTNAM	1
NE	RICHLAND	2
CEN/SE	ROSS	1
W	SANDUSKY	2
CEN/SE	SCIOTO	2
W	SENECA	1
W	SHELBY	1
NE	STARK	7
NE	SUMMIT	9
NE	TRUMBULL	4
NE	TUSCARAWAS	2
CEN/SE	UNION	1
W	VANWERT	1
W	WARREN	3
CEN/SE	WASHINGTON	1
NE	WAYNE	2
W	WILLIAMS	1
W	WOOD	2



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**Table 5. Community Behavioral Health Center (CBHC) Provider Panel.**

Region	County	CMHC	SUD
W	ADAMS	1	-
W	ALLEN	1	2
NE	ASHLAND	3	1
NE	ASHTABULA	1	3
CEN/SE	ATHENS	1	2
W	AUGLAIZE	-	-
CEN/SE	BELMONT	3	1
W	BROWN	-	-
W	BUTLER	7	4
W	CHAMPAIGN	-	-
W	CLARK	4	2
W	CLERMONT	3	2
W	CLINTON	-	-
NE	COLUMBIANA	2	1
CEN/SE	COSHOCTON	-	1
CEN/SE	CRAWFORD	1	1
NE	CUYAHOGA	28	29
W	DARKE	1	1
W	DEFIANCE	1	1
CEN/SE	DELAWARE	1	1
NE	ERIE	2	2
CEN/SE	FAIRFIELD	3	2
CEN/SE	FAYETTE	-	-
CEN/SE	FRANKLIN	23	19
W	FULTON	-	-
CEN/SE	GALLIA	1	5
NE	GEAUGA	3	3

Region	County	CMHC	SUD
W	GREENE	3	1
CEN/SE	GUERNSEY	5	1
W	HAMILTON	22	15
W	HANCOCK	-	1
CEN/SE	HARDIN	-	1
W	HENRY	1	-
W	HIGHLAND	1	1
NE	HOCKING	-	1
NE	HURON	-	-
CEN/SE	JACKSON	-	1
CEN/SE	JEFFERSON	1	1
CEN/SE	KNOX	-	1
NE	LAKE	9	5
CEN/SE	LAWRENCE	3	4
CEN/SE	LICKING	4	1
CEN/SE	LOGAN	1	1
NE	LORAIN	2	4
W	LUCAS	12	11
CEN/SE	MADISON	1	-
NE	MAHONING	10	8
CEN/SE	MARION	1	1
NE	MEDINA	3	3
W	MERCER	1	1
W	MIAMI	1	1
W	MONTGOMERY	12	10
CEN/SE	MORGAN	-	1
CEN/SE	MUSKINGUM	2	1

Region	County	CMHC	SUD
CEN/SE	NOBLE	-	1
W	PAULDING	1	-
CEN/SE	PERRY	-	1
CEN/SE	PICKAWAY	-	1
CEN/SE	PIKE	-	1
NE	PORTAGE	5	3
W	PREBLE	-	1
W	PUTNAM	-	-
NE	RICHLAND	6	10
CEN/SE	ROSS	2	3
W	SANDUSKY	1	1
CEN/SE	SCIOTO	1	7
W	SENECA	-	-
W	SHELBY	1	1
NE	STARK	6	6
NE	SUMMIT	11	9
NE	TRUMBULL	5	1
NE	TUSCARAWAS	1	1
CEN/SE	UNION	-	-
W	VANWERT	-	-
W	WARREN	1	1
CEN/SE	WASHINGTON	1	1
NE	WAYNE	6	4
W	WILLIAMS	-	-
W	WOOD	2	1

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**Table 6. Other Behavioral Health Provider Panel (not provider types 84 or 95).**

County	BH	County	BH	County	BH	County	BH
Adams	0	Fayette	0	Lorain	16	Richland	6
Allen	8	Franklin	24	Lucas	25	Ross	5
Ashland	1	Fulton	6	Madison	2	Sandusky	9
Ashtabula	8	Gallia	1	Mahoning	13	Scioto	1
Athens	5	Geauga	3	Marion	5	Seneca	0
Auglaize	0	Greene	14	Medina	13	Shelby	0
Belmont	2	Guernsey	1	Meigs	0	Stark	16
Brown	0	Hamilton	25	Mercer	3	Summit	29
Butler	17	Hancock	2	Miami	7	Trumbull	13
Carroll	0	Hardin	3	Monroe	0	Tuscarawas	4
Champaign	0	Harrison	0	Montgomery	20	Union	0
Clark	5	Henry	1	Morgan	0	VanWert	1
Clermont	4	Highland	0	Morrow	0	Vinton	0
Clinton	2	Hocking	2	Muskingum	6	Warren	7
Columbiana	7	Holmes	0	Noble	0	Washington	0
Coshocton	2	Huron	3	Ottawa	1	Wayne	4
Crawford	0	Jackson	2	Paulding	0	Williams	3
Cuyahoga	55	Jefferson	0	Perry	0	Wood	12
Darke	1	Knox	5	Pickaway	2	Wyandot	0
Defiance	0	Lake	12	Pike	0		
Delaware	4	Lawrence	2	Portage	5		
Erie	5	Licking	4	Preble	0		
Fairfield	3	Logan	1	Putnam	0		

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**Table 7. Medication Assisted Treatment Provider Panel.**

County	MAT	County	MAT	County	MAT	County	MAT
Adams	0	Fayette	1	Lorain	2	Richland	6
Allen	6	Franklin	43	Lucas	14	Ross	3
Ashland	0	Fulton	0	Madison	1	Sandusky	1
Ashtabula	2	Gallia	2	Mahoning	12	Scioto	8
Athens	3	Geauga	1	Marion	4	Seneca	0
Auglaize	0	Greene	5	Medina	1	Shelby	1
Belmont	1	Guernsey	1	Meigs	2	Stark	6
Brown	0	Hamilton	30	Mercer	0	Summit	14
Butler	8	Hancock	1	Miami	2	Trumbull	4
Carroll	0	Hardin	1	Monroe	0	Tuscarawas	1
Champaign	1	Harrison	0	Montgomery	18	Union	0
Clark	2	Henry	0	Morgan	1	VanWert	0
Clermont	4	Highland	1	Morrow	0	Vinton	1
Clinton	0	Hocking	3	Muskingum	3	Warren	4
Columbiana	3	Holmes	0	Noble	0	Washington	0
Coshocton	0	Huron	1	Ottawa	0	Wayne	1
Crawford	1	Jackson	0	Paulding	0	Williams	1
Cuyahoga	34	Jefferson	0	Perry	2	Wood	2
Darke	0	Knox	1	Pickaway	2	Wyandot	0
Defiance	1	Lake	4	Pike	1		
Delaware	1	Lawrence	1	Portage	2		
Erie	2	Licking	4	Preble	0		
Fairfield	3	Logan	2	Putnam	0		

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**Table 8. Dental and Vision Provider Panel.** The Dental standards require that the provider not only practice at least 25 hours per week, but they also be willing to serve adult members and members under the age of 18.

Region	County	Dental	Vision	Region	County	Dental	Vision	Region	County	Dental	Vision
W	ADAMS	1	-	W	HAMILTON	50	14	CEN/SE	NOBLE	1	-
W	ALLEN	5	3	W	HANCOCK	2	1	W	OTTAWA	1	-
NE	ASHLAND	3	-	W	HARDIN	1	-	W	PAULDING	-	-
NE	ASHTABULA	3	3	CEN/SE	HARRISON	-	-	CEN/SE	PERRY	1	-
CEN/SE	ATHENS	3	3	W	HENRY	1	-	CEN/SE	PICKAWAY	1	1
W	AUGLAIZE	1	1	W	HIGHLAND	3	2	CEN/SE	PIKE	1	-
CEN/SE	BELMONT	4	4	CEE/SE	HOCKING	1	-	NE	PORTAGE	3	-
W	BROWN	1	-	NE	HOLMES	-	-	W	PREBLE	4	-
W	BUTLER	13	4	NE	HURON	2	2	W	PUTNAM	1	-
NE	CARROLL	-	-	CEN/SE	JACKSON	1	2	NE	RICHLAND	7	2
W	CHAMPAIGN	1	-	CEN/SE	JEFFERSON	3	3	CEN/SE	ROSS	4	2
W	CLARK	6	3	CEN/SE	KNOX	3	2	W	SANDUSKY	3	-
W	CLERMONT	5	1	NE	LAKE	6	6	CEN/SE	SCIOTO	2	2
W	CLINTON	1	2	CEN/SE	LAWRENCE	3	3	W	SENECA	2	-
NE	COLUMBIANA	3	-	CEN/SE	LICKING	4	2	W	SHELBY	1	-
CEN/SE	COSHOCTON	3	1	CEN/SE	LOGAN	1	2	NE	STARK	17	7
CEN/SE	CRAWFORD	1	2	NE	LORAIN	11	11	NE	SUMMIT	23	13
NE	CUYAHOGA	102	32	W	LUCAS	29	9	NE	TRUMBULL	11	4
W	DARKE	1	1	CEN/SE	MADISON	1	-	NE	TUSCARAWAS	4	-
W	DEFIANCE	-	2	NE	MAHONING	14	5	CEN/SE	UNION	1	1
CEN/SE	DELAWARE	3	3	CEN/SE	MARION	3	2	W	VANWERT	2	-
NE	ERIE	2	2	NE	MEDINA	4	4	CEN/SE	VINTON	-	-
CEN/SE	FAIRFIELD	4	3	CEN/SE	MEIGS	-	-	W	WARREN	1	-
CEN/SE	FAYETTE	1	-	W	MERCER	1	-	CEN/SE	WASHINGTON	3	2
CEN/SE	FRANKLIN	95	20	W	MIAMI	3	-	NE	WAYNE	3	-
W	FULTON	1	-	CEN/SE	MONROE	-	-	W	WILLIAMS	1	-
CEN/SE	GALLIA	1	2	W	MONTGOMERY	25	-	W	WOOD	2	-
NE	GEAUGA	1	1	CEN/SE	MORGAN	-	-	W	WYANDOT	1	-
W	GREENE	3	3	CEN/SE	MORROW	1	-				
CEN/SE	GUERNSEY	3	2	CEN/SE	MUSKINGUM	4	4				

The sanctions for noncompliance with requirements in this appendix are listed in Appendix N of this Agreement.

## APPENDIX I

### PROGRAM INTEGRITY

The MCP shall comply with all applicable state and federal program integrity requirements, including, but not limited to, those specified in Ohio Administrative Code (OAC) rule 5160-26-06, 42 CFR Part 455, 42 CFR Part 1002 and 42 CFR Part 438 Subpart H.

1. **Fraud, Waste and Abuse Program.** In addition to the specific requirements of OAC rule 5160-26-06, the MCP shall have a program that includes administrative and management arrangements or procedures to detect and prevent fraud, waste and abuse. The MCP's compliance program shall address the following:
  - a. **Compliance Program.** In accordance with 42 CFR 438.608, the MCP shall implement and maintain a compliance program that includes all of the following:
    - i. A mandatory compliance plan that includes 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 MCP will determine the effectiveness of the compliance plan.
    - ii. Written policies, procedures and standards of conduct that demonstrate compliance with all applicable requirements and standards under this Agreement, as well as all federal and state requirements related to program integrity.
    - iii. A designated Compliance Officer who is responsible for developing and implementing policies and procedures designed to ensure compliance with program integrity requirements. The Compliance Officer shall report to the Chief Executive Officer and the Board of Directors.
    - iv. A Regulatory Compliance Committee, consisting of members of the Board of Directors and senior management, which is responsible for oversight of the MCP's compliance program.
    - v. A system for training and education for the Compliance Officer, the MCP's senior management, and the MCP's employees regarding the MCP's compliance program and program integrity related requirements.
    - vi. Effective lines of communication between the Compliance officer and the MCP's employees.
    - vii. Enforcement of standards through well-publicized disciplinary guidelines.
    - viii. A system of dedicated staff with established and implemented procedures for routine internal monitoring and auditing of service patterns of providers and subcontractors, compliance risks, prompt response to compliance issues, investigations of potential compliance problems identified in the course of self-evaluation and audits, correction of

identified compliance problems and ongoing compliance with program integrity related requirements.

- ix. Education of providers and delegated entities about fraud, waste and abuse.
  - x. Establishment and/or modification of internal MCP controls to ensure the proper submission and payment of claims.
  - xi. Prompt reporting of all instances of suspected provider fraud, waste and abuse to ODM and suspected member fraud, waste and abuse to ODM's Bureau of Program Integrity.
- b. **Employee Education about False Claims Recovery.** The MCP shall comply with Section 6032 of the Deficit Reduction Act of 2005 regarding employee education and false claims recovery, specifically the MCP shall:
- i. Establish and make readily available to all employees, including the MCP's management, the following written policies regarding false claims recovery:
    - 1. Detailed information about the Federal False Claims Act and other state and federal laws related to the prevention and detection of fraud, waste and abuse, including administrative remedies for false claims and statements, as well as civil or criminal penalties;
    - 2. The MCP's policies and procedures for detecting and preventing fraud, waste and abuse; and
    - 3. The laws governing the rights of employees to be protected as whistleblowers. In addition, the MCP shall communicate the following whistleblower fraud and/or abuse reporting contacts to all employees, providers and subcontractors:
      - a. Ohio Department of Medicaid (ODM) 1-614-466-0722 or at <http://medicaid.ohio.gov/RESOURCES/HelpfulLinks/ReportingSuspectedMedicaidFraud.aspx>;
      - b. Medicaid Fraud Control Unit (MFCU) 1-800-642-2873 or at <http://www.ohioattorneygeneral.gov/Individuals-and-Families/Victims/Submit-a-Tip/Report-Medicaid-Fraud>; and
      - c. The Ohio Auditor of State (AOS) 1-866-FRAUD-OH or by email at [fraudohio@ohioauditor.gov](mailto:fraudohio@ohioauditor.gov)
  - ii. Include the required written policies regarding false claims recovery in any employee handbook;
  - iii. In accordance with 42 CFR 438.608, establish written policies for any MCP contractors and agents that provide detailed information about the Federal False Claims Act and other state and federal laws related to the prevention and detection of fraud, waste and

abuse, including administrative remedies for false claims and statements, as well as civil or criminal penalties; the laws governing the rights of employees to be protected as whistleblowers; and the MCP's policies and procedures for detecting and preventing fraud, waste and abuse. The MCP shall make such information readily available to their subcontractors; and

- iv. Disseminating the required written policies to all contractors and agents who shall abide by those written policies.
- c. **Monitoring for Fraud, Waste and Abuse.** The MCP shall specifically address the MCP's strategies for prevention, detection, investigation and reporting in at least the following areas:
- i. **Credible allegations of fraud.** The MCP shall monitor activities on an ongoing basis to prevent and detect activities involving suspected fraud, embezzlement, and theft (e.g., by staff, providers, contractors) and report findings promptly to ODM as specified in this appendix.
  - ii. **Underutilization of services.** In order to ensure all Medicaid-covered services are provided as required, monitoring of the following areas shall occur:
    1. The MCP shall annually review their prior authorization (PA) procedures to determine if they unreasonably limit a member's access to Medicaid-covered services;
    2. The MCP shall annually review their appeals process for providers following the MCP's denial of a prior authorization request for a determination as to whether the appeals process unreasonably limits a member's access to Medicaid-covered services;
    3. The MCP shall monitor, on an ongoing basis, service denials and utilization in order to identify member services which may be underutilized; and
    4. If any underutilized services or limits to a member's access to Medicaid-covered services are identified, the MCP shall immediately investigate and, if indicated, correct the problem(s).
  - iii. **Claims submission and billing.** On an ongoing basis, the MCP shall identify and correct claims submission and billing activities which are potentially fraudulent including, at a minimum, double-billing and improper coding, such as upcoding and unbundling, to the satisfaction of ODM.
2. **Special Investigative Unit (SIU).** At a minimum, the MCP shall utilize a single in-state MCP lead investigator to conduct fraud, waste and abuse investigations, prepare investigatory reports, implement the Compliance Plan to guard against fraud, waste and abuse, monitor aberrant providers and refer potential fraud, waste and abuse to ODM.

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- a. The lead investigator shall be a full-time employee in the State of Ohio. He or she shall be dedicated solely to ODM program integrity work and meet the following qualifications:
    - i. A minimum of two years in healthcare field working in fraud, waste and abuse investigations and audits,
    - ii. A Bachelor's degree, or an Associate's degree with an additional two years working in health care fraud, waste and abuse investigations and audits. ODM will accept experience and certifications commensurate with the aforementioned educational requirements. ODM will evaluate the experience and certifications in lieu of the educational requirements; and
    - iii. Ability to understand and analyze health care claims and coding
  - b. The in-state lead investigator shall participate in SIU coordination with ODM Program Integrity in areas such as fraud referrals, audits and investigations, overpayments, provider terminations, among other activities, as well as attend any required meetings as prescribed by ODM.
3. **Reporting MCP monitoring of fraud, waste and abuse activities.** Pursuant to OAC rule 5160-26-06, the MCP shall report annually to ODM a summary of the MCP's monitoring of credible allegations of fraud, waste and abuse, underutilization of member services, limits to Medicaid-covered services and suspicious claims submission and billing. The MCP's report shall also identify any proposed changes to the MCP's compliance plan for the coming year.
- a. **Reporting suspected fraud, waste and abuse.** The MCP is required to promptly report all instances of suspected provider fraud, waste and abuse to ODM and member fraud, waste and abuse to ODM's Bureau of Program Integrity (BPI), copying the appropriate county department of job and family services. If the MCP fails to properly report a case of suspected fraud, waste or abuse before the suspected fraud, waste or abuse is identified by the State of Ohio, its designees, the United States or private parties acting on behalf of the United States, any portion of the fraud, waste or abuse recovered by the State of Ohio or designees shall be retained by the State of Ohio or its designees.
    - i. **Credible allegation of provider fraud.** The MCP shall promptly refer suspected cases of provider fraud in the ODM specified form to ODM for investigation and determination of whether a credible allegation of fraud exists. If a credible allegation of fraud exists, at the direction of ODM, the MCP shall immediately suspend all payments to the provider and shall suspend the provider in accordance with ORC section 5164.36. At the request of ODM staff, ODM's designee, the Ohio Attorney General's Office, or federal agencies, the MCP shall produce copies of all MCP fraud, waste and abuse investigatory files and data (including, but not limited to records of recipient and provider interviews) in 30 calendar days unless otherwise agreed upon by ODM.
    - ii. **Credible allegation of member fraud.** All suspected enrollee fraud and abuse shall be immediately reported to Bureau of Program Integrity (BPI) at [Program\\_Integrity\\_County\\_Referral@medicaid.ohio.gov](mailto:Program_Integrity_County_Referral@medicaid.ohio.gov) and copy the appropriate county department of job and family services (CDJFS).



- b. **Referrals and Attestations.** The MCP shall submit fraud, waste and abuse referrals to ODM using the ODM Referral form. Each referral submitted to ODM will be distributed to all MCPs. Upon receipt of a fraud, waste and abuse referral from ODM, the MCP shall respond by submitting the ODM Attestation form within 90 calendar days. A failure to file an attestation timely, completely, and accurately may result in the MCP waiving its right to participate in any Attorney General Office (AGO) MFCU recoveries.
- c. **Monitoring for prohibited affiliations.** The MCP's policies and procedures for ensuring that, pursuant to 42 CFR 438.610, the MCP will not knowingly have a relationship or prohibited affiliation with individuals debarred by Federal Agencies, as specified in Article XII of this Agreement. Pursuant to 42 CFR 438.608, it is the duty of the MCP to disclose to ODM any prohibited affiliations under 42 CFR 438.610.
- d. **Provider indictment.** If an indictment is issued, charging a non-institutional Medicaid provider or its owner, officer, authorized agent, associate, manager, or employee with committing an offence specified in ORC section 5164.37(E), and ODM suspends this Agreement held by the non-institutional Medicaid provider, at the direction of ODM, the MCP shall immediately suspend the provider and terminate Medicaid payments to the provider for Medicaid services rendered in accordance with ORC section 5164.37(D).
- e. The MCP shall disclose any change in ownership and control information and this information shall be furnished to ODM within 35 calendar days in accordance with 42 CFR 455.104, OAC rule 5160-1-17.3 and subcontractors as governed by 42 CFR 438.230.
- f. In accordance with 42 CFR 455.105, the MCP shall 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 MCP has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request.
  - ii. Any significant business transactions between the MCP and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.
- g. The MCP shall disclose the following information on persons convicted of crimes in accordance with 42 CFR 455.106 who have:
  - i. Ownership or control interest in the provider, or is an agent or managing employee of the provider; and
  - ii. Been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

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

- h. The MCP shall notify ODM when the MCP denies credentialing to providers for program integrity reasons.
- i. The MCP shall notify ODM when there is a change in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including when a provider panel application is denied or a panel provider agreement is terminated for program integrity reasons. The MCP shall provide the reason for the denial or termination.
- j. The MCP shall provide to ODM a quarterly report of all open program integrity related audits and investigations related to fraud, waste and abuse activities for identifying and collecting potential overpayments, utilization review and provider compliance. The report shall include, but is not limited to, audits and investigations performed, overpayments identified, overpayments recovered and other program integrity actions taken; such as, corrective action plans, provider education, financial sanctions and sanctions against a provider, during the previous contracting period and for each ongoing quarter.
- k. **Coordination with Law Enforcement.** The MCP shall request deconfliction to facilitate coordination with law enforcement and to reasonably prevent conflicts with active investigations.
  - i. Prior to initiating an audit, investigation, review, recoupment or withhold, or involuntarily terminating a provider, the MCP must request deconfliction and receive permission from ODM to proceed.

The MCP retains the right to recovery for the costs arising out of provider fraud or abuse as defined by rule 5160-26-01 of the Administrative Code in the following circumstance:

- 1. The AGO MFCU has an open case, and the MCP requested deconfliction and received leave to proceed since there wasn't a conflict with an active law enforcement investigation,
  - 2. The date of the deconfliction request occurred prior to the date that the AGO MFCU opened their case on the same provider, and
  - 3. The MCP submits a referral regarding the same provider after completion of its previously approved audit, investigation or review.
- ii. The AGO MFCU may request that the MCP stand down after submitting a deconfliction request for fraud, waste or abuse. The stand down time-period will last for an initial period of six months after the deconfliction response is sent.

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1. The AGO MFCU may request an additional six months of stand down, if the extension is warranted.
  2. This provision does not apply to federal cases, joint task force cases or other cases which are not under the AGO MFCU's control.
- iii. The MCP may not act to recoup improperly paid funds or withhold funds potentially due to a provider when the issues, services or claims upon which the recoupment or withhold is based on the following:
1. The improperly paid funds 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 MCP had no right of participation, or
  2. The improperly paid funds are currently being investigated by the State of Ohio, are the subject of pending federal or state litigation or investigation, or are being audited by ODM, the Ohio Auditor of State (AOS), CMS, OIG, or their agents.
- iv. Absent any restrictions on recovery, the MCP may otherwise recover from a provider any amount collected from the MCP 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 MCP which resulted from an audit, review or investigation of the provider. The MCP shall retain recovery rights to any amount paid to ODM when a provider self-reports an overpayment arising from a payment made by the MCP to the provider or other reason.
- v. The MCP shall notify ODM when it proposes to recoup or withhold improperly paid funds already paid or potentially due to a provider and obtain ODM approval to recoup or withhold, prior to taking such action.

This provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.

- I. Non-federally qualified MCPs shall report to ODM a description of certain transactions with parties of interest as outlined in Section 1903(m)(4)(A) of SSA [42 U.S.C. 1396b].
- m. **Treatment of Recoveries made by the MCP from Overpayments to Providers.** Pursuant to 42 CFR 438.608, the MCP shall:
  - i. Immediately notify ODM BPI if the MCP acts to recoup improperly paid funds (including overpayments due to fraud, waste and abuse) in violation of this appendix. ODM BPI will issue written instructions, including any applicable timeframes, in response to the notification of improper recovery and the MCP shall comply with those instructions; and
  - ii. Require any network provider to report to the MCP when it has received an overpayment, to return the overpayment to the MCP within 60 calendar days after the

date on which the overpayment was identified, and to notify the MCP in writing of the reason for the overpayment.

This provision does not apply to any amount of a recovery to be retained under the False Claims Act cases or through other investigations.

4. **Data Certification.** Pursuant to 42 CFR 438.604 and 42 CFR 438.606, the MCP is required to provide certification as to the accuracy, completeness and truthfulness of data and documents submitted to ODM which may affect MCP payment.
  - a. **MCP Submissions.** The MCP shall submit the appropriate ODM-developed certification concurrently with the submission of the following data or documents:
    - i. Encounter Data as specified in Appendix L;
    - ii. Prompt Pay Reports as specified in Appendix J;
    - iii. Cost Reports as specified in Appendix J;
    - iv. Care Management Data as specified in Appendix L
    - v. HEDIS IDSS Data/FAR [as specified in Appendix L; and
    - vi. CAHPS Data as specified in Appendix L.
  - b. **Source of Certification.** The above MCP data submissions shall be certified by one of the following:
    - i. The MCP's Chief Executive Officer;
    - ii. The MCP's Chief Financial Officer; or
    - iii. An individual who has delegated authority to sign for, and who reports directly to, the MCP's Chief Executive Officer or Chief Financial Officer. When the authorization is delegated to another MCP employee, the CEO or CFO remains responsible.
  - c. The MCP shall provide certification as to the accuracy, completeness, and truthfulness of additional submissions.
5. **Explanation of Benefits (EOB) Mailings.** Pursuant to 42 CFR 455.20, the MCP shall have a method for verifying with enrollees whether services billed by providers were received; therefore, the MCP is required to conduct a mailing of EOBs to a 95% confidence level (plus or minus 5% margin of error) random sample of the MCP's enrollees once a year. As an option, the MCP may meet this requirement by using a strategy targeting services or areas of concern as long as the number of mailed EOBs is not less than the number generated by the random sample described above. If the MCP opts to use a targeted mailing, they shall submit the proposed strategy in writing to ODM, and receive written prior approval from ODM. The EOB mailing shall 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

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personal health information, outline the recent medical services identified as having been provided to the enrollee and request that the enrollee report any discrepancies to the MCP. The MCP shall inform their Contract Administrator of the date of the EOB mailing and provide results of the mailing 60 to 90 calendar days after the mailing (i.e., number mailed, number of enrollees reporting discrepancies).

6. **Breaches of Protected Health Information.** The MCP shall report the number of breaches of protected health information (PHI) and specify how many breaches were reported to HHS as required by 45 CFR 164.408(b) and (c). This report shall be submitted annually as indicated on the "MCP Calendar of Required Submissions."
7. **Cooperation with State and Federal Authorities.** The MCP shall provide all data, documentation, information and other records requested by ODM, the Ohio Attorney General, law enforcement, etc. in the manner, format and time frame requested. The MCP shall cooperate fully with State and Federal Authorities and:
  - a. The MCP shall cooperate fully in any investigation or prosecution by any duly authorized government agency, whether administrative, civil or criminal including providing, upon request, information, access to records, and access to interview MCP subcontractors, employees and consultants in any manner related to the investigation.
  - b. The MCP, subcontractors and the MCPs' providers shall, upon request, make available to ODM BPI, ODM OMC and AGO MFCU/OIG any and all administrative, financial and medical records relating to the delivery of items or services for which ODM monies are expended. Such records will be made available at no cost to the requesting entity.

The sanctions for noncompliance with requirements in this appendix are listed in Appendix N of this Agreement.

## APPENDIX J

### FINANCIAL PERFORMANCE

1. **Submission of Financial Statements and Reports.** The MCP shall submit the following financial reports to the Ohio Department of Medicaid (ODM) as outlined in Ohio Administrative Code (OAC) rule 5160-26-09: The National Association of Insurance Commissioners (NAIC) quarterly and annual Health Statements (hereafter referred to as the “Financial Statements”). The Financial Statements shall include all required Health Statement filings, schedules and exhibits as stated in the NAIC Annual Health Statement Instructions including, but not limited to, the following sections: Assets, Liabilities, Capital and Surplus Account, Cash Flow, Analysis of Operations by Lines of Business, Five-Year Historical Data, and the Exhibit of Premiums, Enrollment and Utilization and the Modified Supplemental Health Care Exhibit. The Financial Statements shall be submitted to ODM even if the Ohio Department of Insurance (ODI) does not require the MCP to submit these statements to ODI. An electronic copy of the reports in the NAIC-approved format shall be provided to ODM.
  - a. Annual financial statements for those entities who have an ownership interest totaling five percent or more in the MCP or an indirect interest of five percent or more, or a combination of direct and indirect interest equal to five percent or more in the MCP.
  - b. Annual audited Financial Statements prepared by a licensed independent external auditor as submitted to the ODI, as outlined in OAC rule 5160-26-09(B).
  - c. **Quarterly and Annual Medicaid MCP ODM Cost Reports for All Covered Populations.**
    - i. The annual and quarterly cost reports shall adhere to the Agreement, and be submitted in accordance with the cost report instructions and within established timeframes.
    - ii. Annual and quarterly cost reports shall be revised in accordance with the actuaries’ observation log and/or ODM instructions.
    - iii. All non-mandatory observations identified in the actuary observation log shall be appropriately addressed and responses submitted within established timeframes by ODM.
  - d. Annual physician incentive plan disclosure statements and disclosure of and changes to the MCP’s physician incentive plans, as outlined in OAC rule 5160-26-09(B).
  - e. Reinsurance agreements, as outlined in OAC rule 5160-26-09(C).
  - f. Prompt Pay Reports, in accordance with OAC rule 5160-26-09(B). An electronic copy of the reports in the ODM-specified format shall be provided to ODM.
  - g. Notification of requests for information and copies of information released pursuant to a tort action (i.e., third party recovery), as outlined in OAC rule 5160-26-09.1.

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- h. Financial, utilization, and statistical reports, when ODM requests such reports, based on a concern regarding the MCP's quality of care, delivery of services, fiscal operations or solvency, in accordance with OAC rule 5160-26-06(D).
- i. The MCP shall submit ODM-specified reports for the calculation of items 2.b, 2.c and 2.d below in electronic formats.

2. **Financial Performance Measures and Standards.** This appendix establishes specific expectations concerning the financial performance of the MCP. In the interest of administrative simplicity and non-duplication of areas of ODI authority, ODM's emphasis is on the assurance of access to and quality of care. ODM will focus only on a limited number of indicators and related standards to monitor MCP financial performance. The five indicators and standards for this Agreement period are identified below. The source for each indicator will be the NAIC Quarterly and Annual Financial Statements and Modified Supplemental Health Care Exhibit. The measurement period that will be used to determine compliance will be the annual Financial Statement and Modified Supplemental Health Care Exhibit.

- a. **Indicator:** Current Ratio. Refer to the ODM Methods for Financial Performance Measures for the definition and calculations for the Current Ratio.

**Standard:** The Current Ratio shall not fall below 1.00 as determined from the annual Financial Statement submitted to ODI and ODM.

- b. **Indicator:** Medical Loss Ratio. Refer to the ODM Methods for Financial Performance Measures for the definition and calculations for the Medical Loss Ratio indicator.

**Standard:** Minimum Medical Loss Ratio shall not fall below 85%, as determined from the annual Modified Supplemental Health Care Exhibit of the annual Financial Statement submitted to ODM.

- c. **Indicator:** Administrative Expense Ratio. Refer to the ODM Methods for Financial Performance Measures for the definition and calculations for the Administration Expense Ratio indicator.

**Standard:** Administrative Expense Ratio shall not exceed 15%, as determined from the annual Financial Statement submitted to ODI and ODM.

- d. **Indicator:** Overall Expense Ratio. Refer to the ODM Methods for Financial Performance Measures for the definition and calculations for the Overall Expense Ratio indicator.

**Standard:** Overall Expense Ratio shall not exceed 100% as determined from the annual Financial Statement submitted to ODI and ODM.

- e. **Indicator:** Defensive Interval. Refer to the ODM Methods for Financial Performance Measures for the definition and calculations for the Defensive Interval indicator.

**Standard:** The Defensive Interval shall not fall below 30 calendar days as determined from the annual Financial Statement submitted to ODI and ODM.

Long-term investments that can be liquidated without significant penalty within 24 hours, which the MCP includes in cash and short-term investments in the financial performance measures, shall be disclosed in footnotes on the NAIC Reports. Descriptions and amounts shall also be disclosed. Please note that “significant penalty” for this purpose is any penalty greater than 20%. The MCP shall enter the amortized cost of the investment, the market value of the investment, and the amount of the penalty.

3. **Reinsurance Requirements.** Pursuant to the provisions of OAC rule 5160-26-09(C), the MCP shall carry reinsurance coverage from a licensed commercial carrier to protect against inpatient-related medical expenses incurred by Medicaid members.

The annual deductible or retention amount for such insurance shall be specified in the reinsurance agreement and shall not exceed \$100,000.00, unless ODM has provided the MCP with prior approval in writing for a higher deductible amount or alternate reinsurance arrangement. Except for transplant services, and as provided below, this reinsurance shall cover, at a minimum, 80% of inpatient costs incurred by one member in one year, in excess of \$100,000.00 unless ODM has provided the MCP with prior approval in writing for a higher deductible amount or alternate reinsurance arrangement.

For transplant services, the reinsurance shall cover, at a minimum, 50% of inpatient transplant related costs incurred by one member in one year, in excess of \$100,000.00 unless ODM has provided the MCP with prior approval in writing for a higher deductible amount or alternate reinsurance arrangement.

The MCP may request a higher deductible amount and/or that the reinsurance cover less than 80% of inpatient costs in excess of the deductible amount, only after the MCP has one year of enrollment in Ohio. If the MCP does not have more than 75,000 members in Ohio, but does have more than 75,000 members between Ohio and other states, ODM may consider alternate reinsurance arrangements. However, depending on the corporate structures of the Medicaid MCP, other forms of security may be required in addition to reinsurance. These other security tools may include parental guarantees, letters of credit, or performance bonds. In determining whether or not the request will be approved, ODM may consider any or all of the following:

- a. Whether the MCP has sufficient reserves available to pay unexpected claims;
  - b. The MCP’s history in complying with financial indicators as specified in this appendix;
  - c. The number of members covered by the MCP;
  - d. How long the MCP has been covering Medicaid or other members on a full risk basis;
  - e. Risk based capital ratio greater than 2.5 or higher calculated from the last annual ODI financial statement;
  - f. 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.
4. **Prompt Pay Requirements.** In accordance with 42 CFR 447.46, the MCP shall pay 90% of all submitted clean claims within 30 calendar days of the date of receipt and 99% of such claims within 90 calendar



days of the date of receipt, unless the MCP and its contracted provider(s) have established an alternative payment schedule mutually agreed upon and described in their contract. The claim types listed below will be separately measured against the 30 and 90 calendar day prompt pay standards:

a. **Clean nursing facility claims.**

- i. The MCP shall pay 90% of all clean nursing facility claims within 30 calendar days of the date of receipt.
- ii. 99% of such claims within 90 calendar days of the date of receipt.

b. **Clean pharmacy claims.**

- i. The MCP shall pay 90% of all clean pharmacy claims within 30 calendar days of the date of receipt.
- ii. 99% of such claims within 90 calendar days of the date of receipt.

c. **Clean behavioral health claims.**

- i. The MCP shall pay 90% of all clean behavioral health claims within 30 calendar days of the date of receipt.
- ii. 99% of such claims within 90 calendar days of the date of receipt.

d. **All other clean claim types** (excluding clean nursing facility, pharmacy, and behavioral health claims).

- i. The MCP shall pay 90% of all other clean claim types (excluding clean nursing facility, pharmacy, and behavioral health claims) within 30 calendar days of the date of receipt.
- ii. 99% of such claims within 90 calendar days of the date of receipt.

The prompt pay requirement applies to the processing of both electronic and paper claims for contracting and non-contracting providers by the MCP and delegated claims processing entities.

The date of receipt is the date the MCP receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or date of electronic payment transmission. A claim means 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 recipient within a bill. A "clean claim" is 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.

5. **Physician Incentive Plan Disclosure Requirements.** The MCP shall comply with the physician incentive plan requirements stipulated in 42 CFR 438.3(i). If the MCP operates a physician incentive plan, no specific payment shall be made directly or indirectly under this physician incentive plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

If the physician incentive plan places a physician or physician group at substantial financial risk [as determined under paragraph (d) of 42 CFR 422.208] for services that the physician or physician group does not furnish itself, the MCP shall ensure all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with 42 CFR 422.208(f), and conduct periodic surveys in accordance with 42 CFR 422.208(h).

In accordance with 42 CFR 417.479 and 42 CFR 422.210, the MCP shall maintain copies of the following required documentation and submit to ODM upon request:

- a. A description of the types of physician incentive arrangements the MCP has in place which indicates whether they involve a withhold, bonus, capitation, or other arrangement. If a physician incentive arrangement involves a withhold or bonus, the percent of the withhold or bonus shall be specified.
- b. A description of information/data feedback to a physician/group on their: 1) adherence to evidence-based practice guidelines; and 2) positive and/or negative care variances from standard clinical pathways that may impact outcomes or costs. The feedback information may be used by the MCP for activities such as physician performance improvement projects that include incentive programs or the development of quality improvement initiatives.
- c. A description of the panel size for each physician incentive plan. If patients are pooled, then the pooling method used to determine if substantial financial risk exists shall also be specified.
- d. If more than 25% of the total potential payment of a physician/group is at risk for referral services, the MCP shall maintain a copy of the results of the required patient satisfaction survey and documentation verifying that the physician or physician group has adequate stop-loss protection, including the type of coverage (e.g., per member per year, aggregate), the threshold amounts, and any coinsurance required for amounts over the threshold.
- e. Upon request by a member or a potential member and no later than 14 calendar days after the request, the MCP shall provide the following information to the member:
  - i. Whether the MCP uses a physician incentive plan that affects the use of referral services;
  - ii. The type of incentive arrangement;

- iii. Whether stop-loss protection is provided; and
- iv. A summary of the survey results if the MCP was required to conduct a survey.

The information provided by the MCP shall adequately address the member's request.

6. **Notification of Regulatory Action.** If the MCP is notified by the ODI of proposed or implemented regulatory action, they shall report such notification and the nature of the action to ODM no later than one business day after receipt from ODI. ODM may request, and the MCP shall provide, any additional information as necessary to ensure continued satisfaction of program requirements. The MCP may request that information related to such actions be considered proprietary in accordance with established ODM procedures. Failure to comply with this provision will result in an immediate enrollment freeze.

The sanctions for noncompliance with requirements in this appendix are listed in Appendix N of this Agreement.

## APPENDIX K

### QUALITY CARE

This appendix establishes program requirements and expectations related to MCP responsibilities for developing and implementing a population health management program; assuring health, safety, and welfare for members; partnering with Comprehensive Primary Care (CPC) practices to improve population health; coordinating with care management entities; developing and implementing utilization management programs; developing and implementing a Quality Assessment and Performance Improvement (QAPI) program; and participating in external quality review activities. These program requirements support the priorities and goals set forth in the Ohio Medicaid Quality Strategy.

1. **Population Health Management.** The Ohio Department of Medicaid (ODM) seeks to improve the health of the Ohio Medicaid population by identifying and monitoring individual patients within specified groups. A well-designed population health management program is driven by clinical, financial, and operational data from internal departments and larger delivery systems providing actionable data that can be used to improve quality of care, patient experience, health equity and cost of care.

The following section outlines the population health management requirements the MCP shall address as part of its model of care. The MCP shall develop a model of care that broadly defines the way services will be delivered to meet population needs. The MCP shall address the following components as part of its model of care:

- a. **Description of the Population(s) and Specialized Services.** A comprehensive description of the MCP's population and the specialized services and resources tailored to the population are key to the model of care. This section of the model of care shall address the following components:
  - i. **Risk Stratification Levels.** The MCP shall develop a risk stratification level framework for the purpose of targeting interventions and allocating resources based on the member's needs. Using a risk stratification framework comprised of five levels (i.e., from lowest to highest: monitoring, low, medium, high and intensive), the MCP will determine the appropriate risk stratification level based on assessed needs.

The MCP shall identify the factors that will be considered when determining a member's risk stratification level. At a minimum, the MCP shall consider the following current and historical factors: acuity of chronic conditions, substance use and/or mental health disorders, maternal risk (e.g., prior preterm birth), inpatient or emergency department utilization, social determinants of health and/or safety risk factors. The MCP shall develop criteria and thresholds for each level that will be used to determine assignment to the risk stratification level. Criteria and thresholds established by the MCP are subject to ODM approval.

For all new members, within 90 calendar days of enrollment, the MCP shall use the ODM-standardized health risk assessment tool for the purpose of risk stratification and to identify potential needs for care management. Implementation of the ODM-standardized health risk assessment tool will occur no later than 7/1/19.

The MCP shall evaluate a member's stratification level when there is a significant change in the member's need(s), progress in meeting care plan goals, etc. The MCP shall describe the trigger(s) for changing the member's stratification level.

The MCP shall assign each member to a risk stratification level for each month of enrollment with the MCP. For members newly enrolled with the MCP, an initial risk stratification level shall be assigned within the first month of the member's enrollment.

- ii. **Population Stream.** ODM established five population streams—women's health, behavioral health, chronic conditions, healthy children and healthy adults—that will be used to organize work around population health. The MCP shall develop a strategy that assigns each member to a single population stream in accordance with ODM's population stream and corresponding hierarchy and in alignment with ODM's Quality Strategy (i.e., tracking to specific population health outcomes). The MCP shall have a process to identify and track the population stream assigned to each member.

The MCP shall provide a description for each population stream that shall include the incidence and prevalence of medical and behavioral health conditions and issues that might impact health status such as age, gender, race, ethnicity, geography, language, or other socio-economic barriers that might affect the effective provision of health care services, as well as living or caregiver arrangements that might pose challenges for certain members.

- iii. **Specialized Services and Resources.** The MCP shall include a description of specialized services and other resources (e.g., health and wellness programs, 24/7 nurse advice line, care management, etc.) for each population stream tailored to risk level and communities.

ODM may provide structured guidance for priority population streams that the MCP should integrate into the model of care (e.g., Ohio Department of Medicaid's Guidance for Managed Care Plans for the Provision of Enhanced Maternal Care Services).

At a minimum, the MCP shall integrate the following into its model of care:

1. **Care Management.** The MCP shall ensure members are able to access care management services when needed. There shall be a clear delineation of roles and responsibilities between the MCP and other entities (CPC practice, PCMH, community partners, etc.) responsible for, or are contributing, to care management in order to ensure no duplication of, or gaps in, services. If no other accountable entity has been identified for the member, then the MCP is responsible for providing the full scope of care management services to the member.

The MCP's approach to care management shall emulate the features of a high-performing care management system: person and family centeredness; timely, proactive planned communication and action; the promotion self-care and independence; emphasis on cross continuum and system collaboration (e.g.,

behavioral health); and the comprehensive consideration of physical, behavioral and social determinants of health. The MCP shall consider the Case Management Society of America's *Standards of Practice for Case Management*, 2016 when designing and implementing its care management program.

The following components shall be addressed in the care management section of the model of care:

- a. **Assessment.** The MCP shall have a clear description of the process for conducting or arranging for assessments appropriate for their members' unique circumstances and needs (e.g., physical, behavioral, social, and safety) that includes the following:
  - i. Methods utilized to complete assessments, including any variances by risk level.
  - ii. Timeline to complete assessments, including any variances by risk level.
  - iii. Identification of the trigger(s) for completion of a comprehensive assessment, a disease-specific assessment or a re-assessment when there is a change to the member's health status or needs, a significant change event, a change in diagnosis, or as requested by member or his/her provider.
  - iv. How the assessment will be used to develop and update the care plan and confirm the risk stratification level for each member.
  - v. How data from the member's primary care provider will be used to prevent duplication of assessment efforts and to assist with identification of priorities for the member.
  - vi. How members who cannot be reached or who refuse assessments will be handled by the MCP, including multiple contacts if initial contacts are unsuccessful.
  - vii. How assessment data will be stored and made available to members of the multi-disciplinary care team in order to coordinate care.
  - viii. How assessment data will be shared with the member's other payer, as applicable, in order to prevent duplication of efforts.
- b. **Individualized Care Plans.** The MCP shall have a person-centered care planning process that includes the following components:

- i. How an individualized care plan will be developed and updated based on the most recent assessment along with timelines for the initial development and updates.
  - ii. Inclusion of prioritized measurable goals, interventions, and outcomes.
  - iii. Development of goals with, and agreement by, the member.
  - iv. Alignment of care plan goals with the priority issues identified by the primary care provider so the MCP can support the provider-patient relationship.
  - v. Validation that services recommended were received by the member and a provision that if services were not received there is necessary action taken to address and close gaps in care.
  - vi. Updates to the care that occur at least every 12 months or when the member's needs change significantly.
  - vii. Retention of the ICP and making it available to members of the multi-disciplinary team.
- c. **Care Management Staffing.** The MCP staffing model shall address the following components:
- i. How the MCP identifies and determines who will be the accountable point of contact (e.g., care manager);
  - ii. How the MCP determines the composition of the multi-disciplinary team, as needed, when the member's physical, psychosocial, and/or behavioral conditions would benefit from a range of disciplines with different but complementary skills, knowledge and experience working together to deliver a comprehensive, integrated approach to care management;
  - iii. The delineation of roles and responsibilities of the team members (with particular emphasis on non-duplication of activities performed by PCPs, PCMHs, etc.);
  - iv. How the MCP exchanges member information within and across the team;
  - v. How the MCP will ensure staff who are completing care management functions are operating within their professional scope of practice, are appropriate for the member's health care needs, and follow the state's licensure/credentialing

requirements.

- vi. A staff training model that includes the onboarding of new employees and ongoing training for current employees on the MCP's model of care, cultural competency, person centered care planning, motivational interviewing, grievance reporting process/procedure, availability of community resources in the care manager's respective geographic areas, care management strategies for disease specific processes, abuse/neglect/exploitation reporting requirements, and HIPAA;
  - vii. How the MCP will strive for a single point of care management for each member in order to reduce duplication and gaps in services.
  - viii. That the MCP will attest that care managers and MCP employed/delegated members of the care management team 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.
  - ix. A methodology for assigning consistent and appropriate caseloads for care managers that ensures health, welfare and safety for members. The caseload assignment methodology shall consider the following factors: population; acuity status mix; care manager qualifications, years of experience, and responsibilities; provision of support staff; location of care manager (community, MCP office, provider office); geographic proximity of care manager to members (if community based); and access to and capabilities of technology/IT systems.
- d. **Contact Schedule.** The MCP shall establish a contact schedule with the member based on his or her needs and facilitates ongoing communication with the member. When a gap in care and/or a need for follow-up is identified, the MCP shall take action (e.g., close the gap in care, arrange transportation, referral to disease management, referral to behavioral health, etc.) and update the care plan, as appropriate.
- e. **Special Populations.** The MCP shall assess special populations identified by ODM (e.g., children with special health care needs who are not affiliated with an accountable care management entity, children in custody, justice involved, etc. ) to determine if there is a need for care management.
- f. **Care Management Status Indicators.** A care management status will be assigned to each member who is care managed by the MCP regardless



of stratification level: outreach and coordination, engaged, and inactive. A member shall only be assigned to one care management status and they are defined as follows:

- i. **Outreach and coordination.** This indicator is used when the MCP performs one or more of the following activities for a member: conducts outreach; educates the member; makes referrals for physical, behavioral, or social services; or provides service coordination (defined as a planned, active interaction between the MCP and any provider involved with the member).
  - ii. **Engaged.** A member is classified as engaged after the MCP completes an assessment and develops an individualized care plan. Ongoing, the engaged status can be used when the MCP is able to meet the frequency requirements for the member's contact schedule.
  - iii. **Inactive.** A member is regarded as inactive if the MCP has assigned a population stream and risk level but is unable to engage the member in care management and/or is not performing outreach and coordination activities for the member.
- g. **Care Management Information Technology System.** The MCP shall have a care management system that captures, at a minimum, the results of the assessment and the care plan content, including goals, interventions, outcomes and completion dates. Members of the care management team who use the care management system shall also have access to, and meaningfully use, relevant data about the member (claims, prior authorization data) in order to coordinate and communicate care needs across providers and delivery systems. The MCP shall use information technology systems and processes to integrate the following data elements: enrollment data, care management data, claims, member services, 24/7 nurse advice line, prior authorization data, etc. in order to maximize internal MCP communications (e.g., the Utilization Management reviewer is able to see the care management risk level and the name of a care manager for a member) about a specific member. The MCP's system shall also have capability to make care management data available to the member, the PCP and specialists.
- h. **Care Management Program Effectiveness.** ODM will evaluate the effectiveness of the MCP's care management program by administering a provider and consumer satisfaction survey, conducting targeted administrative performance reviews, and/or calculating results for efficiency or fragmentation of care measures. ODM will develop

methods and standards for these activities in Calendar Year (CY) 2018 with anticipated implementation in CY 2019.

2. **Care Transitions.** The MCP shall effectively and comprehensively manage transitions of care between both physical and behavioral health settings in order to prevent unplanned or unnecessary readmissions, emergency department visits, and/or adverse outcomes. The MCP shall have a process to conduct the following:
  - a. Identify members who require assistance transitioning between settings;
  - b. Develop a method for evaluating risk of readmission in order to determine the intensity of follow up required for the member after the date of discharge;
  - c. Designate MCP staff who will communicate with the discharging facility and inform the facility of the MCP's designated contacts;
  - d. Ensure timely notification and receipt of admission dates, discharge dates and clinical information is communicated between MCP departments, care settings and with the primary care provider, as appropriate;
  - e. 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 MCP;
  - f. Obtain a copy of the discharge/transition plan;
  - g. Arrange for services specified in the discharge/transition plan; and
  - h. Conduct timely follow up with the member and the member's primary provider to ensure post discharge services have been provided.

When the MCP is contacted by an inpatient facility with a request to participate in discharge planning, the MCP shall cooperate as outlined above to ensure a safe discharge placement and services are arranged for the member.

3. **Enhanced Maternal Care.** The MCP shall integrate ODM's *Guidance for Managed Care Plans for the Provision of Enhanced Maternal Care Services* into its model of care.

- b. **Data Submission.** The MCP shall submit four electronic files as follows:

- i. **Population stream.** The MCP shall submit to ODM a file that contains a population stream for all specified members. The assigned population stream shall align with

ODM's five population streams: women's health, behavioral health, chronic condition, healthy children, and healthy adults. Requirements for this file submission are specified in Medicaid Managed Care: Population Stream Data Submission Specifications.

- ii. **Risk Stratification Level.** The MCP shall submit a file to ODM that contains a risk stratification level for all specified members. The assigned risk stratification level will be intensive, high, medium, low or monitoring. Requirements for this file submission are specified in Medicaid Managed Care: Risk Stratification Data Submission Specifications.
- iii. **Care Management Status.** The MCP shall submit a file to ODM that contains a care management status for all specified members. The three care management status indicators are outreach and coordination, engaged, inactive. Requirements for this file submission are specified in Medicaid Managed Care: Care Management Status Submission Specifications.
- iv. **Health Risk Assessment.** By July 1, 2019, the MCP shall submit a file to ODM that contains health risk assessment results for all specified members. Requirements for this file submission are specified in Medicaid Managed Care: Health Risk Assessment Submission Specifications.

Submissions to ODM will occur quarterly and in accordance with the specifications referenced in 1.b.i-iv.

ODM, or its designee, may validate the accuracy of the information contained in the four electronic files with the MCP's records for the member.

- c. **Program Submission and Evaluation.** The MCP shall have an ODM-approved Model of Care. The MCP shall assess and enhance specialized programming for each group identified by the MCP's population health management strategy using continuous quality improvement principles.
2. **Member Safeguards.** The MCP shall develop and implement safeguards, systems, and processes that detect, prevent, and mitigate harm and/or risk factors that could impact an individual's health, welfare, and safety. When the MCP identifies or becomes aware of risk factors, it shall put in place services and supports to mitigate and address the identified issues as expeditiously as the situation warrants.

When the member poses or continues to pose a risk to his or her health, safety, and welfare, the MCP may develop and implement an acknowledgement of responsibility plan between the MCP, the member and/or the legal guardian, as applicable, identifying the risks and setting forth interventions recommended by the MCP to remedy risks to the individual's health, safety and welfare. The MCP's process for development and implementation of an acknowledgement of responsibility plan shall be in accordance with ODM's specifications, as described in ODM's "Acknowledgement of Responsibility Guidance" document. The MCP shall also document the member's acknowledgement of responsibility, refusal to sign the acknowledgement of responsibility, and/or lack of adherence to the agreed upon actions or interventions in the clinical record.

ODM or its designee will conduct administrative reviews, in-home checks, and/or other oversight activities to ensure an individual's health, welfare, and safety. The penalties for noncompliance that

places a member at risk for a negative health outcome or jeopardizes the health, safety and welfare of the member are located in Appendix N.

3. **Partnering with Payment Innovation Comprehensive Primary Care (CPC) Practices to Improve Population Health.** The MCP plays a key role in supporting the CPC practice with achieving optimal population-level health outcomes. The MCP shall establish a relationship with each CPC practice and work collaboratively with the CPC to determine the initial and ongoing level of support to be provided by the MCP based on the CPC practice’s infrastructure, capabilities, and preferences for MCP assistance (e.g., addressing social determinants of health, , data sharing, etc.). Based upon this determination, , the MCP shall support each of the CPC activities and the overall initiative:

For each of the following CPC activities,	the MCP shall do the following during the start-up and ongoing phases of the initiative:
24/7 and Same day appointments	<ul style="list-style-type: none"> <li>• Identify and document how the CPC practice offers same day appointments (e.g., extended weekday hours, weekend hours, etc.) and offers 24/7 access to care in order to ensure accurate information and appropriate guidance is provided by member facing departments to attributed members.</li> </ul>
Risk Stratification	<ul style="list-style-type: none"> <li>• Review the risk stratified practice-attribution list (developed by the CPC practice) with the CPC practice and provide additional and/or recent data for high priority patients in order to assist the CPC practice with developing and assigning practice defined patient risk stratification levels as well as ongoing care management responsibilities.</li> <li>• Timely notify the CPC practice of significant change events (Inpatient (IP) hospitalizations, Emergency Department (ED) visits, etc.) that could impact the assigned risk stratification level.</li> <li>• Update the MCP’s care management system to reflect changes to the risk stratification level initiated and communicated by the CPC practice.</li> </ul>
Population Health Management	<ul style="list-style-type: none"> <li>• Provide information about MCP -administered specialized services and resources as part of the MCP’s model of care for which a CPC practice can refer and link members to with assistance by the MCP.</li> <li>• Assist with identification of preventive or chronic services that members have not received in order to identify gaps in care.</li> <li>• Assist in coordinating services as needed (e.g., schedule appointments, arrange transportation, facilitate referrals and linkages to MCP health and wellness programs, etc.) in order to assist with improving health outcomes.</li> <li>• Share timely, meaningful, actionable data with the CPC practice that can facilitate population health activities.</li> </ul>
Team based care delivery	<ul style="list-style-type: none"> <li>• Work with each CPC practice to delineate roles and responsibilities for high priority patients to ensure there are no gaps in or duplication of services.</li> <li>• Support CPC practice’s member outreach efforts, when requested.</li> <li>• Designate points of contact for each CPC practice to clearly identify who will participate in CPC-led patient care team meetings and who will</li> </ul>

For each of the following CPC activities,	the MCP shall do the following during the start-up and ongoing phases of the initiative:
	<p>assist the CPC with effectively and efficiently navigating MCP processes (e.g., facilitating prior authorizations).</p> <ul style="list-style-type: none"> <li>• Participate in CPC-led patient care team meetings, when requested.</li> </ul>
Care management plans	<ul style="list-style-type: none"> <li>• Respond timely to requests from the CPC for action and follow up by the MCP (e.g., arranging transportation, performing outreach to a patient).</li> <li>• Receive and integrate critical CPC data elements (e.g., social determinants of health identified by the CPC) into the MCP's care management system and use the information when interacting with members.</li> <li>• Share timely, meaningful, actionable data with the CPC that can facilitate effective care management activities (e.g., resolution of CPC requests for MCP follow up).</li> </ul>
Follow up after hospital discharge	<ul style="list-style-type: none"> <li>• Notify the CPC of ED visits or IP admissions for high priority patients.</li> <li>• Participate in discharge planning activities with the CPC and inpatient facility in order to support a safe discharge placement and to prevent unplanned or unnecessary readmissions, ED visits, and/or adverse outcomes.</li> <li>• Support the post discharge services as specified in the discharge/transition plan.</li> <li>• Facilitate clinical hand offs, upon request from the CPC, between the discharging facility and other providers (e.g., home health, community behavioral health agencies).</li> <li>• Share timely, meaningful, and actionable data with the CPC that can facilitate effective care transitions.</li> </ul>
Tracking of follow up tests and specialist referrals	<ul style="list-style-type: none"> <li>• When requested assist with bi-directional communication between the CPC and specialists, pharmacies, labs and imaging facilities, as needed, in order to facilitate timely exchange of information.</li> <li>• Share timely, meaningful, and actionable data with the CPC that can facilitate tracking and follow up of tests and referrals (e.g., when patients self-refer).</li> </ul>
Patient Experience	<ul style="list-style-type: none"> <li>• Facilitate a warm hand off between the MCP care manager and the CPC when care management responsibility transitions from the MCP to the CPC.</li> <li>• Provide quantitative or qualitative data with the CPC that can improve the patient experience (e.g., results from the MCP's member advisory groups, member satisfaction surveys, grievances and complaints, member preferences, etc.).</li> <li>• Participate in the CPC's improvement opportunities, as requested, aimed at improving overall patient experience and reducing disparities in patient experience.</li> </ul>

The MCP shall perform the following administrative activities in support of the CPC initiative:

- a. Work with the CPC to identify which members the MCP can assist with contacting.
  - b. Submit the CPC member attribution files as specified by ODM to meet data quality assurance standards described in the CPC Attribution File Submission Specifications and Standards Methodology. Generate and provide a list of attributed members for each CPC.
  - c. Track members who are attributed to each CPC.
  - d. Reimburse CPCs the agreed upon 'per member per month' (PMPM) payment for attributed members and any shared savings for meeting model requirements in accordance with requirements set forth by ODM. The MCP shall send the PMPM payment to CPC practices within 15 business days of receipt from ODM, unless otherwise specified by ODM.
  - e. Reconcile payment data for each CPC.
  - f. Amend contracts, as necessary, with CPCs to reflect the reimbursement of the PMPM payment and the shared savings payment.
  - g. Provide technical support, as needed, to the CPC to assist with its understanding and use of data files provided by the MCP.
  - h. Receive and integrate data provided by the CPC and implement throughout the MCP's systems and operations;
  - i. Integrate results from CPC metrics into the MCP's overall quality improvement program.
  - j. Use regional and community population health priorities to develop a clear improvement strategy in partnership with CPCs.
  - k. Ensure provider- and member-facing departments (provider services, member services or 24/7 nurse advice lines, utilization management) are able to identify when a member is attributed to a CPC 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, etc.) when interacting with members and providers.
4. **Partnering with Qualified Behavioral Health Entities (QBHEs) to Improve Population Health.** MCP members who are attributed to a QBHE shall receive all of their behavioral health care coordination (BHCC) needs from the QBHE. Ideally, the QBHE shall be the member's primary entity for managing behavioral health needs and will coordinate with the member's comprehensive primary care practice or primary care provider to ensure a comprehensive, integrated approach to managing the member's needs. If a QBHE is unable to engage a member after attribution, the MCP may choose to care manage the member until the QBHE is able to successfully engage the member or the MCP may request ODM attribute the member to a different QBHE.

Medicaid Managed Care  
Appendix K  
Quality Care

- a. The effective date of the BHCC initiative will be no earlier than July 1, 2019. Each MCP will be required to perform administrative activities prior to July 1, 2019 as per the following:
  - i. Contract with all ODM-approved QBHEs within 90 calendar days of the approved application date, except when there are documented instances of quality concerns.
  - ii. Implement system edits that are consistent with ODM's policy for the provision and payment of behavioral health services for attributed members as follows:
    1. Payments for community supportive psychiatric treatment and case management as described in OAC rule 5160-27-02 will not be made as these are considered duplicative of BHCC program activities.
    2. For attributed members who are also receiving substance use disorder (SUD) residential treatment, the following applies:
      - a. The eligible member will be attributed to or maintain attribution with a QBHE during the SUD residential treatment period.
      - b. The QBHE may bill the full monthly BHCC payments if the QBHE performed minimum required activities before the beginning of the SUD residential treatment or after an attributed member is no longer receiving SUD residential treatment. The QBHE will not be eligible for BHCC payments during the eligible member's SUD residential treatment period because BHCC is duplicative of the care coordination responsibilities of the SUD residential treatment program.
      - c. The QBHE will immediately re-engage the eligible member for BHCC upon discharge from the SUD residential treatment period.
    3. For eligible members who also meet criteria for assertive community treatment (ACT) as defined in OAC Chapter 5160-27, the following applies:
      - a. The eligible member will be attributed to or maintain attribution with a QBHE.
      - b. ACT is required to begin on the 1<sup>st</sup> calendar day of the month.
      - c. If the QBHE is certified to deliver ACT, it shall provide ACT in lieu of BHCC as long as ACT is medically necessary. When the ACT service is no longer medically necessary, the eligible member shall be transitioned to BHCC.
      - d. If the QBHE is not an eligible provider of ACT, the eligible member may choose to either receive BHCC from the QBHE or opt-out and receive ACT from a provider eligible to deliver ACT. In addition, the QBHE may bill the full monthly BHCC payment after the member is no longer

receiving ACT and the QBHE delivered the minimum required activities.

4. For eligible members who also meet criteria for intensive home-based treatment (IHBT) as defined in OAC Chapter 5160-27, the following applies:
  - a. The eligible member will be attributed to or maintain attribution with a QBHE.
  - b. If the QBHE is certified to deliver IHBT, it shall provide IHBT in lieu of BHCC as long as IHBT is medically necessary. When IHBT is no longer medically necessary, the eligible member shall be transitioned to BHCC.
  - c. If the QBHE is not an eligible provider of IHBT, the QBHE may bill the full monthly BHCC payment if the QBHE delivers minimum required activities before the beginning of IHBT treatment or after the attributed member is no longer receiving IHBT.
- iii. Implement a process to validate target member and attribution files provided by ODM to the MCP.
- iv. Implement a process to receive requests from a provider for a member identified outside of the attribution and make a determination of BHCC service eligibility in accordance with OAC rule 5160-26-03.1. As part of this process, the MCP will work with the other MCPs to develop a standardized prior authorization form for use by providers.
- b. Upon full implementation of the BHCC initiative, the MCP shall play a key role in supporting the QBHEs with achieving optimal population level health outcomes. At a minimum, the MCP shall support each of the behavioral health care coordination activities and the overall initiative:

For each of the following BHCC activities,	The MCP shall have the following roles and responsibilities to support BHCC and QBHEs
Initial outreach/engagement	<ul style="list-style-type: none"> <li>• Educate members and caregivers/families about the program and benefits of program participation.</li> <li>• Process referrals from providers in order to determine program eligibility.</li> </ul>
Comprehensive care plan	<ul style="list-style-type: none"> <li>• Participate in QBHE-led patient care team meetings, when requested.</li> <li>• Respond timely to requests from QBHE for action and follow up by the MCP (e.g., arranging transportation, performing outreach to a patient)</li> <li>• Receive and integrate critical QBHE data elements into the MCP’s care management system and use the information when interacting with members and/or providers.</li> <li>• Share timely, meaningful, actionable data with the QBHE that facilitates effective person centered care planning activities.</li> </ul>



Ongoing engagement and relationship	<ul style="list-style-type: none"> <li>• Designate a single point of contact for the QBHE.</li> <li>• Work with each QBHE to delineate roles and responsibilities for high priority patients to ensure there are no gaps in or duplication of services.</li> <li>• Assist with outreach to members, when requested.</li> <li>• Assist with cross-system communication and collaboration between the QBHE and CPC practice, or PCP, or other providers, when requested.</li> </ul>
Individual transition	<ul style="list-style-type: none"> <li>• Notify the QBHE of emergency department or inpatient visits for members.</li> <li>• Participate in discharge planning activities, upon request, with the QBHE and inpatient facility in order to support a safe discharge placement and prevent unplanned or unnecessary readmissions, ED visits, and/or adverse outcomes.</li> <li>• Support the post discharge services as specified in the discharge/transition plan.</li> <li>• Assist with cross-system communication and collaboration between the QBHE and CPC practice, or PCP, or other providers, when requested.</li> <li>• Share timely, meaningful, and actionable data with the QBHE that facilitates effective care transitions.</li> </ul>
Individual engagement and access to appropriate care	<ul style="list-style-type: none"> <li>• Assist with addressing barriers to care, upon request.</li> <li>• Share timely, meaningful, and actionable data with the QBHE that facilitates access to appropriate care.</li> </ul>
Engaging supportive services	<ul style="list-style-type: none"> <li>• Provide assistance with referral and linkage to supportive services as requested by the QBHE.</li> </ul>
Population health management	<ul style="list-style-type: none"> <li>• Provide information about MCP-administered specialized services and resources as part of the MCP’s model of care for which a QBHE can refer and link members to with assistance from the MCP.</li> <li>• Assist with identification of services that members have not received in order to address and close gaps in care.</li> <li>• Assist with coordinating services as needed (e.g., schedule appointments, arrange transportation, facilitate referrals and linkages to MCP health and wellness programs) in order to optimize health outcomes.</li> <li>• Share timely, meaningful, actionable data with the QBHE that can facilitate population health activities.</li> </ul>

- c. Upon full implementation of the BHCC initiative, the MCP shall perform the following ongoing administrative activities in support of the behavioral health care coordination initiative:
- i. Reimburse the QBHEs for performing the BHCC service at the rate specified by ODM in accordance with requirements set forth by ODM. This includes assuring that system edits are consistent with ODM’s policy for the provision and payment of behavioral

health services for attributed members as specified in this appendix.

- ii. Reimburse QBHEs incentive payments for meeting quality, efficiency, or total cost of care metrics in accordance with requirements set forth by ODM.
- iii. Provide technical support, as needed, to the QBHE to assist with its understanding and use of: 1) data files provided by the MCP; and 2) interacting with the MCP's portal, as specified by ODM, to obtain information about member attribution to the QBHE.
- iv. Validate target member and attribution files provided by ODM to the MCP to ensure that members are appropriately determined as eligible for the BHCC program, that those members are enrolled with the MCP for the relevant time period, and any other quality assurance needed to verify that the files contain accurate information regarding included members and attributed QBHEs.
- v. Provide ODM with a monthly add/delete file per ODM's specifications that contains information about members: 1) who have been referred and approved; 2) who have selected or have been attributed by claims to a new QBHE; 3) who are no longer enrolled with the MCP; or 4) any other changes in status regarding a member's enrollment with a QBHE.
- vi. Receive and integrate data provided by the QBHE and implement through the MCP's systems and operations.
- vii. Integrate results from the QBHE metrics into the MCP's overall quality improvement program.
- viii. Evaluate regional and community population health priorities to develop a clear improvement strategy in partnership with the QBHE.
- ix. Ensure member and provider facing departments (provider services, member services or nurse advice lines, utilization management) are able to identify when a member is attributed to a QBHE and use related information when interacting with members and providers.

**5. Coordination and Collaboration with Care Management Entities.**

- a. The MCP shall collaborate and coordinate with agencies that provide case management services to managed care members who receive services from any of the following Medicaid waiver programs: Ohio Home Care waiver, PASSPORT waiver, Assisted Living waiver, and DODD-administered waivers; and agencies that provide recovery management services to individuals eligible for Specialized Recovery Services. The MCP shall support these agencies per the following:
  - i. Delineating responsibilities between the case management agency and the MCP in order to avoid duplication or gaps in services.

- ii. Maintaining a single point of contact for the case management agency.
    - iii. Transmission of requested data, information and reports in a timely manner.
    - iv. Responding to requests for assistance or support in a timely manner.
  - b. Pursuant to 438.208(b), for all members, the MCP shall coordinate services received from any other payer, with the services received in FFS Medicaid, and with services received from community and social support providers.
6. **Transition of Care from the Ohio Department of Rehabilitation and Correction's Facilities to the Community for Critical Risk Individuals.** The MCP is responsible for facilitating and managing transitions of care for pending members who are designated as critical risk (refer to ODM's Methodology for Identification of Critical Risk Individuals) and are being discharged from Ohio Department of Rehabilitation and Correction's (ODRC's) facilities.
- a. Upon receiving notification from ODM and/or ODRC about pending members who will be released from the ODRC facility and will be enrolled with the MCP, the MCP shall identify which pending members meet the critical risk criteria. For pending members confirmed as meeting the critical risk criteria, the MCP will receive clinical information from ODRC and other entities. The MCP may request additional information for these pending members from the ODRC facility using the process prescribed by ODM. The MCP will notify ODRC if the requested records are not received within the timeframes established by ODRC & ODM.
  - b. The MCP shall develop a transition plan using the approved ODM form with information provided by ODRC and other programs/entities (e.g., Ohio Department of Mental Health and Addiction Services' Community Linkages program). The MCP shall facilitate input to the transition plan by entities specified by ODM. The MCP will conduct an interactive session (e.g., videoconference) to review the completed transition plan with each pending member who meets the critical risk criteria. The MCP will request the interactive session and submit a copy of the transition plan to the ODRC facility according to the methods and timeframes prescribed by ODM. The MCP shall make reasonable effort to conduct this interactive session at least 14 calendar days prior to the pending member's scheduled release date from the ODRC facility. The MCP shall review the transition plan with the pending member during the interactive session and identify/confirm necessary changes that will be made to the transition plan. The MCP shall update the transition plan, as appropriate, and submit the final transition plan to ODRC/Operations Support Center and the ODRC facility as prescribed by ODM.
  - c. After the pending member is released from the ODRC facility, the MCP shall contact the member as expeditiously as the member's condition warrants but not later than five calendar days from the date of release to assist the member with accessing care according to the transition plan, including identifying and removing barriers to care, and addressing additional needs expressed by the member. If the MCP is unable to contact the member within the first five calendar days (by making three different attempts over the 5 days), the MCP shall send a letter to the member no later than seven calendar days from the release date. The letter shall include contact information for member services and the care management department the member can use to request assistance with accessing services or community supports. The MCP

shall document all outreach attempts and contacts with the member.

- d. The MCP shall assess the member's need for care management using processes established in this appendix.

7. **Quality Improvement (QI) Program.** ODM defines quality improvement as a deliberate and defined, science-informed approach that is responsive to member needs and incorporates systematic methods for discovering reliable approaches to improving population health. Following this definition, the MCP shall make continuous and ongoing efforts to achieve measurable improvements in efficiency, effectiveness, performance, accountability, outcomes and other indicators of quality in services or processes that achieve equity and improve population health. Often these efforts require manual, rapid cycle, iterative work to determine effective strategies that may need to be "hard-wired" into plan processes.

As required by 42 CFR 438.330, the MCP shall establish and implement an ongoing comprehensive QAPI program for the services it delivers to its members. Updates to the MCP's QI program shall be submitted to ODM annually within the QAPI template and shall include the following elements:

- a. **QI Program Structure.** The MCP's quality improvement efforts should be integrated throughout the organization so that: (1) staff at all levels of the organization are fully equipped and have a commitment to improving health outcomes, (2) the results of successful and unsuccessful QI efforts are openly and transparently communicated across the organization, as well as externally in order to foster a culture of innovation, and (3) staff across all levels of the organization are empowered to seek out the root cause of problems and collaboratively test improvement strategies in order to rapidly learn what works and maintain and spread successes.

The MCP shall establish appropriate administrative oversight arrangements and accountability for the QAPI program. This includes: assignment of a senior QI leadership team responsible for the QI program (e.g., Quality Improvement Director, Medical Director, etc.); provision for ongoing transparent communication and coordination between the QI leadership team, the CEO and relevant functional areas of the organization so that QI activities are regularly assessed and lessons are learned from failures and successes; assurance that the Medical Director is involved in all clinically-related projects; and a commitment to providing staff at all levels of the organization with the appropriate education, experience, training, and authority to test and implement improvements that promote population health.

- b. **Senior QI leadership team.** The MCP's senior-level leadership team shall provide direction and routine oversight of improvement initiatives. The senior-leadership team is responsible for assuring that all improvement activities are evaluated and that results are used to inform future activities.

The lead for this team shall report directly to the organization's CEO. The team shall manage the organization's QI portfolio and shall be responsible for promoting a culture of QI throughout the organization with improved health outcomes for the Medicaid population as the primary goal. The MCP shall indicate commitment to improved outcomes and encourage improvement at all levels through activities that may include the following: clearly linking the MCP's quality

improvement strategy to the organization's and ODM's mission and vision, integrating the voices of members and providers into quality improvement activities (e.g., GEMBA walks, active involvement on QI teams), developing the capacity of MCP staff at all levels of the organization to apply quality improvement tools and principles, dedicating resources and tools to quality initiatives, consistently and frequently using data and analytics strategically to identify improvement opportunities and learn from improvement initiatives to maximize successes, and transparently sharing quality improvement opportunities and the results of quality improvement initiatives throughout the organization and with ODM.

The senior level QI leadership team structure submitted for approval shall include:

- i. Position role and responsibility on the QI leadership team;
- ii. Quality improvement training and experience;
- iii. The role of each team member in the quality improvement process;
- iv. Framework for frequently and transparently sharing information and data throughout the organization to inform improvement activities (e.g. dashboards; newsletters; staff meetings);
- v. Dedicated analytic and project management support;
- vi. Methods for identifying and assigning needed quality improvement resources;
- vii. Methods for building and sustaining quality improvement culture and capacity throughout the organization;

By June 30, 2019, each MCP shall have established an ODM-approved, senior leadership QI structure that is responsible for ensuring on-going, rapid-cycle improvement of the quality of care and services and championing improvement efforts through high-impact leadership activities.<sup>3</sup>

- c. **QI Initiative Staffing.** In an organization with an exemplary QI culture, quality improvement is fully embedded in the way the organization does business, across all levels, departments and programs, allowing staff to continue to seek out the root cause of problems, establish measurable objectives and quantify progress towards goals even when leadership changes.

As MCPs strive to develop an organization-wide QI culture, dedicated staff shall be devoted to fulfilling a set of clearly defined QI functions and responsibilities that are proportionate to, and adequate for, the planned number and types of QI initiatives. The dedication of resources should allow the plan to determine effectiveness of initiatives on a small scale through quality improvement science-based methods prior to plan-wide implementation, as well as allowing for

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<sup>3</sup> Swensen S, Pugh M, McMullan C, and 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.

long-term maintenance and spread of effective efforts.

- i. Quality improvement teams shall be composed of MCP staff dedicated to the Ohio line of business that represent the following areas of expertise:
  1. Continuous quality improvement,
  2. Analytics,
  3. Subject matter expertise in clinical and/or nonclinical improvement topic(s) being addressed through improvement efforts,
  4. Health equity,
  5. Member- and provider-perspectives; and
  6. MCP policies and processes related to the improvement topic.

Team members shall be empowered to test and promote improved MCP operations, as illustrated by at least one member of each improvement team having decision-making authority for testing and evaluating changes to plan processes.

Decision-making authority allows the team to undertake small tests of change by the individuals who are actively involved in the day-to-day work of the programmatic area or who have developed a thorough understanding of the work.

Additionally, in order for improvement projects to actively incorporate the perspective of members and providers and be responsive to areas identified for improvement, at least one member of the team shall be designated as a direct contact for physician and/or member partners. Direct contacts for physician or member partners in the QI effort help assure that the voice of the customer is integrated into improvement efforts. These individuals may be staff of or liaisons with the plan member and provider services.

- ii. Required QI responsibilities include:
  1. Frequent and ongoing data analysis to quickly determine the effectiveness of interventions;
  2. Longitudinal data monitoring and analysis using methods such as statistical process control to differentiate common and special cause variation in order to identify successes and opportunities for improvement;
  3. Frequent communication with team members and the senior leadership team regarding the status of improvement projects, intervention successes and failures, data used to determine success, lessons learned, opportunities and progress;

4. Full preparation for and active participation in ODM-sponsored QI meetings;
5. Cross-organization collaboration to further quality goals;
6. Analyzing data to identify disparities in services and/or care and tailoring interventions to specific populations when needed; and
7. Active incorporation of member and provider perspectives into improvement activities.

By June 30, 2019, the Ohio Medicaid-dedicated quality improvement support structure should be fully operational as specified by ODM.

- d. **Capacity Building.** The MCP shall build internal quality improvement capacity at all levels of the organization through investment in staff training and application of ODM-approved quality improvement science tools, methods, and principles.

As a foundation to build upon, MCP Medical Directors, Quality Improvement Directors, analytic support staff, and at least one MCP staff person assigned to each improvement team shall complete coursework, from an ODM-approved entity<sup>4</sup>, which includes the active application of rapid cycle quality improvement tools and methods.

Coursework does not substitute for the certification required in Appendix C.

By June 30, 2019, the MCP shall be in the process of implementing the ODM-approved plan for spreading the use of these improvement concepts to all staff within the organization.

- i. **QI Coursework Content.** Content shall include, but not be limited to, topics such as:

1. The Model for Improvement<sup>5</sup> developed by the Associates in Process Improvement and popularized by the Institute for Healthcare Improvement (IHI),
2. Edward W. Deming's System of Profound Knowledge,
3. Listening to and incorporating the Voice of the Customer (VOC),
4. Process mapping/flow charting,

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<sup>4</sup> Examples of approved entities offering coaching and/or training in these areas include: the Institute for Healthcare Improvement, the Intermountain Healthcare Leadership Institute, the Cincinnati Children's Hospital Anderson Center for Health System Excellence, the American Society for Quality's Learning Institute, the Deming Institute, and the National Association for Healthcare Quality.

<sup>5</sup> Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance (2<sup>nd</sup> edition). San Francisco: Jossey-Bass Publishers; 2009.

5. SMART Aim development and the use of key driver diagrams<sup>1</sup> for building testable hypotheses,
  6. Methods for barrier identification and intervention selection (e.g., root cause analyses, Pareto charts, failure mode and effects analysis, the 5 whys technique, etc.),
  7. Selection and use of process, outcome and balancing measures,
  8. Testing change through the use of PDS(C)A cycles<sup>6</sup>,
  9. The use of statistical process control, such as the Shewart control chart<sup>7</sup>, and
  10. Tools for spread and sustainability planning.
- ii. **Coursework Completion.** Training curricula for staff outlined in this appendix shall be submitted to ODM for approval prior to enrollment. Evidence of coursework completion shall be submitted within 1 month of completion.
  - iii. **Applying Coursework Concepts.** During and subsequent to quality improvement training, MCP staff should be actively involved as team members in at least one quality improvement project in order to continue to build the quality improvement capacity of the MCP. Active involvement in quality improvement projects involves the applying of quality improvement tools, methods and concepts to a clinical or nonclinical problem, including: root cause determination, barrier assessment, intervention design and testing, and longitudinal measurement, and assessment of intervention impact on outcome measures using statistical process control methods.
  - iv. **Coursework Exemptions.** Staff will be exempt from this requirement, if one of the following is completed within the two years prior to this contract's effective date: 1) an accredited/certified education course in quality improvement science or 2) satisfactory completion of NCQA, CPHQ or ASQ CQIA certification. Medical Directors with a substantial role in improvement projects or who are accountable for the QAPI program, as well as Quality Improvement Directors who are hired after July 1, 2016, shall complete the course work within six (6) months of their start date unless they have evidence of course completion within the two years prior to their effective start date.
  - v. **ODM Funded QI Training Efforts.** MCP staff at all levels of the organization shall be required to actively participate in all ODM-funded QI training, as illustrated by fully-being prepared for class, active engagement in class activities, meeting with team and sponsor prior to class, and applying learned concepts to current MCP improvement projects.

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<sup>6</sup> Deming WE. [The New Economics for Industry, Government, and Education](#). Cambridge, MA: The MIT Press; 2000

<sup>7</sup> Revelle JB. [Quality Essentials: A Reference Guide from A to Z](#), ASQ Quality Press, 2004.



- e. **Quality Improvement Strategy.** The MCP shall submit a clearly delineated, outcomes-driven strategy for improvement (e.g., work plan) as part of its annual QAPI submission. The strategy shall measure, analyze, and track performance indicators that reflect the ODM Quality Strategy population health focus, including: population streams (e.g., women of reproductive age, chronic conditions, and behavioral health), value-based purchasing strategies (e.g., comprehensive primary care, episode-based payments), and health equity focus. The MCP's quality improvement strategy shall, at minimum, describe:
- i. The MCP leadership team, including leadership positions and how each role supports and champions the MCP's quality improvement strategy and related initiatives and projects;
  - ii. How the MCP strategy aligns with the current ODM quality strategy, including how the MCP will collaborate with other MCPs on ODM-directed population health efforts;
  - iii. The MCP's quality improvement initiatives, including:
    1. How the initiative inter-relates to MCP initiatives, as well as to MCP and ODM quality strategies;
    2. The theory of change for each improvement project (i.e., cause and effect diagrams, key driver diagrams);
    3. Criteria considered when choosing and prioritizing the MCP's improvement projects and initiatives by population stream;
    4. The process for identifying the root causes of prioritized improvement initiatives;
    5. The process(es) for identifying and incorporating the voice of the customer (e.g., member, provider) into continual efforts to identify areas for improvement, design and prioritize interventions, and improve services and population health;
    6. The roles and responsibilities of staff assigned to the project and resources allocation to support the improvement effort;
    7. Baseline, measures and measure frequency, target goals and the timeline for their achievement;
    8. Methods and data used to evaluate intervention effectiveness and a description regarding how positive and negative results contribute to lessons learned;
    9. How newly identified areas for improvement from data analysis and customer input, as well as from the previous year's evaluation are reflected in the quality strategy; and

10. The development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, enrollee satisfaction, and other targets of improvement efforts.

- f. **Improvement Projects.** Improvement projects are sponsored by MCP leadership and are assigned appropriate staffing resources as described in this appendix. In addition to operationalizing the MCP's improvement strategy, improvement projects build confidence among internal and external customers regarding the MCP's commitment to population health and focus on continual improvement of services and outcomes.

Improvement projects use rapid-cycle continuous quality improvement methods to identify and address root cause, 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 consumers.

Through the use of rapid cycle continuous quality improvement science techniques used in improvement projects, the MCP is expected to quickly learn the effectiveness of interventions on a small scale prior to investing significant time or resources into "hard-wiring" the change or into implementing the change at the organization level. The "all-teach, all-learn" approach to quality improvement values input from staff at all levels of the organization, encourages transparency, and views problems as opportunities to improve population health. Ongoing analysis, data feedback, and associated learning is used to guide improvement efforts and shall be shared frequently within improvement teams, QI leadership, and ODM.

The MCP shall evaluate all improvement projects, interventions and initiatives so that the knowledge gained regarding effectiveness can be integrated into its overall quality assessment and improvement program.

Knowledge gained from intervention testing within improvement projects, as well as project outcomes, shall be transparently shared across MCPs and with ODM to inform population health planning statewide.

- i. **Performance Improvement Projects.** In accordance with federal requirements, the MCP shall conduct clinical and non-clinical performance improvement projects (PIPs) using rapid cycle quality improvement science techniques. The MCP shall initiate and complete PIPs in topics selected by ODM. All PIPs designed and implemented by the MCP shall be approved by ODM when there is demonstrated improvement and the MCP can clearly articulate lessons learned during the course of the initiative. The MCP shall adhere to ODM-specified reporting, submission and frequency guidelines during the life of the PIP, establish and implement mechanisms for rapidly testing interventions, and establish mechanisms for spreading and sustaining successful interventions in order to optimize improvement gains. Upon request, the MCP shall 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 external quality review organization (EQRO).

The EQRO will assist the MCP with the development and implementation of at least one PIP by providing technical assistance, and will annually validate the PIPs in accordance with the Centers for Medicare and Medicaid Services' protocols.

- ii. **Quality Improvement Projects.** Quality Improvement Projects (QIPs) use rapid cycle quality improvement science principles and may be required by the state or initiated by the MCP. Like PIPs, the QIPs can focus on clinical or non-clinical areas, are intended to achieve significant and sustained improvement over time, and have favorable effects on health outcomes, quality of life and provider/consumer satisfaction. Although QIPs are not validated by the EQRO, the MCP shall adhere to ODM-specified reporting and submission requirements.

The MCP shall actively participate in performance and quality improvement initiatives facilitated by ODM, the EQRO, or both. This includes improvement projects focused on topics within each population stream, MCP support of CPC practices, and efforts with other state agencies, collaborative or community-based organizations impacting MCP membership. MCP participation shall also be required in ODM-directed population health efforts that require collaboration between all MCPs and may include standardization of program processes across plans.

- g. **Program Communication.** Each MCP shall have a clearly defined communication strategy for quality improvement activities. This includes:
  - i. Mechanisms for data receipt and exchange, analyzing and interpreting data, and transparently and proactively involving stakeholders and partners in applying data to improvement efforts;
  - ii. 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 and to executive leadership. Status updates shall include: lessons learned from intervention testing, advances to the theory of knowledge, and the progress on process and outcome measures;
  - iii. Mechanisms for proactive, regular communication with ODM and/or EQRO staff regarding improvement opportunities and priorities, intervention successes, lessons learned and future activities; and
  - iv. Responding promptly and transparently to data and information requests by ODM or the EQRO.
- h. **Clinical Practice Guidelines.** The MCP's QAPI shall describe how the MCP will ensure that the clinical practice guidelines are valid and represent reliable clinical evidence or a consensus of healthcare professionals in a particular field. MCPs shall follow the guidance in the QAPI submission template when describing this aspect of the program.
- i. **Assessment of Health Care Service Utilization.** The MCP shall have mechanisms in place to detect under- and over-utilization of health care services. The MCP shall follow the guidance in the QAPI submission template when specifying the mechanisms used to monitor utilization in

the submission of the QAPI program to ODM. The MCP shall ensure the utilization analysis documented in the QAPI is linked to ensuring population health outcomes, and is incorporated into the quality strategy.

Pursuant to the program integrity provisions outlined in Appendix I, the MCP shall monitor for the potential under-utilization of services by its members in order to ensure all Medicaid-covered services are being provided, as required. If any underutilized services are identified, the MCP shall immediately investigate the underutilization in order to determine root cause, take corrective action and monitor data over time to ensure the problem which resulted in such service underutilization has been corrected.

In addition, the MCP shall conduct an ongoing review of service denials and shall monitor utilization on an ongoing basis in order to identify services which may be underutilized.

- j. **Assessment of the Quality and Appropriateness of Care for Members with Special Health Care Needs and Enrollees Receiving Long-term Services and Supports.** The MCP shall have mechanisms in place to assess the quality and appropriateness of care furnished to members with special health care needs. The MCP shall follow the guidance in the QAPI submission template when describing and evaluating these aspects of the program.
- k. **Addressing Health Disparities.** The MCP shall participate in, and support, ODM's efforts to eliminate health disparities in Ohio. According to the U.S. Department of Health and Human Services' Office of Minority Health, a health disparity is "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). In support of ODM's effort to achieve health equity, the MCP shall collect and meaningfully use race, ethnicity and language data to identify and reduce disparities in health care access, services and outcomes.

Support of ODM's health equity efforts includes having MCP health equity representatives actively involved in improvement initiatives, determining the root cause of inequities, developing targeted interventions and measures, and collecting and analyzing data to track progress in disparity reduction efforts. These efforts move beyond agenda setting, and instead focus on the work needed for change to occur, and place greater responsibility for improvement on all parties participating in improvement efforts.

- l. **Submission of Performance Measurement Data.** The MCP shall submit data as required by ODM that enables ODM to calculate standard measures as defined in Appendices L and M. The MCP shall also submit self-reported, audited Healthcare Effectiveness Data and Information Set (HEDIS) data (see ODM Methodology for MCP Self-Reported, HEDIS-Audited Data) for performance measures set forth in Appendix M. A separate, duplicative submission of performance measurement data is not required as part of the annual QAPI submission.
- m. **QAPI Program Impact and Effectiveness.** The MCP shall evaluate the impact and effectiveness of each effort within the QAPI program, including efforts to reduce health disparities. The MCP

shall update the QAPI program based on the findings of the self-evaluation and submit both the evaluation results and updates annually to ODM for review and approval following the template provided in the QAPI guidance document. Evaluation should, at a minimum, include:

- i. The outcomes and trended results of each improvement project, including documentation of successful and unsuccessful interventions;
  - ii. The results of any efforts to support community integration for enrollees using long-term services and supports; and
  - iii. How these results will be incorporated into the MCP's quality strategy.
8. **External Quality Review.** ODM will select an external quality review organization (EQRO) to provide for an annual, external, and independent review of the quality, outcomes, timeliness of and access to services provided by the MCP. The MCP shall participate in annual external quality review which will include but not be limited to the following activities:
- a. Administrative compliance assessment as required by 42 CFR 438.358 and as specified by ODM.
    - i. **Non-duplication Exemption.** As allowed by 42 CFR 438.360 and 438.362, an MCP with accreditation from a national organization approved by the Centers for Medicare and Medicaid services may request to be exempted from certain portions of the administrative compliance assessment. ODM will inform the MCP when a non-duplication exemption may be requested.
    - ii. The EQRO may conduct focused reviews of MCP performance in the following domains which include, but are not limited to:
      1. Availability of services;
      2. Assurance of adequate capacity and services;
      3. Coordination and continuity of care;
      4. Coverage and authorization of services;
      5. Credentialing and re-credentialing of services;
      6. Sub contractual relationships and delegation;
      7. Enrollee information and enrollee rights;
      8. Confidentiality of health information;
      9. Enrollment and disenrollment;

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10. Grievance process;
  11. Practice guidelines;
  12. Quality assessment and performance improvement program;
  13. Health information systems; and
  14. Fraud and abuse.
- b. Encounter data studies.
  - c. Validation of performance measurement data.
  - d. Review of information systems.
  - e. Validation of performance improvement projects.
  - f. Member satisfaction and/or quality of life surveys.

The MCP shall submit data and information, including member medical records, at no cost to, and as requested by, ODM or its designee for the annual external quality review.

The sanctions for noncompliance with requirements in this appendix are listed in Appendix N of this Agreement.

## APPENDIX L

### DATA QUALITY

A high level of performance on the data quality standards and requirements established in this appendix is crucial in order for the Ohio Department of Medicaid (ODM) to determine the value of the Medicaid Managed Health Care Program and to evaluate Medicaid consumers' access to and quality of services. Data collected from the MCP is used in key performance assessments such as the external quality review, clinical performance measures, utilization review, care coordination and care management, and in determining incentives. The data will also be used in conjunction with the cost reports in setting the premium payment rates. Data sets collected from the MCP with data quality standards and/or submission requirements include: encounter data; Healthcare Effectiveness Data and Information Set (HEDIS) data; care management data; appeals and grievances data; utilization management data; Consumer Assessment of Healthcare Providers and Systems (CAHPS) data, third party liability data, and primary care provider data.

The measures in this appendix are calculated per MCP using statewide results that include all regions in which the MCP has membership. Unless otherwise specified, each measure is calculated for the MCP's overall Ohio Medicaid population (i.e., ABD, MAGI, and Adult Extension members).

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

1. **Encounter Data.** For detailed descriptions of the encounter data quality measures below, see *ODM Methods for the MAGI, ABD, and Adult Extension Encounter Data Quality Measures*.

The MCP's encounter data submissions will be assessed for completeness and accuracy. The MCP is responsible for collecting information from providers and reporting the data to ODM in accordance with program requirements established in Appendix C. Failure to do so jeopardizes the MCP's ability to demonstrate compliance with other performance standards.

- a. **Encounter Data Completeness.**

- i. **Encounter Data Volume.** This measure is calculated separately for ABD adults, ABD children, MAGI members (adults and children combined), and Adult Extension members. Measure 1 is applicable for SFY 2018-2019 per Tables 1 and 2. Beginning with SFY 2019, Q3 2018 report period, the measure methodology has been revised to better align with Cost Report category of service methodology. Measure 2 is applicable starting SFY 2019, Q3 2018 report period per Tables 3 and 4. Beginning with January 1, 2019, the data quality standards per plan has been updated. Measure 3 is applicable starting SFY 2020, Q1 2019.

1. **Measure 1.** The volume measure for each population and service category, as listed in Table 2 of this appendix, is the rate of utilization (e.g., admits, visits) per 1,000 member months (MM).

**Measurement Period.** The relevant measurement periods for each population for the State Fiscal Year (SFY) 2018 and SFY 2019 contract periods are listed in Table 1

below.

**Data Quality Standards.** The data quality standards, per population, plan, and service category, are listed in Table 2 below. This measure is calculated separately for each population and plan. For each population, the MCP shall meet or exceed the standard for every service category, in all quarters of the measurement period.

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

**Table 1. Measurement Periods for the SFY 2018 and SFY 2019 Contract Periods.**

MAGI Measurement Periods	ABD Adult Measurement Periods	ABD Child Measurement Periods	Adult Extension Members Measurement Periods	Data Source: Estimated Encounter Data File Update	Report Estimated Issue Date	Contract Period
Qtr 2 thru Qtr 4: 2014, Qtr 1 thru Qtr 4: 2015, 2016, Qtr 1 2017	Qtr 2 thru Qtr 4: 2014, Qtr 1 thru Qtr 4: 2015, 2016, Qtr 2017	Qtr 2 thru Qtr 4: 2014, Qtr 1 thru Qtr 4: 2015, 2016, Qtr 2017	Qtr 2 thru Qtr 4: 2014, Qtr 1 thru Qtr 4: 2015, 2016, Qtr 2017	August 2017	September 2017	SFY 2018
Qtr 3, Qtr 4: 2014, Qtr 1 thru Qtr 4: 2015, 2016, Qtr 1, Qtr 2: 2017	Qtr 3, Qtr 4: 2014, Qtr 1 thru Qtr 4: 2015, 2016, Qtr 1, Qtr 2: 2017	Qtr 3, Qtr 4: 2014, Qtr 1 thru Qtr 4: 2015, 2016, Qtr 1, Qtr 2: 2017	Qtr 3, Qtr 4: 2014, Qtr 1 thru Qtr 4: 2015, 2016, Qtr 1, Qtr 2: 2017	November 2017	December 2017	
Qtr 4: 2014, Qtr 1 thru Qtr 4: 2015, 2016, Qtr 1 thru Qtr 3: 2017	Qtr 4: 2014, Qtr 1 thru Qtr 4: 2015, 2016, Qtr 1 thru Qtr 3: 2017	Qtr 4: 2014, Qtr 1 thru Qtr 4: 2015, 2016, Qtr 1 thru Qtr 3: 2017	Qtr 4: 2014, Qtr 1 thru Qtr 4: 2015, 2016, Qtr 1 thru Qtr 3: 2017	February 2018	March 2018	
Qtr 1 thru Qtr 4: 2015, 2016, 2017	Qtr 1 thru Qtr 4: 2015, 2016, 2017	Qtr 1 thru Qtr 4: 2015, 2016, 2017	Qtr 1 thru Qtr 4: 2015, 2016, 2017	May 2018	June 2018	
Qtr 2 thru Qtr 4: 2015, Qtr 1 thru Qtr 4: 2016, 2017, Qtr 1 2018	Qtr 2 thru Qtr 4: 2015, Qtr 1 thru Qtr 4: 2016, 2017, Qtr 1 2018	Qtr 2 thru Qtr 4: 2015, Qtr 1 thru Qtr 4: 2016, 2017, Qtr 1 2018	Qtr 2 thru Qtr 4: 2015, Qtr 1 thru Qtr 4: 2016, 2017, Qtr 1 2018	August 2018	September 2018	SFY 2019
Qtr 3, Qtr 4: 2015, Qtr 1 thru Qtr 4: 2016, 2017, Qtr 1 2018	Qtr 3, Qtr 4: 2015, Qtr 1 thru Qtr 4: 2016, 2017, Qtr 1 2018	Qtr 3, Qtr 4: 2015, Qtr 1 thru Qtr 4: 2016, 2017, Qtr 1 2018	Qtr 3, Qtr 4: 2015, Qtr 1 thru Qtr 4: 2016, 2017, Qtr 1 2018	November 2018	December 2018	
Qtr 4: 2015, Qtr 1 thru Qtr 4: 2016, 2017, Qtr 1 thru Qtr 3: 2018	Qtr 4: 2015, Qtr 1 thru Qtr 4: 2016, 2017, Qtr 1 thru Qtr 3: 2018	Qtr 4: 2015, Qtr 1 thru Qtr 4: 2016, 2017, Qtr 1 thru Qtr 3: 2018	Qtr 4: 2015, Qtr 1 thru Qtr 4: 2016, 2017, Qtr 1 thru Qtr 3: 2018	February 2019	March 2019	

Note: Qtr 1 = January to March; Qtr 2 = April to June; Qtr 3 = July to September; Qtr 4 = October to December



**Table 2. Data Quality Standards.**

Category	Measure per 1,000/MM	MAGI Standards	ABD Adult Standards	ABD Child Standards	Adult Extension Standards	Description
Inpatient Hospital	Discharges	4.2	17.8	4.2	7.5	General/acute care, excluding newborns and mental health and chemical dependency services
Emergency Department	Visits	65.5	126.0	60.8	90.1	Includes physician and hospital emergency department encounters
Dental	Visits	45.2	30.9	35.5	42.3	Non-institutional and hospital dental visits
Vision		14.9	21.3	15.3	17.3	Non-institutional and hospital outpatient optometry and ophthalmology visits
Primary and Specialist Care		224.4	451.6	196.3	285.6	Physician/practitioner and hospital outpatient visits
Behavioral Health	Service	35.9	74.9	120.2	62.4	Inpatient and outpatient behavioral encounters
DME	Service	10.1	116.4	54.8	27.5	Durable Medical Equipment
Pharmacy	Prescriptions	600.3	3717.3	834.9	1511.8	Prescribed drugs

2. **Measure 2.** The volume measure for each population and service category, as listed in Table 3 of this appendix, is the rate of utilization (e.g., admits, visits) per 1,000 member months (MM).

**Measurement Period.** The measurement periods for each population for the State Fiscal Year (SFY) 2019 contract periods are listed in Table 3 below.

**Data Quality Standards.** The data quality standards, per population, plan, and service category, are listed in Table 4 below. This measure is calculated separately for each population and plan. For each population, the MCP shall meet or exceed the standard for every service category, in all quarters of the measurement period. Revised standards will take effect on July 1, 2018 for the new category of service methodology. Previous quarters from Q3 2018 will not be held to the revised standards due to the change in measure methodology.

**Table 3. Measurement Periods for SFY 2019 Contract Periods.**

MAGI Measurement Periods	ABD Adult Measurement Periods	ABD Child Measurement Periods	Adult Extension Members Measurement Periods	Data Source: Estimated Encounter Data File Update	Report Estimated Issue Date	Contract Period
Qtr 3: 2018	Qtr 3: 2018	Qtr 3: 2018	Qtr 3: 2018	February 2019	March 2019	SFY 2019
Qtr 3 thru Qtr 4: 2018	Qtr 3 thru Qtr 4: 2018	Qtr 3 thru Qtr 4: 2018	Qtr 3 thru Qtr 4: 2018	May 2019	June 2019	

Note: Qtr 1 = January to March; Qtr 2 = April to June; Qtr 3 = July to September; Qtr 4 = October to December

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**Table 4. Measure 2 Data Quality Standards Per Managed Care Plan.**

**Buckeye**

Category of Service	MAGI	ABD Adult	ABD Child	Adult Extension
Behavioral Health	17.0	21.7	19.0	20.0
DME	16.9	116.9	82.5	38.8
Emergency	410.6	1559.7	960.5	651.7
Inpatient	1.7	15.0	4.7	5.9
Primary & Specialist Care	287.9	653.3	321.8	409.1
Outpatient	63.3	134.8	133.3	76.8
Pharmacy	600.5	3547.0	903.1	1492.9
Dental	54.5	37.4	44.0	46.0
Vision	14.4	19.1	14.9	15.0

**CareSource**

Category of Service	MAGI	ABD Adult	ABD Child	Adult Extension
Behavioral Health	28.1	41.6	32.2	42.7
DME	22.7	123.0	70.0	47.0
Emergency	433.5	1269.8	548.0	723.6
Inpatient	1.9	16.6	4.2	6.7
Primary & Specialist Care	316.6	772.9	344.2	504.5
Outpatient	78.8	147.7	145.5	96.2
Pharmacy	779.5	4716.8	1187.3	2123.8
Dental	66.2	40.9	50.2	56.4
Vision	18.8	25.7	19.4	21.9

**Molina**

Category of Service	MAGI	ABD Adult	ABD Child	Adult Extension
Behavioral Health	19.4	31.8	26.3	28.7
DME	17.1	118.8	88.4	37.8
Emergency	406.8	1553.4	1106.1	653.3
Inpatient	1.6	13.6	4.6	5.6
Primary & Specialist Care	288.1	716.9	347.8	415.5
Outpatient	72.6	127.0	181.4	75.9
Pharmacy	625.3	4339.4	985.4	1632.0
Dental	58.0	35.6	45.6	43.2
Vision	17.0	23.6	18.6	17.7

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**Paramount**

Category of Service	MAGI	ABD Adult	ABD Child	Adult Extension
Behavioral Health	23.2	36.8	27.1	28.1
DME	23.0	101.9	93.9	38.6
Emergency	431.2	1304.7	844.1	619.7
Inpatient	2.2	16.7	5.0	7.0
Primary & Specialist Care	306.7	691.9	346.5	420.9
Outpatient	46.0	109.5	115.6	71.5
Pharmacy	642.2	3335.6	974.8	1530.1
Dental	50.2	38.6	43.2	40.8
Vision	17.8	21.7	20.9	16.3

**United**

Category of Service	MAGI	ABD Adult	ABD Child	Adult Extension
Behavioral Health	18.3	28.1	20.6	25.3
DME	16.2	116.7	74.7	38.9
Emergency	398.3	1165.5	578.3	635.5
Inpatient	1.4	10.9	3.0	4.9
Primary & Specialist Care	290.5	698.5	327.0	446.9
Outpatient	71.2	116.6	137.4	85.7
Pharmacy	634.2	3824.6	926.9	1642.4
Dental	54.2	39.5	43.9	47.0
Vision	15.6	21.3	16.7	18.2

3. **Measure 3.** The volume measure for each population and service category, as listed in Table 7 of this appendix, is the rate of utilization (e.g., admits, visits) per 1,000 member months (MM).

**Measurement Period.** The measurement periods for each population for SFY 2020 contract periods are listed in Table 7 below. Measurement periods for SFY 2020 through Q4 2018 will be informational.

**Data Quality Standards.** The data quality standards, per population, plan, and service category, are listed in Table 8 below. This measure is calculated separately for each population and plan. For each population, the MCP shall meet or exceed the standard for every service category, in all quarters of the measurement period. Revised standards will take effect on July 1, 2018 for the new category of service methodology. Previous quarters from Q1 2019 will not be held to the revised standards due to the change in measure methodology. For each measure, two conditions must be met for each quarter in order for the MCP to successfully meet the standard for that quarter:

- a. The plan specific, category of service specific, standard of encounter data volume as listed in Table 8.

- b. The maximum percentage decrease of encounter data volume allowed for each MCP for each category of service per Tables 5 and 6:
- i. From one quarter to the following quarter (e.g. the percentage decrease from Q1 2019 to Q2 2019).
  - ii. From one quarter to the quarter not directly following it but two quarters later from the first quarter (e.g. the percentage decrease from Q1 2019 to Q3 2019).

**Table 5. Maximum Percent (%) Reduction for One Quarter Difference.**

Quarters Included	Maximum % Reduction Allowed	Categories of Service Included
% Difference between Q1 2019 and Q2 2019 in EDV/MM	22.50%	Behavioral Health, Dental, DME, Emergency
% Difference between Q2 2019 and Q3 2019 in EDV/MM	12.50%	Behavioral Health, Dental, DME, Emergency
% Difference between Q3 2019 and Q4 2019 in EDV/MM	12.50%	Behavioral Health, Dental, DME, Emergency
% Difference between Q4 2019 and Q1 2020 in EDV/MM	12.50%	Behavioral Health, Dental, DME, Emergency
% Difference between Q1 2019 and Q2 2019 in EDV/MM	22.50%	Outpatient, Pharmacy, Primary and Specialty
% Difference between Q2 2019 and Q3 2019 in EDV/MM	12.50%	Outpatient, Pharmacy, Primary and Specialty
% Difference between Q3 2019 and Q4 2019 in EDV/MM	12.50%	Outpatient, Pharmacy, Primary and Specialty
% Difference between Q4 2019 and Q1 2020 in EDV/MM	12.50%	Outpatient, Pharmacy, Primary and Specialty
% Difference between Q1 2019 and Q2 2019 in EDV/MM	27.50%	Vision
% Difference between Q2 2019 and Q3 2019 in EDV/MM	17.50%	Vision
% Difference between Q3 2019 and Q4 2019 in EDV/MM	17.50%	Vision
% Difference between Q4 2019 and Q1 2020 in EDV/MM	17.50%	Vision
% Difference between Q1 2019 and Q2 2019 in EDV/MM	No maximum % reduction	Deliveries*
% Difference between Q2 2019 and Q3 2019 in EDV/MM	No maximum % reduction	Deliveries*
% Difference between Q3 2019 and Q4 2019 in EDV/MM	No maximum % reduction	Deliveries*
% Difference between Q4 2019 and Q1 2020 in EDV/MM	No maximum % reduction	Deliveries*
% Difference between Q1 2019 and Q2 2019 in EDV/MM	No maximum % reduction	Inpatient
% Difference between Q2 2019 and Q3 2019 in EDV/MM	No maximum % reduction	Inpatient
% Difference between Q3 2019 and Q4 2019 in EDV/MM	No maximum % reduction	Inpatient
% Difference between Q4 2019 and Q1 2020 in EDV/MM	No maximum % reduction	Inpatient

\*Deliveries category of services only applies to CFC population

**Table 6. Maximum Percent (%) Reduction for Two Quarter Difference.**

Quarters Included	Maximum % Reduction Allowed	Categories of Service Included
% Difference between Q1 2019 and Q3 2019 in EDV/MM	30.00%	Behavioral Health, Dental, DME, Emergency
% Difference between Q2 2019 and Q4 2019 in EDV/MM	20.00%	Behavioral Health, Dental, DME, Emergency
% Difference between Q3 2019 and Q1 2020 in EDV/MM	20.00%	Behavioral Health, Dental, DME, Emergency
% Difference between Q4 2019 and Q2 2020 in EDV/MM	20.00%	Behavioral Health, Dental, DME, Emergency
% Difference between Q1 2019 and Q3 2019 in EDV/MM	30.00%	Outpatient, Pharmacy, Primary and Specialty
% Difference between Q2 2019 and Q4 2019 in EDV/MM	20.00%	Outpatient, Pharmacy, Primary and Specialty
% Difference between Q3 2019 and Q1 2020 in EDV/MM	20.00%	Outpatient, Pharmacy, Primary and Specialty
% Difference between Q4 2019 and Q2 2020 in EDV/MM	20.00%	Outpatient, Pharmacy, Primary and Specialty
% Difference between Q1 2019 and Q3 2019 in EDV/MM	35.00%	Vision
% Difference between Q2 2019 and Q4 2019 in EDV/MM	25.00%	Vision
% Difference between Q3 2019 and Q1 2020 in EDV/MM	25.00%	Vision
% Difference between Q4 2019 and Q2 2020 in EDV/MM	25.00%	Vision
% Difference between Q1 2019 and Q3 2019 in EDV/MM	No maximum % reduction	Deliveries*
% Difference between Q2 2019 and Q4 2019 in EDV/MM	No maximum % reduction	Deliveries*
% Difference between Q3 2019 and Q1 2020 in EDV/MM	No maximum % reduction	Deliveries*
% Difference between Q4 2019 and Q2 2020 in EDV/MM	No maximum % reduction	Deliveries*
% Difference between Q1 2019 and Q3 2019 in EDV/MM	No maximum % reduction	Inpatient
% Difference between Q2 2019 and Q4 2019 in EDV/MM	No maximum % reduction	Inpatient
% Difference between Q3 2019 and Q1 2020 in EDV/MM	No maximum % reduction	Inpatient
% Difference between Q4 2019 and Q2 2020 in EDV/MM	No maximum % reduction	Inpatient

\*Deliveries category of services only applies to CFC population

**Table 7. Measurement Periods for the SFY 2020 Contract Periods.**

MAGI Quarterly Measurement Periods	ABD Adult Quarterly Measurement Periods	ABD Child Quarterly Measurement Periods	Adult Extension Members Quarterly Measurement Periods	Data Source: Estimated Encounter Data File Update	Quarterly Report Estimated Issue Date	Contract Period
Qtr 1: 2019	Qtr 1: 2019	Qtr 1: 2019	Qtr 1: 2019	August 2019	September 2019	SFY 2020
Qtr 1 thru Qtr 2: 2019	Qtr 1 thru Qtr 2: 2019	Qtr 1 thru Qtr 2: 2019	Qtr 1 thru Qtr 2: 2019	November 2019	December 2019	
Qtr 1 thru Qtr 3: 2019	Qtr 1 thru Qtr 3: 2019	Qtr 1 thru Qtr 3: 2019	Qtr 1 thru Qtr 3: 2019	February 2020	March 2020	
Qtr 1 thru Qtr 4: 2019	Qtr 1 thru Qtr 4: 2019	Qtr 1 thru Qtr 4: 2019	Qtr 1 thru Qtr 4: 2019	May 2020	June 2020	

Note: Qtr 1 = January to March; Qtr 2 = April to June; Qtr 3 = July to September; Qtr 4 = October to December

**Table 8. Measure 3 Data Quality Standards Per Managed Care Plan.**

**Buckeye**

Category of Service	MAGI	ABD Adult	ABD Child	Adult Extension
Behavioral Health	229.8	555.9	620.6	318.4
DME	17.4	139.3	103.2	43.0
Emergency	462.1	1926.9	1248.6	755.9
Inpatient	1.5	18.4	5.9	6.0
Primary & Specialist Care	318.2	816.7	420.7	481.0
Outpatient	73.1	152.4	171.0	89.0
Pharmacy	629.2	4276.1	950.6	1719.7
Dental	60.2	43.0	50.7	50.4
Vision	18.4	26.3	21.7	20.3
Deliveries	2.8	N/A	N/A	N/A

**CareSource**

Category of Service	MAGI	ABD Adult	ABD Child	Adult Extension
Behavioral Health	250.5	621.8	767.9	395.9
DME	25.8	164.9	116.0	56.0
Emergency	503.0	1585.6	762.4	854.0
Inpatient	1.6	20.7	5.5	6.9
Primary & Specialist Care	357.2	978.5	469.4	588.6
Outpatient	85.0	160.1	162.2	102.2
Pharmacy	854.8	5804.7	1469.4	2518.9
Dental	76.7	48.1	55.3	63.4
Vision	23.2	34.4	30.2	27.5
Deliveries	2.5	N/A	N/A	N/A

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Appendix L  
Data Quality

**Molina**

Category of Service	MAGI	ABD Adult	ABD Child	Adult Extension
Behavioral Health	230.5	547.9	629.3	350.7
DME	18.7	148.3	125.2	41.8
Emergency	464.3	1866.4	1386.0	756.7
Inpatient	1.4	17.4	6.4	6.1
Primary & Specialist Care	322.9	887.2	460.9	484.1
Outpatient	79.4	138.9	205.8	85.5
Pharmacy	681.0	4980.6	1322.0	1784.8
Dental	65.4	39.1	53.3	46.7
Vision	20.3	29.6	24.8	21.7
Deliveries	2.4	N/A	N/A	N/A

**Paramount**

Category of Service	MAGI	ABD Adult	ABD Child	Adult Extension
Behavioral Health	249.5	551.2	660.4	377.7
DME	22.8	122.3	128.7	41.0
Emergency	495.8	1573.1	1086.8	722.7
Inpatient	1.9	20.3	6.1	7.4
Primary & Specialist Care	347.6	853.6	451.7	493.8
Outpatient	53.8	131.4	140.4	83.7
Pharmacy	711.7	3862.7	1256.2	1789.2
Dental	53.7	41.3	47.7	43.2
Vision	20.3	26.4	26.3	19.1
Deliveries	3.1	N/A	N/A	N/A

**United**

Category of Service	MAGI	ABD Adult	ABD Child	Adult Extension
Behavioral Health	246.3	563.4	711.0	338.7
DME	17.3	139.1	97.1	44.4
Emergency	446.4	1393.1	771.0	760.2
Inpatient	1.2	14.4	3.7	5.3
Primary & Specialist Care	316.2	852.3	421.1	519.7
Outpatient	79.5	136.4	160.6	98.1
Pharmacy	666.2	4439.5	1242.1	1951.9
Dental	60.1	44.8	52.4	51.4
Vision	19.2	29.4	23.1	23.7
Deliveries	2.4	N/A	N/A	N/A

- ii. **Incomplete Rendering Provider Data.** This measure is calculated to ensure the MCP is reporting individual-level rendering provider information to ODM so that Ohio Medicaid complies with federal reporting requirements.
  1. **Measure.** The percentage of rendering providers reported on encounters without individual-level Medicaid and/or Reporting provider numbers as identified in MITS.
  2. **Measurement Period.** The measurement periods for the SFY 2018 and SFY 2019 contract periods are listed in Table 9 below. The MCP shall meet or exceed the standard in all quarters of the measurement period.
  3. **Data Quality Standard.** Less than or equal to 4.0%.

**Table 9. Measurement Periods for the SFY 2018 and SFY 2019 Contract Periods - Incomplete Rendering Provider Data.**

Quarterly Measurement Periods	Data Source: Estimated Encounter Data File Update	Quarterly Report Estimated Issue Date	Contract Period
Qtr 1 thru Qtr 4: 2016; Qtr 1: 2017	July 2017	August 2017	SFY 2018
Qtr 1 thru Qtr 4: 2016; Qtr 1, Qtr 2: 2017	October 2017	November 2017	
Qtr 1 thru Qtr 4: 2016; Qtr 1 thru Qtr 3: 2017	January 2018	February 2018	
Qtr 1 thru Qtr 4: 2016; Qtr 1 thru Qtr 4: 2017	April 2018	May 2018	
Qtr 2 thru Qtr 4: 2016; Qtr 1 thru Qtr 4 2017; Qtr 1 2018	July 2018	August 2018	SFY 2019
Qtr 3 thru Qtr 4: 2016; Qtr 1 thru Qtr 4 2017; Qtr 1 thru Qtr 2 2018	October 2018	November 2018	
Qtr 4 2016; Qtr 1 thru Qtr 4 2017; Qtr 1 thru Qtr 3 2018	January 2019	February 2019	
Qtr 1 thru Qtr 4 2017; Qtr 1 thru Qtr 4 2018	April 2019	May 2019	

Note: Qtr 1 = January-March; Qtr 2 = April-June; Qtr 3 = July-September; Qtr 4 = October-December

- iii. **NPI Provider Number Usage Without Medicaid/Reporting Provider Numbers.** This measure is calculated to ensure providers reported on encounters can be associated with Medicaid and/or Reporting providers in MITS.
  1. **Measure.** The percentage of institutional (837 I), professional (837 P), and dental (837 D) EDI transactions with an NPI provider number in the billing provider EDI data field that do not have a NPI and Medicaid or Reporting Provider Number in MITS.



2. **Measurement Period.** The measurement periods for the SFY 2018 and SFY 2019 contract periods are listed in Table 9 above. The MCP shall meet or exceed the standard in all quarters of the measurement period.
  3. **Data Quality Standard.** Less than or equal to 4.0%.
- iv. **NPI Provider Number for Ordering, Referring and Prescribing Providers.** This measure is calculated per MCP and includes all Ohio [MCP/MCOP] members receiving services from the MCP. The NPI Provider Number Usage for Ordering, Referring and Prescribing Providers measure is calculated to ensure these providers reported on encounters can be verified by ODM in compliance with 42 CFR 438.602 and 42 CFR 455.410.
1. **Measure.** Percentage of EDI transactions with qualifying billing provider types and specialties with an NPI provider number in the ordering/referring/prescribing provider EDI data field that do not pass check digit as having a valid NPI. Please refer to the “NPI Provider Number for Ordering, Referring and Prescribing Providers” section of the ODM Encounter Data Quality Measures document for SFY2019 for the qualifying billing provider type and specialties.
  2. **Measurement Period.** The reporting periods for the current contract period are listed in Table 3 above. Results for CY19 will be informational only. Results for the first two quarters of CY19 will be used to set a baseline for CY20. This measure will be used for informational purposes until CY20. Beginning in CY20, this measure will be used to determine compliance.
  3. **Data Quality Standard.** To be determined.
- v. **Rejected Encounters.** Encounters submitted to ODM that are incomplete or inaccurate are rejected and reported back to the MCPs on the exception report. If the MCP does not resubmit rejected encounters, ODM’s encounter data set will be incomplete.

For this measure, a rejected encounter is defined as an encounter that is accepted into MITS but receives a threshold error during encounter processing. Encounters or files rejected at the translator or preprocessor are not included in this measure.

1. **Measure** The percentage of encounters submitted to ODM that are rejected.
2. **Measurement Period.** For the SFY 2019 contract period, performance will be evaluated using the following measurement periods: July – September 2018; October – December 2018; January – March 2019; and April – June 2019.
3. **Data Quality Standard.** The data quality standard is a maximum encounter data rejection rate for each file type in the ODM-specified format as follows:

837 Dental:	15%
837 Institutional:	15%

837 Professional: 15%  
NCPDP: 15%

Information from ODM encounter reports for January 1, 2017 through June 30, 2017, were used as a baseline to set these data quality standards for this measure.

- vi. **Acceptance Rate.** This measure only applies to MCPs that have had Medicaid membership for one year or less.
  - 1. **Measure.** The rate of encounters that are submitted to ODM and accepted (i.e. accepted encounters per 1,000-member months).
  - 2. **Measurement Period.** The measurement period for this measure is monthly. Results are calculated and performance is monitored monthly. The first reporting month begins with the third month of enrollment. This measure will not be calculated for SFY 2017.
  - 3. **Data Quality Standard.** The data quality standard is a monthly minimum accepted rate of encounters for each file type in the ODM-specified medium per format as follows:
    - a. Third through sixth month with membership: Not Applicable for SFY 2017.
    - b. Seventh through twelfth month of membership: Not Applicable for SFY 2017.
- b. **Encounter Data Accuracy Studies.** As with data completeness, the MCP is responsible for assuring the collection and submission of accurate data to ODM. Failure to do so jeopardizes the MCPs' performance, credibility and, if not corrected, will be assumed to indicate a failure in actual performance.
  - i. **Measure 1** (*This measure is calculated for MAGI and Adult Extension members only*). The focus of this accuracy study will be on delivery encounters. Its primary purpose will be to verify that the MCP submits encounter data accurately and to ensure only one payment is made per delivery. The rate of appropriate payments will be determined by comparing a sample of delivery payments to the medical record.
    - 1. **Measurement Period.** In order to provide timely feedback on the accuracy rate of encounters, the measurement period will be the most recent from when the measure is initiated. This measure is conducted annually.

Medical records retrieval from the provider and submittal to ODM or its designee is an integral component of the validation process. ODM has optimized the sampling to minimize the number of records required. This methodology requires a high record submittal rate. To aid the MCP in achieving a high

submittal rate, ODM will give at least an 8-week period to retrieve and submit medical records as a part of the validation process. A record submittal rate will be calculated as a percentage of all records requested for the study.

2. **Data Quality Standard 1 for Measure 1.** For results that are finalized during the contract year, the accuracy rate for encounters generating delivery payments is 100%.
  3. **Data Quality Standard 2 for Measure 1.** A minimum record submittal rate of 85%.
- ii. **Measure 2.** This accuracy study will compare the accuracy and completeness of payment data stored in the MCPs' claims systems during the study period to payment data submitted to and accepted by ODM. Two levels of analysis will be conducted: one to evaluate encounter data completeness for which two rates will be calculated and one to evaluate payment data accuracy. Encounter data completeness and payment accuracy will be determined by aggregating data across claim types i.e., dental, institutional (inpatient, outpatient, and other), professional, and pharmacy. Encounter data completeness for all claim types will be evaluated at the detail level. Payment data accuracy for each claim type will be evaluated based on how encounters are processed—i.e., either paid at the detail level or at the header level. As such, evaluation of payment data accuracy will be as follows: Dental and professional payment comparisons will be at the detail level; Inpatient-institutional payment comparisons will be at the header level, while outpatient-institutional and other-institutional payment comparisons will be at the detail level; and Pharmacy payment comparisons will be at the header level.
1. **Encounter Data Completeness (Level 1).**
    - a. **Omission Encounter Rate.** The percentage of encounters in the MCP's fully adjudicated claims file not present in the ODM encounter data files.
    - b. **Surplus Encounter Rate.** The percentage of encounters in the ODM encounter data files not present in the MCP's fully adjudicated claims files.
  2. **Payment Data Accuracy (Level 2).** Payment Error Rate. The percentage of matched encounters between the ODM encounter data files and the MCP's fully adjudicated claims files where a payment amount discrepancy was identified.
  3. **Measurement Period.** In order to provide timely feedback on the omission rate of encounters, the measurement period will be the most recent from when the study is initiated. This study is conducted annually.
  4. **Data Quality Standard for Measure 2 (For SFY 2018 and SFY 2019).**

- a. **For Level 1.** An omission encounter rate and a surplus encounter rate of no more than 10% at the line-level records.
- b. **For Level 2.** A payment error rate of no more than 4% for each claim type based on how encounters are processed—i.e., either paid at the detail level or at the header level.
- c. **Encounter Data Payments Compared to Managed Care Cost Report Information.** This measure is calculated separately for the ABD, CFC, and Adult Extension populations.
  - i. **Measure.** The difference between the MCP payment amounts as reported on the encounter data and on the Managed Care Reports, as a percentage of the total cost reported on the Managed Care Cost Reports, by category of service and rate cell.
  - ii. **Measurement Period.** The measurement periods for the SFY 2018 and SFY 2019 are outlined in Table 10 below. This measure will be *informational only* for the duration of this Agreement.

**Table 10. Measurement Periods for the SFY 2018 and SFY 2019 Contract Periods – Encounter Data Payments Compared to Managed Care Cost Report Information.**

Quarterly Measurement Periods	Encounter Data File Update	Quarterly Report Estimated Issue Date
<b>SFY 2018 Contract Period</b>		
Qtr 1: 2018	June 2018	June 2018
Qtr 2: 2018	September 2018	September 2018
Qtr 3:2018	December 2018	December 2018
Qtr 4: 2018	March 2019	March 2019
<b>SFY 2019 Contract Period</b>		
Qtr 1:2019	June 2019	June 2019
Qtr 2: 2019	September 2019	September 2019
Qtr 3:2019	December 2019	December 2019
Qtr 4:2019	March 2020	March 2020

Qtr 1-January to March; Qtr 2= April to June; Qtr 3= July to September; Qtr4= October to December

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

Information concerning Managed Care encounter data measures may be obtained from the Ohio Department of Medicaid's Methodology for Covered Families & Children (CFC), Aged, Blind, or Disabled (ABD), and Adult Extension (Group VIII) Encounter Data Quality Measures document also located on the ODM website. This document gives additional guidance on the methodologies used to create the measures in Appendix L of this Agreement. This document also provides the Encounter Data Minimum Number of Encounters required by each plan, the Encounter Data Submission Schedule and the Encounter Data Certification Letter guidelines.

For specific encounter data submission guidelines related to Delivery Kick Payments (DKP), please refer to the Modified Adjusted Gross Income (MAGI) and MAGI Adult Extension Delivery Payment Reporting Procedures and Specifications for ODM Managed Care Plans document located on the ODM website.

- i. **Encounter Data Submission Procedure.** The MCP shall submit encounter data files to ODM per the specified schedule and within the allotted amount established in the Ohio Department of Medicaid's Methodology for Covered Families & Children (CFC), Aged, Blind, or Disabled (ABD), and Adult Extension (Group VIII) Encounter Data Quality Measures document.

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

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

- ii. **Timeliness of Encounter Data Submission.** ODM requires MCP-paid encounters be submitted no later than 35 calendar days after the end of the month in which they were paid. MCPs shall report encounter data submission lag time on a monthly basis to ODM. Results may be subject to an audit by ODM and/or its designee.
  1. **Measure.** The percentage of the MCP's total monthly paid encounters that are submitted to ODM and accepted within 35 calendar days of the month in which they were paid, (e.g., encounters paid by the MCP in January 2018 that are submitted to ODM and accepted on or before March 7<sup>th</sup>2018, divided by the total number of encounters paid by the MCP in January 2018).
  2. **Measurement Periods.**
    - a. **SFY 2018.** The monthly report received in May 2018 and June 2018.
    - b. **SFY 2019.** The monthly report received in July 2018, August 2018, September 2018, October 2018, November 2018, December 2018, January 2019, February 2019, March 2019, April 2019, May 2019, and June 2019.

3. **Data Quality Standard.** The data quality standard is greater than or equal to 90%.
  - iii. **Timeliness of NCPDP Pharmacy Encounter Data Submission:** ODM additionally requires NCPDP encounters to be submitted no later than 15 calendar days after the date the MCP’s PBM adjudicates the claim. MCPs shall report NCPDP encounter data submission lag time on a monthly basis to ODM. Results may be subject to an audit by ODM and/or its designee.
    1. **Measure.** The percentage of the MCP’s total monthly paid pharmacy encounters that are submitted to ODM and accepted within 15 calendar days of the date the MCP’s PBM adjudicates the claim. This includes claims that were paid at zero dollars, if zero dollars is the correct payment.
    2. **Measurement Periods.**
      - a. **SFY 2018.** Monthly beginning with September 2017, through June 2018.
      - b. **SFY 2019.** Monthly from July 2018 through June 2019.
    3. **Data Quality Standard.** This measure will be informational only until July 1, 2019. ODM will develop a data quality standard based on data submitted by the MCPs beginning with September 2017 payment dates.

iv. **Required Monthly Minimum Number of Encounters Accepted Into MITS.**

Managed Care Plan	Required Number of Institutional and Professional	Required Number of Pharmacy NCPDP	Required Number of Dental
CareSource	750,000	1,000,000	32,000
UnitedHealthcare	275,000	320,000	15,000
Molina	222,000	312,000	14,000
Buckeye	160,000	240,000	10,000
Paramount	176,000	172,000	9,600

1. **Measure.** The percentage of the number of required monthly encounters accepted into MITS per the table above.
2. **Measurement Periods.**
  - a. **SFY 2018.** April 2018, May 2018 and June 2018.
  - b. **SFY2019.** July 2018, August 2018, September 2018, October 2018, November 2018, December 2018, January 2019, February 2019, March 2019, April 2019, May 2019, and June 2019.
3. **Data Quality Standard.** The data quality standard is equal or greater than 100%.

2. **MCP Self-reported, Audited HEDIS Data.**

- a. **Annual Submission of HEDIS IDSS Data.** The MCP is required to collect, report, and submit to ODM self-reported, audited HEDIS data (see *ODM Specifications for the Submission of MCP Self-Reported, Audited HEDIS Results*) for the full set of HEDIS measures reported by the MCP to NCQA for Ohio Medicaid members. This shall include all HEDIS measures listed in Appendix M. The self-reported, audited HEDIS data are due to ODM no later than five business days after the NCQA due date.
- b. **Annual Submission of Final HEDIS Audit Report (FAR).** The MCP is required to submit to ODM their FAR that contains the audited results for the full set of HEDIS measures reported by the MCP to NCQA for Ohio Medicaid members. This shall include all HEDIS measures listed in Appendix M. The FAR is due to ODM no later than five business days after the NCQA due date (see *ODM Specifications for the Submission of MCP Self-Reported, Audited HEDIS Results*).

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

- c. **Data Certification Requirements for HEDIS IDSS Data and Final HEDIS Audit Report.** In accordance with 42 CFR 438.600, the MCP shall submit a signed data certification letter to ODM attesting to the accuracy and completeness of its audited HEDIS IDSS data submitted to ODM. The MCP shall also submit to ODM a signed data certification letter attesting to the accuracy and completeness of its final HEDIS audit report (FAR) submitted to ODM.

Each data certification letter is due to ODM on the same day the respective HEDIS IDSS data/FAR is to be submitted. For complete instructions on submitting the data certification letters, see *ODM Specifications for the Submission of MCP Self-Reported, Audited HEDIS Results*.

- d. **Annual Submission of Member Level Detail Records for Specified HEDIS Measures.** The MCP is required to submit member level detail records for specific HEDIS measures, in accordance with *ODM Specifications for the Submission of MCP Self-Reported, Audited HEDIS Results*. The required member level detail will be used to meet CMS reporting requirements for the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set).
3. **Care Management Data.** ODM designed a Care Management System (CAMS) in order to monitor MCP compliance with program requirements specified in Appendix K. The MCP's care management data submission will be assessed for completeness and accuracy. The MCP is responsible for submitting a care management file per ODM's specifications. Failure to do so jeopardizes the MCP's ability to demonstrate compliance with care management requirements. The MCP shall also submit a letter of certification, using the form required by ODM, with each CAMS data submission file. The specifications for submitting the care management file and instructions for submitting the data certification letter are provided in *the ODM Care Management Excel File and Submission Specifications*.

4. **Timely Submission of Care Management Files.** The MCP shall submit Care Management files on a monthly basis according to the specifications established in the *ODM Care Management Excel File and Submission Specifications*.
5. **Appeals and Grievances Data.** Pursuant to OAC rule 5160-26-08.4, the MCP is required to submit appeal and grievance activity to ODM as directed. ODM requires appeal and grievance activity to be submitted at least monthly in an electronic data file format pursuant to the *ODM Appeal File and Submission Specifications* and *ODM Grievance File and Submission Specifications*.

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

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

6. **Utilization Management Data.** Pursuant to OAC rule 5160-26-03.1, the MCP is required to submit information on prior authorization requests as directed by ODM. ODM requires information on prior authorization requests to be submitted in an electronic data file formats pursuant to the *ODM Utilization Management Tracking Database: Prior Authorization File and Submission Specifications* document.

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

7. **CAHPS Data.**
  - a. **Annual CAHPS Survey Administration and Data Submission.** The MCP is required to contract with an NCQA Certified HEDIS Survey Vendor to administer an annual CAHPS survey to the MCP's Ohio Medicaid members, per the survey administration requirements outlined in the *ODM CAHPS Survey Administration and Data Submission Specifications*. The survey data shall be submitted to NCQA, The CAHPS Database, and ODM's designee per the data submission requirements and by the due dates established in the *ODM CAHPS Survey Administration and Data Submission Specifications*.
  - b. **CAHPS Data Certification Requirements.** The MCP is required to annually submit to ODM three CAHPS data certification letters, one that attests to the MCP's adherence to ODM's requirements for the CAHPS survey administration and data submission to NCQA, a second that attests to the MCP's adherence to ODM's requirements for the CAHPS data submission to The CAHPS Database, and a third that attests to the MCP's adherence to ODM's requirements for the CAHPS data submission to ODM's designee. . The MCP's CAHPS data certification letters shall be submitted per the instructions and by the due dates provided in the *ODM CAHPS Survey Administration and Data Submission Specifications*.



8. **Third Party Liability Data Submissions.** No later than the 20th of each month, the MCP shall either (1) provide ODM with a Third-Party Liability (TPL) data file that includes all TPL information for members effective the first calendar day of that month or (2) reconcile the ODM monthly TPL file with their data and provide ODM with a data file that contains any discrepancies, additions, and deletions. The MCP shall submit this information electronically to ODM pursuant to the *ODM Third Party Liability File and Submission Specifications*.
9. **Primary Care Provider (PCP) Data.** ODM requires assignment of primary care providers (PCPs) to members as specified in OAC rule 5160-26-03.1.
  - a. The MCP is responsible for submitting a PCP data file every quarter. The MCP's PCP data file submission will be assessed for completeness and accuracy. The MCP shall also submit a letter of certification, using the form required by ODM, with each PCP data file submission. The specifications for submitting the PCP data file and instructions for submitting the data certification letter are provided in the *ODM Primary Care Provider Data File and Submission Specifications*.
  - b. **Timely Submission of PCP Data Files.** The MCP shall submit a PCP data file, and corresponding certification letter, on a quarterly basis according to the specifications established in the *ODM Primary Care Provider Data File and Submission Specifications*.
10. **Medicaid Managed Care Quarterly Enrollment Files.** Accurate MCP enrollment records are a critical component of determining accurate rates for measures where recipient enrollment is used as the basis for calculating rates. In order to ensure the most accurate and complete enrollment records possible for the MCP, ODM is creating Quarterly Enrollment files to be sent to the MCP for the purpose of enrollment verification. Details regarding specifications for these enrollment files can be found in *ODM's Medicaid Managed Care Plan Quarterly Enrollment Data File Specifications*.

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

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

11. **Submission of Provider Preventable Conditions Data.** Pursuant to 42 CFR 438.3(g), the MCP shall identify the occurrence of all provider preventable conditions (PPCs). The MCP shall report identified PPCs, regardless of the provider's intention to bill for that event, to ODM in a manner specified by ODM.

The sanctions for noncompliance with requirements in this appendix are listed in Appendix N of this Agreement.

## APPENDIX M

### QUALITY MEASURES AND STANDARDS

The Ohio Department of Medicaid (ODM) has established Quality Measures and Standards to evaluate MCP performance in key program areas (i.e., access, clinical quality, consumer satisfaction). The selected measures align with specific priorities, goals, and/or focus areas of the ODM Quality Strategy. Most measures have one or more Minimum Performance Standards. Specific measures and standards are used to determine MCP performance incentives. Measures with a minimum performance standard are used to determine MCP noncompliance sanctions. A limited number of measures are informational/reporting only and have no associated standards, incentives, or sanctions. All of the measures utilized for performance evaluation are derived from national measurement sets (e.g., HEDIS, AHRQ), widely used for evaluation of Medicaid and/or managed care industry data. Performance measures and standards are subject to change based on the revision or update of applicable national measures, methods, benchmarks, or other factors as deemed relevant.

The establishment of Quality Measures and Standards in this appendix is not intended to limit the assessment of other indicators of performance for quality improvement activities. Performance on multiple measures will be assessed and reported to the MCPs and others, including Medicaid consumers.

1. **Quality Measures.** For State Fiscal Year (SFY) SFY 2018, specific measures are designated for use in the Pay-for-Performance (P4P) Incentive System (see Appendix O, *Pay-for-Performance (P4P)*). For these measures, performance exceeding the Minimum Performance Standard may result in the receipt of financial incentives for participating MCPs. For the remaining measures that include a Minimum Performance Standard, failure to meet a standard will result in the assessment of a noncompliance penalty (see Appendix N).

For SFY 2019 and SFY 2020, specific measures are designated for use in the Quality Based Assignment and Quality Withhold Incentive Systems (see Appendix O). For these measures, results will be used in determining the award of incentives for participating MCPs. For the measures that include a Minimum Performance Standard, failure to meet a standard will result in the assessment of a noncompliance penalty (see Appendix N).

The MCP is evaluated on each measure using statewide results that include all regions in which the MCP has membership. Performance results will be used to assess the quality of care provided by the MCP to the managed care population, and may be used for federal reporting and ODM public reporting purposes (e.g., MCP report cards). Results for each measure are calculated per MCP and include all of the MCP's Ohio Medicaid members who meet the criteria specified by the methodology for the given measure. MCP performance is assessed using ODM calculated performance measurement data for the CHIPRA, AHRQ, and AMA/PCPI measures; NCQA calculated summary rates for the HEDIS/CAHPS survey measures; and MCP self-reported, audited HEDIS data for the NCQA HEDIS measures listed in Table 1 below. The ODM methodology for the CHIPRA, AHRQ, and AMA/PCPI measures in Table 1 is posted, upon publication, to the *Medicaid Managed Care Program* page of the ODM website. The HEDIS measures and HEDIS/CAHPS survey measures in Table 1 are calculated in accordance with *NCQA's Volume 2: Technical Specifications* and *NCQA's Volume 3: Specifications for Survey Measures*, respectively. The previous calendar year is the standard measurement year for HEDIS data.

Medicaid Managed Care  
Appendix M  
Quality Measures and Standards

**Measures, Measurement Sets, Standards, and Measurement Years.** The measures, accompanying Minimum Performance Standards, and measurement years for the SFY 2018, SFY 2019, and SFY 2020 contract periods are listed in Table 1 below. The measurement set associated with each measure is also provided. The measures used in the Pay for Performance (P4P) Incentive System are denoted with an asterisk (\*) in the respective Minimum Performance Standard columns and the standard is bolded. The measures used in the Quality Based Assignment and Quality Withhold Incentive Systems each year are denoted with a QBA or QW in the respective Minimum Performance Standard columns. No standard will be established or compliance assessed for measures designated ‘reporting only’ for the corresponding year. Minimum performance standards will be established for the subsequent SFY for Reporting Only measures denoted with a double asterisk (Reporting Only \*\*).

**Table 1. SFY 2018, SFY 2019 and SFY 2020 Performance Measures, Measurements Sets, Standards, and Measurement Years.**

Measure	Measurement Set	SFY 2018 Minimum Perf. Std.	SFY 2018 Measurement Year	SFY 2019 Minimum Perf. Std.	SFY 2019 Measurement Year	SFY 2020 Minimum Perf. Std.	SFY 2020 Measurement Year
Quality Strategy Population Stream: <b>Healthy Children</b>							
Well-Child Visits in the First 15 Months of Life – Six or More Well-Child Visits	NCQA/HEDIS	≥ 53.5%	CY 2017	<b>QW</b>	CY 2018	<b>QW</b>	CY 2019
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	NCQA/HEDIS	≥ 64.7%	CY 2017	<b>QW</b>	CY 2018	<b>QW</b>	CY 2019
Adolescent Well-Care Visits	NCQA/HEDIS	≥ <b>40.9%*</b>	CY 2017	<b>QW</b>	CY 2018	<b>QW</b>	CY 2019
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Percentile Documentation	NCQA/HEDIS	Reporting Only	CY 2017	≥ 40.24%	CY 2018	<b>QW</b>	CY 2019
Children and Adolescents’ Access to Primary Care Practitioners - 12-24 Months, 25 Months - 6 Years, 7-11 Years, and 12-19 Years	NCQA/HEDIS	12-24 mos. ≥ 93.1%	CY 2017	12-24 Mos. ≥ 93.27%	CY 2018	12-24 Mos. ≥ 93.64%	CY 2019
		25 Mos. - 6 Yrs. ≥ 84.8%		25 Mos. - 6 Yrs. ≥ 84.94%		25 Mos. - 6 Yrs. ≥ 84.39%	
		7-11 Yrs. ≥ 87.9%		7-11 Yrs. ≥ 87.58%		7-11 Yrs. ≥ 87.73%	
		12-19 Yrs. ≥ 85.8%		12-19 Yrs. ≥ 85.65%		12-19 Yrs. ≥ 85.81%	
Appropriate Testing for Children With Pharyngitis	NCQA/HEDIS	Not Applicable	Not Applicable	Reporting Only**	CY 2018	≥ 76.52%	CY 2019
General Child Rating of Health Plan (CAHPS Health Plan Survey)	NCQA/HEDIS/CAHPS	≥ 2.51	CY 2017 (Survey conducted in CY 2018)	≥ 2.51	CY 2018 (Survey conducted in CY 2019)	≥ 2.60	CY 2019 (Survey conducted in CY 2020)
General Child - Customer Service Composite (CAHPS Health Plan Survey)	NCQA/ HEDIS/ CAHPS	≥ 2.50	CY 2017 (Survey conducted in CY 2018)	≥ 2.50	CY 2018 (Survey conducted in CY 2019)	≥ 2.54	CY 2019 (Survey conducted in CY 2020)
Annual Dental Visits, Total Rate	NCQA/HEDIS	Reporting Only	CY 2017	Reporting Only	CY 2018	≥ 36.14%	CY 2019

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Childhood Immunization Status (Combo 2)	NCQA/HEDIS	Reporting Only	CY 2017	Reporting Only	CY 2018	Reporting Only	CY 2019
Childhood Immunization Status (Combo 3)	NCQA/HEDIS	Reporting Only	CY 2017	Reporting Only	CY 2018	Reporting Only	CY 2019
Childhood Immunization Status (Combo 10)	NCQA/HEDIS	Reporting Only	CY 2017	Reporting Only	CY 2018	Reporting Only	CY 2019
Immunizations for Adolescents (Combo 1)	NCQA/HEDIS	Reporting Only	CY 2017	Reporting Only	CY 2018	Reporting Only	CY 2019
Immunization for Adolescents (HPV)	NCQA/HEDIS	Reporting Only	CY 2017	Reporting Only	CY 2018	Reporting Only	CY 2019
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Counseling for Nutrition, Counseling for Physical Activity	NCQA/HEDIS	Reporting Only	CY 2017	Reporting Only	CY 2018	Reporting Only	CY 2019
<b>Quality Strategy Population Stream: Women's Health</b>							
Prenatal and Postpartum Care - Timeliness of Prenatal Care	NCQA/HEDIS	≥ 74.2%*	CY 2017	QBA ≥ 64.48%	CY 2018	QBA ≥ 69.83%	CY 2019
Prenatal and Postpartum Care - Postpartum Care	NCQA/HEDIS	≥ 55.5%*	CY 2017	QBA ≥ 45.76%	CY 2018	QBA ≥ 53.53%	CY 2019
Percent of Live Births Weighing Less Than 2,500 Grams	CHIPRA	≤ 10.3%	CY 2017	QBA ≤ 9.2%	CY 2018	QBA ≤ 9.2%	CY 2019
Breast Cancer Screening	NCQA/HEDIS	Reporting Only	CY 2017	QBA ≥ 43.68%	CY 2018	QBA ≥ 48.31%	CY 2019
Cervical Cancer Screening	NCQA/HEDIS	Reporting Only	CY 2017	QBA ≥ 38.36%	CY 2018	QBA ≥ 46.72%	CY 20189
Chlamydia Screening in Women, Total	NCQA/HEDIS	Reporting Only	CY 2017	Reporting Only	CY 2018	Reporting Only**	CY 2019
<b>Quality Strategy Population Stream: Behavioral Health</b>							
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Initiation of AOD Treatment Total, Engagement of AOD Treatment Total	NCQA/HEDIS	Reporting Only	CY 2017	Initiation Total QW	CY 2018	Initiation Total QW	CY 2019
				Engagement Total Reporting Only**		Engagement Total ≥ 6.05%	
Follow-Up After Hospitalization for Mental Illness	NCQA/HEDIS	7-Day Follow-up ≥ 34.2%*	CY 2017	7-Day Follow-up QW	CY 2018	7-Day Follow-up QW	CY 2019
		30-Day Follow-up Reporting Only		30-Day Follow-up Reporting Only**		30-Day Follow-up ≥ 40.00%	
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics, Total	NCQA/HEDIS	≥ 48.8%	CY 2017	≥ 53.81%	CY 2018	≥ 53.01%	CY 2019
Use of Multiple Concurrent Antipsychotics in Children and Adolescents, Total	NCQA/HEDIS	≤ 3.1%	CY 2017	QW	CY 2018	QW	CY 2019
Antidepressant Medication Management – Effective Acute Phase Treatment, Effective Continuation Phase Treatment	NCQA/HEDIS	Reporting Only	CY 2017	Acute Phase ≥ 42.17%	CY 2018	Acute Phase ≥ 45.34%	CY 2019
				Continuation Phase Reporting Only**		Continuation Phase ≥ 29.85%	
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	NCQA/HEDIS	Reporting Only	CY 2017	Reporting Only	CY 2018	≥ 45.00%	CY 2019

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Follow-Up Care for Children Prescribed ADHD Medication - Continuation & Maintenance Phase	NCQA/HEDIS	Reporting Only	CY 2017	Reporting Only	CY 2018	≥ 57.09%	CY 2019
Mental Health Utilization, all rates (except Inpatient)	NCQA/HEDIS	Reporting Only	CY 2017	Reporting Only	CY 2018	Reporting Only	CY 2019
Mental Health Utilization - Inpatient	NCQA/HEDIS	Reporting Only	CY 2017	Reporting Only	CY 2018	≤ 1.13	CY 2019
Follow-Up After Emergency Department Visit for Mental Illness	NCQA/HEDIS	Not Applicable	CY 2017	7-Day Follow-up Reporting Only	CY 2018	7-Day Follow-up ≥ 37.04%	CY 2019
				30-Day Follow-up Reporting Only		30-Day Follow-up ≥ 52.59%	
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence, Total	NCQA/HEDIS	Not Applicable	CY 2017	7-Day Follow-up Reporting Only	CY 2018	7-Day Follow-up ≥ 10.36%	CY 2019
				30-Day Follow-up Reporting Only		30-Day Follow-up ≥ 16.01%	
Use of Opioids at High Dosage	NCQA/HEDIS	Not Applicable	CY 2017	Reporting Only	CY 2018	Reporting Only**	CY 2019
Use of Opioids From Multiple Providers- Multiple Providers, Multiple Pharmacies, Multiple Prescribers and Multiple Pharmacies	NCQA/HEDIS	Not Applicable	CY 2017	Reporting Only	CY 2018	Reporting Only**	CY 2019
Risk of Continued Opioid Use	NCQA/HEDIS	Not Applicable	CY 2017	Reporting Only	CY 2018	Reporting Only	CY 2019
<b>Quality Strategy Population Stream: Chronic Conditions</b>							
Comprehensive Diabetes Care – HbA1c Poor Control (>9.0%)	NCQA/HEDIS	≤ 52.3%	CY 2017	QW	CY 2018	QW	CY 2019
Comprehensive Diabetes Care – HbA1c Testing	NCQA/HEDIS	Reporting Only	CY 2017	QW	CY 2018	QW	CY 2019
Comprehensive Diabetes Care - Eye Exam (Retinal) Performed	NCQA/HEDIS	≥ 44.5%	CY 2017	QW	CY 2018	QW	CY 2019
Comprehensive Diabetes Care - Blood Pressure Control (<140/90 mm Hg)	NCQA/HEDIS	≥ 52.3%	CY 2017	QW	CY 2018	QW	CY 2019
Comprehensive Diabetes Care – HbA1c Control (<8.0%)	NCQA/HEDIS	Reporting Only	CY 2017	Reporting Only	CY 2018	≥ 37.47%	CY 2019
Comprehensive Diabetes Care: Medical Attention for Nephropathy	NCQA/HEDIS	Reporting Only	CY 2017	Reporting Only	CY 2018	≥ 88.56%	CY 2019
Statin Therapy for Patients With Diabetes, Received Statin Therapy	NCQA/HEDIS	≥ 55.7%	CY 2017	≥ 57.73%	CY 2018	≥ 58.15%	CY 2019
PQI 16: Lower-Extremity Amputation, Patients w/ Diabetes	AHRQ	≤ 2.4	CY 2017	≤ 2.4	CY 2018	≤ 2.4	CY 2019
Controlling High Blood Pressure	NCQA/HEDIS	≥ 46.9%*	CY 2017	QW	CY 2018	QW	CY 2019
Statin Therapy for Patients With Cardiovascular Disease, Received Statin Therapy, Total	NCQA/HEDIS	≥ 76.3%	CY 2017	QW	CY 2018	QW	CY 2019
Adult BMI Assessment	NCQA/HEDIS	Reporting Only	CY 2017	≥28.79%	CY 2018	QW	CY 2019
Annual Monitoring for Patients on Persistent Medication, Total	NCQA/HEDIS	Not Applicable	CY 2017	Reporting Only	CY 2018	Reporting Only	CY 2019
Medication Management for People With Asthma – Medication Compliance 50%, Total Rate;	NCQA/HEDIS	50% Total Rate Not Applicable	CY 2017	50% Total Rate	CY 2018	50% Total Rate	CY 2019

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Medication Compliance 75 %, Total Rate		75% Total Rate ≥ 25.1%		Reporting Only		Reporting Only	
				75% Total Rate ≥ 19.97%		75% Total Rate ≥ 24.47%	
Pharmacotherapy Management of COPD Exacerbation	NCQA/HEDIS	Reporting Only	CY 2017	Dispensed Systemic Corticosteroid Within 14 calendar days: Reporting Only**	CY 2018	Dispensed Systemic Corticosteroid Within 14 calendar days Reporting Only	CY 2019
				Dispensed a Systemic Bronchodilator within 30 calendar days: Reporting Only		Dispensed a Systemic Bronchodilator within 30 calendar days Reporting Only	
<b>Quality Strategy Population Stream: Healthy Adults</b>							
Adults' Access to Preventive/Ambulatory Health Services – Total	NCQA/HEDIS	≥ 77.2%	CY 2017	≥76.17%	CY 2018	≥75.84%	CY 2019
Tobacco Use: Screening and Cessation	AMA-PCPI	Reporting Only	CY 2017	Reporting Only**	CY 2018	≥ 10%	CY 2019
Adult Rating of Health Plan (CAHPS Health Plan Survey)	NCQA/HEDIS/CAHPS	≥2.37	CY 2017 (Survey conducted in CY 2018)	≥ 2.35	CY 2018 (Survey conducted in CY 2019)	≥ 2.39	CY 2019 (Survey conducted in CY 2020)
Adult - Customer Service Composite (CAHPS Health Plan Survey)	NCQA/ HEDIS/ CAHPS	≥ 2.48	CY 2017 (Survey conducted in CY 2018)	≥ 2.48	CY 2018 (Survey conducted in CY 2019)	≥ 2.52	CY 2019 (Survey conducted in CY 2020)
Ambulatory Care-Emergency Department (ED) Visits	NCQA/HEDIS	Reporting Only	CY 2017	Reporting Only	CY 2018	≤ 82.21	CY 2019
Inpatient Utilization – General Hospital/Acute Care	NCQA/HEDIS	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Reporting Only	CY 2019

\*This Minimum Performance Standard and associated measure are used in the Pay for Performance (P4P) Incentive System for the respective year listed in Table 1 above, and as outlined in Appendix O. No penalty will be assessed for noncompliance with this Minimum Performance Standard and measure for the corresponding year.

Note: no standard will be established or compliance assessed for the measures designated 'reporting only' or 'QW' in the Minimum Performance Standard column for the corresponding year.

\*\* = Minimum Performance Standard will be established for the subsequent state fiscal year

TBD= Minimum Performance Standard: to be determined

QBA = Quality-Based Auto-Assignment measure

QW = Quality Withhold measure

**2. Additional Operational Considerations.**

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

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- b. **Performance Standards – Compliance Determination.** In the event the MCP’s performance cannot be evaluated for a performance measure and measurement year established in Table 1. of this appendix, ODM in its sole discretion will deem the MCP to have met or to have not met the standard(s) for that particular measure and measurement year depending on the circumstances involved (e.g., if a HEDIS measure was assigned an audit result of “Not Report” on the MCP’s Final Audit Report and the “Not Report” designation was determined to be the result of a material bias caused by the MCP, ODM would deem the MCP to have not met the standard(s) for that measure and measurement year).
  
- c. **Performance Standards – Retrospective Adjustment.** ODM will implement the use of a uniform methodology, as needed, for the retrospective adjustment of any Minimum Performance Standard listed in Table 1 of this appendix, except for the CAHPS measure standards. This methodology will be implemented at ODM’s sole discretion.

For a comprehensive description of the standard adjustment methodology, see *ODM Methods for the Retrospective Adjustment of Quality and P4P Measure Standards*.

The sanctions for noncompliance with requirements in this appendix are listed in Appendix N of this Agreement.

## APPENDIX N

### COMPLIANCE ASSESSMENT SYSTEM

#### 1. General Provisions of the Compliance Assessment System.

- a. The Compliance Assessment System (CAS) sets forth sanctions that may be assessed by the Ohio Department of Medicaid (ODM) against the MCP if the MCP is found to have violated this Agreement, or any other applicable law, rule, or regulation. It does not in any way limit ODM from requiring Corrective Action Plans (CAPs) and program improvements, or from imposing any of the sanctions specified in 42 CFR 438.706 and OAC rule 5160-26-10 or any other additional compliance actions, including the proposed termination, amendment, or nonrenewal of this Agreement. Any actions undertaken by ODM under this appendix are not exclusive to any other compliance action it may impose or available to ODM under applicable law or regulations. Pursuant to 42 CFR 438.704, any civil monetary penalties imposed by ODM shall not exceed mandated maximum figures.
- b. As set forth in OAC rule 5160-26-10, regardless of whether ODM imposes a sanction, the MCP is required to initiate corrective action for any MCP program violation or deficiency as soon as the violation or deficiency is identified by the MCP or ODM. The MCP is required to report to ODM when it becomes aware of any violation that could impair a member's ability to obtain correct information regarding services, impair member rights, affect the ability of the MCP to deliver covered services, or affect the member's ability to access covered services.
- c. If ODM determines the MCP 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 (1) require the MCP to permit any of its members to disenroll from the MCP without cause, or (2) suspend any further new member enrollments to the MCP, or both.
- d. Program violations that reflect noncompliance from the previous compliance term will be subject to remedial action under CAS at the time that ODM first becomes aware of this noncompliance.
- e. ODM retains the right to use its discretion to determine and apply the most appropriate compliance action based on the severity of the noncompliance, a pattern of repeated noncompliance, and number of beneficiaries affected. In instances where the MCP is able to document, to the satisfaction of ODM, that the violation and precipitating circumstances were 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, etc.), ODM may, in its discretion, utilize alternative methods (i.e., a remediation plan) in lieu of the imposition of sanctions/remedial actions as defined in this appendix.

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



f. ODM will issue all notices of noncompliance in writing to the identified MCP contact.

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

a. **Corrective Action Plans (CAPs).** A CAP is a structured activity, process or quality improvement initiative implemented by the MCP to improve identified operational and clinical quality deficiencies. All CAPs shall be submitted in the manner specified by ODM.

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

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

Where a sanction is assessed for a violation in which the MCP has previously been assessed a CAP the MCP may be assessed escalating sanctions under this Agreement.

b. **Financial Sanctions**

i. **Financial Sanctions Assessed Due to Accumulated Points.** Points will accumulate over a rolling 12-month schedule. Points more than 12 months old will expire.

No points will be assigned for a violation if the MCP is able to document that the precipitating circumstances were completely beyond its control and could not have been foreseen (e.g., a construction crew severs a phone line, a lightning strike disables a computer system, etc.).

In cases where an MCP-contracted healthcare provider is found to have violated a program requirement (e.g., failing to provide adequate contract termination notice, marketing to potential members, inappropriate member billing, etc.), ODM may assess points unless to the satisfaction of ODM: (1) the MCP can document that it provided sufficient notification or education to providers of applicable program requirements and prohibited activities; and (2) the MCP took immediate and appropriate action to correct the problem and to ensure it will not reoccur. ODM will review repeated incidents and determine whether the MCP has a systemic problem. If ODM determines that a systemic problem exists, further sanctions or remedial actions may be assessed against the MCP.

1. **5 Points.** ODM may in its discretion assess five (5) points for any instance of noncompliance with applicable rules, regulations or contractual requirements. Instances of noncompliance can include, but are not limited to, those that (1) impair a member's or potential enrollee's ability to obtain accurate information regarding MCP services, (2) violate a care management process, (3) impair a member's or potential enrollee's ability to obtain correct information regarding services or (4) infringe on the rights of a member or potential enrollee. Examples of five (5) point violations include, but are not limited to the following:
  - a. Failure to provide accurate provider panel information.
  - b. Failure to provide member materials to new members in a timely manner.
  - c. Failure to comply with appeal, grievance, or state hearing requirements, including the failure to notify a member of his or her right to a state hearing when the MCP proposes to deny, reduce, suspend or terminate a Medicaid-covered service.
  - d. Failure to staff a 24-hour call-in system with appropriate trained medical personnel.
  - e. Failure to meet the monthly call-center requirements for either the member services or the 24-hour call-in system lines.
  - f. Provision of false, inaccurate or materially misleading information to ODM, health care providers, the MCP's members, or any eligible individuals.
  - g. Use of unapproved marketing or member materials.
  - h. Failure to appropriately notify ODM, or members, of provider panel terminations.
  - i. Failure to update website provider directories as required.
  - j. Failure to comply with an open remediation plan or CAP or a CAP closed in the last twelve (12) months.
  - k. Failure to actively participate in quality improvement projects or performance improvement projects facilitated by ODM and/or the EQRO.
  - l. Failure to meet provider network performance standards.
  - m. A violation of a care management process specified in Appendix K of the

Agreement that does not meet the standards for a 10-point violation.  
Examples include but are not limited to the following:

- i. Failure to ensure staff performing care management functions are operating within their professional scope of practice, are appropriately responding to a member's care management needs, or are complying with the state's licensure/credentialing requirements;
  - ii. Failure to adequately assess an individual's needs including the evaluation of mandatory assessment domains;
  - iii. Failure to update an assessment upon a change in health status, needs or significant health care event;
  - iv. Failure to develop or update a care plan that appropriately addresses assessed needs of a member;
  - v. Failure to monitor the care plan;
  - vi. Failure to complete a care gap analysis that identifies gaps between recommended care and care received by a member;
  - vii. Failure to update the care plan in a timely manner when gaps in care or change in need are identified;
  - viii. Failure to coordinate care for a member across providers, specialists, and team members, as appropriate;
  - ix. Failure to adhere to a documented communication plan, including the contact schedule for in-person visits and telephone calls; or
  - x. Failure to make reasonable attempts to obtain a discharge/transition plan from an inpatient facility; conduct timely follow up with the member and provider, as appropriate; or arrange for services specified in the discharge/transition plan.
2. **10 Points.** ODM may in its discretion assess ten (10) points for any instance of noncompliance with applicable rules, regulations or contractual requirements that could, as determined by ODM: (1) affect the ability of the MCP to deliver, or a member to access, covered services; (2) place a member at risk for a negative health outcome; or (3) jeopardize the safety and welfare of a member. Examples include, but are not limited to, the following:
- 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 by individuals whose medical condition indicates probable need for substantial future medical services).

- b. Failure to assist a member in accessing needed services in a timely manner after receiving a request from the member.
  - c. Failure to provide medically-necessary Medicaid covered services to members.
  - d. Failure to participate in transition of care activities or discharge planning activities.
  - e. Failure to process prior authorization requests within the prescribed time frames.
  - f. Repeated failure to comply with an open remediation plan or CAP or a CAP closed in the last twelve (12) months.
  - g. The imposition of premiums or charges on members in excess of the premiums or charges permitted under the Medicaid program.
  - h. Misrepresentation or falsification of information that the MCP furnishes to ODM.
  - i. Misrepresentation or falsification of information that the MCP furnishes to a member, potential member, or health care provider.
  - j. Failure to comply with the requirements for physician incentive plans, as set forth in 42 CFR 422.208 and 422.210.
  - k. Violation of a care management process as specified in Appendix K.
3. **Progressive Sanctions Based on Accumulated Points.** Progressive sanctions will be based on the number of points accumulated at the time of the most recent incident. A CAP or other sanction may be imposed in addition to the financial sanctions listed below. The designated financial sanction amount will be assessed when the number of accumulated points falls within the ranges specified below:

0 -15 Points	CAP + No financial sanction
16-25 Points	CAP + \$5,000 financial sanction
26-50 Points	CAP + \$10,000 financial sanction

51-70 Points	CAP + \$20,000 financial sanction
71-100 Points	CAP + \$30,000 financial sanction
100+ Points	Proposed Agreement Termination

ii. **Specific Pre-Determined Sanctions**

1. **Adequate Network-Minimum Provider Panel Requirements.** Any deficiencies in the MCP's provider network specified in Appendix H of this Agreement or by ODM, may at ODM's discretion, result in the assessment of a \$1,000 nonrefundable financial sanction for each category (practitioners, PCP capacity, hospitals), for each county. Compliance will be assessed at least quarterly.

ODM may assess additional sanctions (e.g., CAPs, points, financial sanctions) if the MCP violates any other provider panel requirements or the MCP's member has experienced problems accessing necessary services due to lack of an adequate provider panel.

2. **Adequate Provider Panel Time and Distance Requirements.** The MCP shall submit to ODM electronic time and distance reports as per Appendix H for each county on a quarterly basis and according to ODM's specifications. This will include all required time and distance reports needed to calculate each measure under this requirement. Reports will be due to ODM on the first Monday of January, April, July and October. The MCP shall ensure that 90% of beneficiaries in each county have access to at least one provider or facility for each type within the published county at all times. If ODM determines that the MCP is noncompliant with the standard, a \$1,000 financial sanction will be assessed per county, per provider or facility type that does not meet the time and distance requirements. Compliance will be assessed for each quarter. ODM may assess additional sanctions (e.g., CAPs, points, financial sanctions) if the MCP violates any other time and distance requirements or the MCP's member was unable to access the necessary services due to the MCP's failure to assure that time and distance requirements are met. Any monetary damages that otherwise would be assessed pursuant to this appendix may be reduced, at ODM's discretion, if the MCP reports the failure or noncompliance to ODM prior to notice of noncompliance. The amount of the reduction shall be no more than ninety percent of the total value of the monetary damages.
3. **Network Performance Baseline Measure.** ODM may assess a \$50,000 nonrefundable financial sanction for each baseline measure not met on the bi-annual Network Performance surveys.
4. **Late Submissions.** All submissions, data and documentation submitted by the MCP shall be received by ODM within the specified deadline and shall represent the MCP in an honest and forthright manner. If the MCP fails to provide ODM with any required submission, data or documentation, ODM may assess a

nonrefundable financial sanction of \$100 per calendar day, unless the MCP requests and is granted an extension by ODM. Assessments for late submissions will be done monthly.

If the MCP is unable to meet a program deadline or data/documentation submission deadline, the MCP shall submit a written request to its Contract Administrator for an extension of the deadline, as soon as possible, but no later than 3 PM, EST, on the date of the deadline in question. Requests for extensions should only be submitted where unforeseeable circumstances have made it impossible for the MCP to meet a deadline stipulated by ODM. All such requests will be evaluated upon this standard. ODM may assess compliance against the MCP for late submission unless ODM has granted written approval for a deadline extension request.

5. **Noncompliance with Claims Adjudication Requirements.** If ODM finds the MCP is unable to (1) electronically accept and adjudicate claims to final status, or (2) notify providers of the status of their submitted claims, ODM may assess the MCP with a financial sanction of \$20,000 per calendar day for the period of noncompliance. Additionally, the MCP may be assessed 5 points per incident of noncompliance.

If ODM has identified specific instances where the MCP has failed to take the necessary steps to comply with the requirements specified in Appendix C of the Agreement by (1) failing to notify non-contracting providers of procedures for claims submissions when requested or (2) failing to notify contracting and non-contracting providers of the status of their submitted claims, the MCP may be assessed 5 points per incident of noncompliance.

6. **Noncompliance with Financial Performance Measures or the Submission of Financial Statements.** If the MCP fails to meet any standard for section 2 of Appendix J, ODM may require the MCP to complete a CAP and specify the date by which compliance shall be demonstrated. Failure by the MCP to meet the standard or otherwise comply with the CAP by the specified date may result in a new enrollment freeze unless ODM determines that the deficiency does not potentially jeopardize access to or quality of care or affect the MCP's ability to meet administrative requirements (e.g., prompt pay requirements). Justifiable reasons for noncompliance may include one-time events (e.g., MCP investment in information system products).

If Financial Statements are not submitted to the Ohio Department of Insurance (ODI) by the due date, the MCP continues to be obligated to submit the report to ODM by ODI's originally specified due date unless the MCP requests and is granted an extension by ODM.

If the MCP fails to submit complete quarterly and annual Financial Statements on a timely basis, ODM will deem this a failure to meet the standards and may impose the noncompliance sanctions listed above for the indicators in Appendix

J, Section 2, including a new enrollment freeze. The new enrollment freeze will take effect on the first of the month following the month ODM has determined that the MCP was non-compliant for failing to submit financial reports timely.

7. **Noncompliance with Medical Loss Ratio (MLR) Requirements.** For all enrollees, ODM shall perform an MLR calculation as defined in the ODM Methods for Financial Performance Measures for the periods stated below.
  - a. ODM shall perform MLR calculations for the incurred periods of January 1, 2018 through December 31, 2018, (“first period”), and January 1, 2019 through December 31, 2019, (“second period”).
  - b. For each period, ODM or its designee will initiate the MLR calculation 6 months after the end of each period.
  - c. The MCP shall provide and certify any data used in the calculation of the MLR in accordance with 42 CFR 438.600 et al. Data submitted to ODM is subject to review or audit by ODM or its designee.
8. **Noncompliance with Reinsurance Requirements.** If ODM determines that (1) the MCP has failed to maintain reinsurance coverage as specified in Appendix J, (2) the MCP’s deductible exceeds \$100,000 without approval from ODM, or (3) the MCP’s reinsurance for non-transplant services covers less than 80% of inpatient costs in excess of the deductible incurred by one member for one year without approval from ODM, then ODM may require the MCP to pay a financial sanction to ODM. The amount of the sanction will be the lesser of (1) 10% of the difference between the estimated amount of what the MCP would have paid in premiums for the reinsurance policy if it had been in compliance and what the MCP actually paid while it was out of compliance or (2) \$50,000.

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

9. **Noncompliance with Prompt Payment.** ODM may impose progressive sanctions on the MCP for not complying with the prompt pay requirements as specified in Appendix J of this Agreement. For claims received January 1, 2017 through June 30, 2017, sanctions will be based on the ODM Ohio Medical Assistance Provider Agreement in effect January 1, 2017. For claims received July 1, 2017 going forward:
  - a. For the first instance of noncompliance during a rolling 12-month period for each claim type listed in Appendix J, ODM may assess a refundable financial sanction equal to .04% of the amount calculated in accordance with this appendix on each claim type and timeframe separately. The refundable financial sanction amount will be returned to the MCP if ODM determines the MCP is in full compliance with the prompt pay

standards within the five consecutive reporting periods following the report period for which the refundable financial sanction was issued.

- b. For the second instance of noncompliance during a rolling 12-month period for each claim type listed in Appendix J, ODM may assess a nonrefundable financial sanction equal to .08% of the amount calculated in accordance with this appendix on each claim type and timeframe separately.
- c. Subsequent violations during a rolling 12-month period may result in an enrollment freeze of not less than three (3) months duration or until the MCP has come back into compliance.

**10. Noncompliance with claims payment systemic errors (CPSEs).** ODM may impose financial and progressive sanctions on the MCP for not complying with claims payment systemic error(s) policies and corrective activities as specified in Appendix C.

- a. ODM may assess a \$5,000 non-refundable sanction for failure to identify CPSEs based on the ODM approved process and for failure to:
  - i. Meet the dates identified in the monthly report to ODM;
  - ii. Re-adjudicate all impacted claims within required time frames.
- b. ODM may assess a non-refundable sanction of \$25,000 per calendar day that the MCP is out of compliance.

**11. Noncompliance with Clinical Laboratory Improvement Amendments (CLIA).** If the MCP fails to comply with CLIA requirements as specified by ODM, then ODM may impose a nonrefundable financial sanction in the amount of a \$1,000 for each documented violation.

**12. Noncompliance with Abortion and Sterilization Hysterectomy Requirements.** If the MCP fails to comply with abortion and sterilization requirements as specified by ODM, then ODM may impose a nonrefundable financial sanction in the amount of \$2,000 for each documented violation. Additionally, the MCP shall take all appropriate action to correct each violation documented by ODM.

**13. Refusal to Comply with Program Requirements.** If ODM has instructed the MCP that it shall comply with a specific program requirement and the MCP refuses, such refusal constitutes documentation that the MCP is no longer operating in the best interests of the MCP's members or the state of Ohio, and ODM may move to terminate or non-renew this Agreement.

**14. Data Quality Submission Requirements and Measures (as specified in Appendix L).** ODM reserves the right to withhold an assessment of noncompliance under this appendix due to unforeseeable circumstances.



a. **Data Quality Submission Requirements.**

i. **Annual Submission of MCP Self-Reported, Audited HEDIS Data.** Performance is monitored annually. If the MCP fails to submit its self-reported, audited HEDIS data to ODM as specified in Appendix L, the MCP will be considered non-compliant with the standards for the self-reported, audited HEDIS performance measures in Appendix M for the corresponding contract period per this appendix. In addition, ODM may impose a non-refundable \$300,000 financial sanction if the MCP's HEDIS data submission does not contain any measure(s) designated as 'reporting only' and/or 'informational only' in Appendix M for the corresponding contract period. Furthermore, the MCP may be disqualified from participation in the P4P incentive system in Appendix O for the corresponding contract period.

ii. **Annual Submission of Final HEDIS Audit Report (FAR).** Performance is monitored annually. If the MCP fails to submit its FAR to ODM as specified in Appendix L, the MCP will be considered non-compliant with the standards for the self-reported, audited HEDIS performance measures in Appendix M for the corresponding contract period per this appendix. In addition, the MCP may be disqualified from participation in the P4P incentive system in Appendix O for the corresponding contract period.

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

iii. **Data Certification Requirements for HEDIS IDSS Data and HEDIS Audit Report.** Performance is monitored annually. If the MCP fails to submit a required data certification letter to ODM within the required time frame, ODM may impose a nonrefundable financial sanction of \$100 per calendar day, unless the MCP requests and is granted an extension by ODM.

iv. **Annual Submission of Member Level Detail Records for Specified HEDIS Measures.** Performance is monitored annually.

If the MCP fails to submit the required HEDIS measure member level detail records to ODM within the required time frame, ODM may impose a nonrefundable financial sanction of \$100 per calendar day, unless the MCP requests and is granted an extension by ODM.

- v. **Annual CAHPS Survey Administration and Data Submission.** Performance is monitored annually. If the MCP fails to administer a CAHPS survey and submit the survey data to NCQA, the CAHPS Database, and ODM's designee, as specified in Appendix L, ODM may impose a non-refundable \$300,000 financial sanction. In addition, the MCP will be considered non-compliant with the standards for the CAHPS performance measure in Appendix M for the corresponding contract period, per this appendix.
  - vi. **CAHPS Data Certification Requirements.** Performance is monitored annually. If the MCP fails to submit a required CAHPS data certification letter to ODM within the required time frame, ODM may impose a nonrefundable financial sanction of \$100 per calendar day, unless the MCP requests and is granted an extension by ODM.
- b. **Data Quality Measures.** The MCP shall submit to ODM, by the specified deadline and according to ODM's specifications, all required data files and requested documentation needed to calculate each measure listed under this section. If the MCP fails to comply with this requirement for any measure listed under this section, then the MCP will be considered noncompliant with the standard(s) for that measure.

Unless otherwise specified, sanctions for noncompliance are assessed per MCP and measure for the MCP's overall Ohio Medicaid population (i.e., ABD, MAGI, and Adult Extension members).

- i. **Encounter Data Volume.** Performance is monitored once every quarter for the entire measurement period for each of the following populations: ABD adults, ABD children, MAGI members, and Adult Extension members. Sanctions for noncompliance will be assessed separately, by population. For each population, if the standard is not met for every service category in all quarters of the measurement period, the MCP will be determined to be noncompliant for the measurement period.

ODM will issue a CAP for all instances of noncompliance with this measure that are not consecutive. ODM will issue a series of progressive sanctions for consecutive instances of

noncompliance. The first time the MCP is determined to be noncompliant with the standard for this measure, ODM will issue a CAP. If the MCP is determined to be noncompliant with the standard in a second, consecutive quarter, ODM will impose a financial sanction of two percent of the amount calculated in accordance with this appendix. (Financial sanctions will not be levied in subsequent, consecutive quarters the MCP is determined to be noncompliant.) If the MCP is determined to be noncompliant with the standard in a third, consecutive quarter, ODM will impose a new member enrollment freeze. A financial sanction issued under this section will be returned to the MCP if ODM determines the MCP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the financial sanction was issued. A new member enrollment freeze issued under this section will be lifted after ODM determines the MCP is in full compliance with this program requirement.

- ii. **Rejected Encounters.** Performance is monitored once every quarter for Measure 1 and once every month for Measure 2. Compliance determination with the standard applies only to the measurement period under consideration and does not include performance in previous measurement periods. Files in the ODM-specified medium per format that are totally rejected will not be considered in the determination of noncompliance. If the standard is not met for every file type, the MCP may be determined to be noncompliant for the measurement period.

Effective SFY 2016, ODM may issue a CAP for all instances of noncompliance with this measure that are not consecutive. ODM may issue a series of progressive sanctions for consecutive instances of noncompliance. The first time the MCP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If the MCP is determined to be noncompliant with the standard in a second, consecutive measurement period, ODM may impose a financial sanction of two percent of the amount calculated in accordance with this appendix. If the MCP is determined to be noncompliant with the standard in a third, consecutive measurement period, ODM may impose a new member enrollment freeze. Special consideration may be made for MCPs with less than 1,000 members.

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

under this section will be lifted after ODM determines the MCP is in full compliance with this program requirement.

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

ODM may issue a CAP for all instances of noncompliance with this measure that are not consecutive. ODM may issue a series of progressive sanctions for consecutive instances of noncompliance. The first time the MCP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If the MCP is determined to be noncompliant with the standard in a second, consecutive measurement period, ODM may impose a financial sanction of two percent of the amount calculated in accordance with this appendix. If the MCP is determined to be noncompliant with the standard in a third, consecutive measurement period, ODM may impose a new member enrollment freeze. Special consideration may be made for MCPs with less than 1,000 members.

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

- iv. **Encounter Data Accuracy Study - Payment Accuracy Measure.** The first time the MCP is determined to be noncompliant with the standard for either level 1 or level 2 for this measure, the MCP shall implement a CAP which identifies interventions and a timeline for resolving data quality issues related to payments. Additional reports to ODM addressing targeted areas of deficiencies and progress implementing data quality improvement activities may be required. Upon all subsequent measurements of performance, if the MCP is again determined to be noncompliant with the standard for either level 1 or level 2 for this measure, ODM may impose a financial sanction of one percent of the amount calculated in accordance with this appendix. A financial sanction issued under this section will be returned to the MCP if ODM determines the MCP is in full compliance with this program requirement within the five

consecutive report periods following the report period for which the financial sanction was issued.

- v. **Encounter Data Accuracy Study - Delivery Payment Measure.** Compliance with this measure will only be assessed for the MAGI population and Adult Extension members (combined). The MCP shall participate in a detailed review of delivery payments made for deliveries during the measurement period. The required accuracy rate for encounters generating delivery payments is 100%; therefore, any duplicate delivery payments or delivery payments not validated shall be returned to ODM. For all encounter data accuracy studies completed during the contract period, if the MCP does not meet the minimum record submittal rate of 85%, ODM may impose a non-refundable \$10,000 financial sanction. However, no financial sanctions will be imposed if the MCP is in its first contract year of Medicaid program participation.
- vi. **Incomplete Rendering Provider Data.** Performance is monitored once every quarter for all measurement periods. If the standard is not met in all quarters of the measurement period, the MCP will be noncompliant for the measurement period.

Effective SFY 2016, ODM may issue a CAP for all instances of noncompliance with this measure that are NOT consecutive. ODM may issue a series of progressive sanctions for consecutive instances of noncompliance. The first time the MCP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If the MCP is determined to be noncompliant with the standard in a second, consecutive quarter, ODM may impose a financial sanction of two percent of the amount calculated in accordance with this appendix. If the MCP is determined to be noncompliant with the standard in a third, consecutive quarter, ODM may impose a new member enrollment freeze.

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

- vii. **NPI Provider Number Usage without Medicaid/Reporting Provider Numbers. Performance** is monitored once every quarter for all measurement periods. If the standard is not met in all quarters of the measurement period, the MCP may be determined to be noncompliant for the measurement period.

Effective SFY 2016, ODM may issue a CAP for all instances of noncompliance with this measure that are NOT consecutive. ODM may issue a series of progressive sanctions for consecutive instances of noncompliance. The first time the MCP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If the MCP is determined to be noncompliant with the standard in a second, consecutive quarter, ODM may impose a financial sanction of two percent of the amount calculated in accordance with this appendix. If the MCP is determined to be noncompliant with the standard in a third, consecutive quarter, ODM may impose a new member enrollment freeze.

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

- viii. **Encounter Submissions per The Ohio Department of Medicaid's Methodology for Covered Families & Children (CFC), Aged, Blind, or Disabled (ABD), and Adult Extension (Group VIII) Encounter Data Quality Measures document.** Performance is monitored once every month. If the standard is not met for the measurement period, the MCP will be noncompliant for the measurement period.

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

A financial sanction issued under this section will be returned to the MCP if ODM determines the MCP is in full compliance with

this program requirement within the five consecutive report periods following the report period for which the financial sanction was issued.

- ix. **Timeliness of Encounter Data Submission.** Performance is monitored once every month. If the standard is not met for the measurement period, the MCP will be noncompliant for the measurement period.

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

A financial sanction issued under this section will be returned to the MCP if ODM determines the MCP is in full compliance anytime within the five consecutive report periods following the report period for which the financial sanction was issued.

- 15. **Quality Measures (as specified in Appendix M).** This section sets forth sanctions for those quality measure standards in Appendix M subject to corrective action.

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

For each measure in Table 1 of Appendix M, one or more rates are calculated. Each rate has an associated Minimum Performance Standard. When the MCP fails to meet a Minimum Performance Standard listed in Appendix M, for a measure for which noncompliance sanctions are applicable, the MCP may be assessed a sanction for noncompliance with the standard. ODM has established uniform noncompliance sanctions for these standards.

A series of progressive sanctions may be issued for consecutive instances of noncompliance with the standard established for a given rate. For example, four rates, corresponding to the HEDIS age breakouts, are calculated for the *Children and Adolescents' Access to Primary Care Practitioners* measure. The MCP failing to meet the standard established for the '12-24 Months' rate in three consecutive measurement periods would be subject to progressive sanctions. However, the MCP failing to meet the standard established for the '7-11 Years' rate in one measurement period and the '12-19 Years' rate in the next would

not be subject to progressive sanctions, as these only apply to the standard established for the same rate.

For the standard established for each rate listed in Table 1 of Appendix M, for measures for which noncompliance sanctions are applicable, the MCP may be assessed sanctions for instances of noncompliance as follows:

- a. **First instance, or subsequent but nonconsecutive instance, of noncompliance.** ODM may impose a financial sanction in the amount of one quarter of one percent of the amount calculated in accordance with this appendix for the twelve months prior to the month in which the compliance action is issued to the MCP. If the MCP is determined to be in full compliance with this program requirement within the following five consecutive report periods, the financial sanction will be returned.
- b. **Second consecutive instance of noncompliance.** ODM may impose a financial sanction in the amount of one quarter of one percent of the amount calculated in accordance with this appendix for the twelve months prior to the month in which the compliance action is issued to the MCP. The financial sanction is non-refundable.
- c. **Third consecutive, and any additional consecutive, instance of noncompliance.** ODM may impose a financial sanction in the amount of one half of one percent of the amount calculated in accordance with this appendix for the twelve months prior to the month in which the compliance action is issued to the MCP. The financial sanction is non-refundable.

In addition, if ODM determines the MCP is noncompliant with greater than 50% of the quality standards listed in Appendix M, for which noncompliance sanctions are applicable, for two consecutive contract years, ODM will have the option to terminate the MCP's Agreement.

16. **Quality Care (as specified in Appendix K).** ODM reserves the right to withhold an assessment of noncompliance under this section due to unforeseeable circumstances.
  - a. **Administrative Compliance Assessment.** Compliance with administrative standards is performed by the external quality review organization, as specified by ODM. For each documented instance of noncompliance with an administrative standard, the MCP may be required to submit a CAP as specified by ODM to remedy the identified deficiency.
  - b. **Member Safeguards.** In addition to points that may be assessed pursuant to this appendix, ODM may assess a non-refundable financial sanction of \$50,000 (per case) for any instance of noncompliance that



places a member at risk for a negative health outcome or jeopardizes the health, safety and welfare of the member. This financial sanction may be imposed for any instance where plan action or inaction has come to ODM's attention and in accordance with ODM's Health, Safety, Welfare Improvement Process for Medicaid Managed Care Consumers, ODM has determined, the MCP to be noncompliant with a specific program requirement, contractual requirement, rule and/or regulation.

c. **Maintenance of National Committee for Quality Assurance Health Plan Accreditation.** For the standard established in Appendix C, ODM may assess the following sanctions for noncompliance as follows:

- i. **If the MCP receives a Provisional accreditation status** - the MCP will be required to complete a resurvey within 12 months of the accreditation decision. If the resurvey results in a Provisional or Denied status, ODM will consider this a material breach of this Agreement may terminate the provider agreement with the managed care plan.
- ii. **If the MCP receives a Denied accreditation status** - then ODM considers this a material breach of the provider agreement and may terminate the provider agreement with the MCP.

17. **Noncompliance with Provision of Transportation Services.** If the MCP fails to comply with the transportation requirements specified in Appendix C, or if the MCP fails to transport a member to a pre-scheduled appointment on time, which results in a missed appointment, when providing Medicaid-covered transportation services and when members shall travel more than 30 miles to receive services, ODM may impose a nonrefundable financial sanction in the amount of \$1,000 for each violation. ODM may assess additional sanctions (e.g., CAPs, points, financial sanctions) as provided for in this appendix for any violation of the requirements to provide Medicaid-covered transportation services.

a.

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

1. Refundable and nonrefundable financial sanctions/assurances assessed against the MCP shall be directly deducted from the net premium amount paid to the MCP. ODM will specify on the invoice the date the funds will be deducted.

2. If an Electronic Funds Transfer (EFT) is requested by ODM, the refundable and nonrefundable financial sanction/assurance shall be paid by the MCP to ODM within 30 calendar days of invoice date by the MCP, or as otherwise directed by ODM in writing. In addition, per ORC section 131.02, payments owed to the State not received within 45 calendar days will be certified to the Attorney General's (AG's) office. The AG's Office will assess the appropriate collection fee for MCP payments certified to the AG's Office.
  3. For financial sanctions calculated in accordance with this section, ODM will use the MCP's average monthly net premium amount, disregarding refundable and nonrefundable financial sanctions for the twelve months prior to the month in which the compliance action is issued to the MCP.
  4. Unless otherwise specified, any monies collected through the imposition of a refundable financial sanction will be returned to the MCP (minus any applicable collection fees owed to the AG's Office if the MCP has been delinquent in submitting payment) after it has demonstrated full compliance with the particular program requirement, as determined by ODM. Refunds will be added to the net premium amount paid to the MCP.
  5. The MCP is required to submit a written request for refund to ODM at the time it believes is appropriate before a refund of monies will be considered.
  6. Refundable financial sanctions issued under sections of this appendix will be returned to the MCP in the event ODM replaces or eliminates the sanction's applicable measure(s) from the Agreement for the measurement period immediately following the measurement period for which the sanction was assessed.
- iv. **New Enrollment Freezes.** Notwithstanding any other sanction or point assessment that ODM may impose on the MCP under this Agreement, ODM may prohibit the MCP from receiving new enrollment through consumer initiated selection or the assignment process if any of the following occur: (1) the MCP has accumulated a total of 51 or more points during a rolling 12-month period; (2) the MCP has failed to fully implement a plan of correction within the designated time frame; (3) circumstances exist that potentially jeopardize the MCP's members' access to care, as solely determined by ODM; or (4) the MCP is found to have 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:
1. The MCP has been found by ODM to be noncompliant with the prompt payment or the non-contracting provider payment requirements;
  2. The MCP has been found by ODM to be noncompliant with the provider panel requirements specified in Appendix H;

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3. The MCP has refused to comply with a program requirement after ODM has directed the MCP to comply with the specific program requirement;
4. The MCP has received notice of proposed or implemented adverse action by the ODI; or
5. The MCP has failed to provide adequate provider or administrative capacity.

Payments provided for under the Agreement will be denied for new enrollees, when and for so long as, payments for those enrollees are denied by CMS in accordance with the requirements in 42 CFR 438.726.

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

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

- v. **Reduction of Assignments.** ODM has discretion over how member auto-assignments are made. ODM may reduce the number of assignments the MCP receives to ensure program stability within a region, or upon a determination that the MCP lacks sufficient capacity to meet the needs of the increased enrollment volume. ODM may determine the MCP has demonstrated a lack of sufficient capacity under circumstances that include, but are not limited to the following:
  1. The MCP has failed to maintain an adequate provider network;
  2. The MCP has failed to provide new member materials by the member's effective date;
  3. The MCP has failed to meet the minimum call center requirements;
  4. The MCP has failed to meet the minimum performance standards for members with special health care needs; or
  5. The MCP has failed to provide complete and accurate data files regarding appeals or grievances, primary care providers, or its Care Management System (CAMS) files.
- vi. **Death or Injury to Member.** ODM may immediately terminate or suspend this Agreement if the MCP's failure to perform, or properly perform, any of the requirements in this Agreement results in the death of or serious injury to, the MCP's member, as determined by ODM.

3. **Request for Reconsiderations.** Unless otherwise specified below, the MCP may seek reconsideration of any sanction or remedial action imposed by ODM including points, financial sanctions, and member enrollment freezes. The MCP may seek reconsideration of CAPs only when a CAP is required for the first violation in a series of progressive compliance actions.
  - a. The MCP may not seek reconsideration of:
    - i. An action by ODM that results in changes to the auto-assignment of members; or
    - ii. The imposition of directed CAPs, as defined in this appendix.
  - b. The MCP shall submit a request for reconsideration on the form required by ODM, in accordance with the following procedure:
    - i. The MCP shall submit a request for reconsideration either by email to the designated Contract Administrator (CA), or by overnight mail to ODM's Office of Managed Care (OMC). The request for reconsideration shall be received by ODM no later than the tenth business day after the date that the MCP receives notice of the imposition of the remedial action by ODM. If ODM imposes an enrollment freeze based on access to care concerns, the enrollment freeze will be imposed concurrent with initiating notification to the MCP.
    - ii. A request for reconsideration shall explain in detail why the specified sanction should not be imposed. At a minimum, the reconsideration request shall include: a statement of the proposed action being contested; the basis for requesting reconsideration; and any supporting documentation. In considering the MCP's request for reconsideration, ODM will review only the written material submitted by the MCP.
    - iii. ODM will take reasonable steps to make a final decision, or request additional information, within ten business days after receiving the request for reconsideration. If ODM requires additional time, the MCP will be notified in writing.
    - iv. If ODM approves a reconsideration request, in whole, the associated sanctions or remedial actions will be rescinded. The MCP will not be required to submit a CAP.
    - v. If ODM approves, in part, the MCP's reconsideration request the sanction, remedial action and/ or remedial actions may be rescinded or reduced, at the discretion of ODM. The MCP may still be required to submit a CAP if ODM, in its discretion, believes that a CAP is still warranted under the circumstances.
    - vi. If ODM denies a reconsideration request, any CAP, sanction, or remedial action, and/or points outlined in the original notice of noncompliance will be assessed.

## APPENDIX O

### PAY-FOR-PERFORMANCE (P4P) and QUALITY WITHHOLD

The Ohio Department of Medicaid (ODM) established a Pay for Performance (P4P) Incentive System and a Quality Withhold Program to provide financial rewards and quality payments to MCPs that achieve specific levels of performance in program priority areas. Standardized clinical quality measures derived from a national measurement set (i.e., HEDIS) are used to determine incentive payments. The P4P Incentive System will be phased out after State Fiscal Year (SFY) 2018 (measurement year 2017) and replaced with the Quality Withhold Program in SFY 2019 (measurement year 2018).

1. **P4P Incentive System.** The SFY 2018 P4P determination will evaluate MCP clinical quality. For SFY 2018, one P4P Incentive System determination will be made per MCP. Results for each P4P measure will be calculated per MCP, statewide, and include all regions in which the MCP has membership as specified in this appendix. For the Clinical Performance P4P determinations, the MCP will be required to develop and implement improvement initiatives in areas of low performance as specified in this appendix.
  - a. **SFY 2018 Determination.** For SFY 2018, ODM will make one P4P Incentive System determination per MCP, as outlined below.

Clinical Performance P4P Incentive System Determination:

- i. **Frequency.** MCP performance is assessed annually (i.e., ODM will issue one assessment and payment, if applicable, per MCP for SFY 2018).
- ii. **Measures.** Performance is assessed on six measures, as listed in Table 1 below.
- iii. **Report Period.** The measurement year for the six clinical quality measures is CY 2017.
- iv. **Standards.** A set of ten performance levels, with corresponding standards, is established for each of the six measures, as provided in Table 1 below.
- v. **Potential Payout.** The potential payout for this determination is an amount equal to 1.25% of the net premium and delivery payments made to the MCP between January 1, 2017 and December 31, 2017, pursuant to the applicable Medicaid Managed Care Provider Agreements.
- vi. **Calculation.** ODM calculates the MCP's potential payout (i.e., 1.25%) and divides this equally among the six measures. The MCP is then awarded a percentage (0-100) of the potential payout allotted to each measure. This determination is made on a measure by measure basis, using the MCP's performance measure result in comparison to the ten performance levels, and corresponding standards, established for each measure. If the MCP fails to meet the standard for level one, they are awarded 0% for the measure.

**Table 1. SFY 2018 P4P Clinical Performance Measures and Standards.**

SFY 2018 P4P Clinical Performance Measures and Standards							
Standards that Determine % of Potential Payout Awarded, by Measure							
P4P Perf. Level	Percent of Potential Payout Awarded	Follow-Up After Hospitalization for Mental Illness (7 Days)	Prenatal and Postpartum Care: Timeliness of Prenatal Care	Prenatal and Postpartum Care: Postpartum Care	Controlling High Blood Pressure (Patients with Hypertension)	Adolescent Well-Care Visits	Comprehensive Diabetes Care: HbA1c Poor Control (> 9.0%)
10	100%	45.8%	87.6%	67.5%	64.0%	57.7%	36.9%
9	87%	43.9%	86.5%	66.2%	62.1%	55.8%	38.3%
8	74%	42.1%	85.4%	64.9%	60.3%	54.0%	39.6%
7	61%	40.2%	84.4%	63.6%	58.5%	52.1%	41.0%
6	50%	38.3%	83.3%	62.3%	56.6%	50.3%	42.4%
5	39%	36.5%	82.3%	61.0%	54.8%	48.4%	43.8%
4	28%	35.1%	80.6%	59.9%	53.2%	46.9%	45.5%
3	19%	33.7%	79.0%	58.8%	51.6%	45.4%	47.2%
2	11%	32.4%	77.4%	57.7%	50.0%	43.9%	48.9%
1	4%	31.0%	75.8%	56.6%	48.5%	42.4%	50.6%
	0%	≤ 30.9%	≤75.7%	≤56.5%	≤48.4%	≤42.3%	≥50.7%
<b>MPS</b>		29.6%	74.2%	55.5%	46.9%	40.9%	52.3%

MPS = Minimum Performance Standard (established in Appendix M, and provided above for reference)

Note: MCP performance is assessed using MCP self-reported, audited HEDIS data calculated in accordance with NCQA HEDIS 2018, Volume 2: Technical Specifications.

- b. **SFY 2018 Quality Improvement.** The clinical measures used in the P4P Incentive System evaluate healthcare delivery to clinical populations of high priority to Ohio Medicaid. The MCP is expected to maintain a focus on continuous quality improvement in their provision of care and services to these populations. To monitor MCP quality improvement, ODM will require the MCP to develop and implement one Quality Improvement Project (QIP), as outlined in paragraph 7.e.b) of Appendix K, for each MCP SFY 2018 P4P clinical measure result that does not meet the corresponding standard listed below. The MCP shall adhere to ODM-specified reporting and submission guidelines in completing the QIP.

Follow-Up After Hospitalization for Mental Illness (7 Days)	≥ 16.9%
Prenatal and Postpartum Care: Timeliness of Prenatal Care	≥ 63.6%
Prenatal and Postpartum Care: Postpartum Care	≥ 43.6%
Controlling High Blood Pressure (Patients with Hypertension)	≥ 33.8%
Adolescent Well-Care Visits	≥ 26.8%
Comprehensive Diabetes Care: HbA1c Poor Control (> 9.0%)	≤ 68.2%

- 2. **Quality Withhold Program.** Starting with capitation and delivery payments made in April 2018, ODM will withhold 2.0% for use in the Quality Withhold Program. ODM will use Quality Indices to calculate the amount of the withhold payout. Quality Indices will be comprised of multiple performance measures related to the index topic. Quality Indices measure the effectiveness of the MCP’s population health management strategy and quality improvement programs to impact population health outcomes.

Determination of the Quality Withhold payout is specified in this appendix. A bonus pool for high performing MCPs will be established annually based on unreturned quality withhold dollars as specified in this appendix

- a. **SFY 2019 Quality Withhold Payout Determination.** The Department will use the MCPs’ self-reported audited HEDIS data submission for the purpose of evaluating performance related to the Quality Withhold Program.
  - i. **Frequency.** MCP performance will be assessed annually (i.e., ODM will issue one assessment and payment, if applicable, per MCP for SFY 2019).
  - ii. **Quality Indices & Measures.** Performance will be assessed on four equally weighted Quality Indices. The Quality Indices used in the Quality Withhold program for SFY 2019 (measurement year 2018) are: (1) Chronic Condition: Cardiovascular Disease; (2) Chronic Condition: Diabetes; (3) Behavioral Health; and (4) Healthy Children. Each index is composed of multiple quality measures which are assigned different weights. The index measures and weights are described in *ODM’s Quality Indices and Scoring Methodology*.
  - iii. **Report Period.** The measurement year for the measures used in the Quality Indices is CY 2018.
  - iv. **Index Score.** Indices will be scored according to *ODM’s Quality Indices and Scoring Methodology*. A separate Index Score will be calculated for each Index.
  - v. **Potential Payout:** The potential payout for this determination is equal to the amount withheld during CY 2018, i.e., ODM will withhold 2.0% of the capitation and delivery payments from April, 2018 through December, 2018.
  - vi. **Calculation.** After adjusting for specific components of the MCP capitation rate as described below, ODM calculates the MCP’s maximum potential payout for the Quality Indices and divides this equally among the four indices used in the Quality Withhold Program. The MCP is then awarded a percentage (0-100) of the potential payout allotted to each Quality Index. This determination is made on an index-by-index basis, using the MCP’s Index Score for each Quality Index in comparison to Table 2 below.

**Table 2. SFY 2019 Quality Withhold Payout Table.**

SFY 2019 Quality Withhold Program Payout Table	
Index Score	Percent of Potential Payout Awarded
>=50.0	100%
45.0 – 49.9	91.6%
40.0 – 44.9	83.3%
35.0 – 39.9	75.0%
30.0 – 34.9	62.5%
25.0 – 29.9	50.0%
< 25.0	0%

*In recognition of requirements in this Agreement, specified components of the MCP's capitation rate will be automatically assigned a payout award of 100%. These items include the Health Insuring Corporation (HIC) Franchise Fee, MCP Hospital Incentive program, Enhanced Maternal Program, and the Care Innovation and Community Improvement Program (CICIP).*

- vii. **SFY 2019 Bonus Pool Determination.** The SFY 2019 Bonus Pool will be funded by the unreturned SFY 2019 Quality Withhold Program dollars. If \$0 are unreturned, then there will be no bonus pool. Unclaimed Bonus Pool dollars will not carry over to the next year. In order to qualify for a share of the bonus pool, MCPs must achieve the following:
1. An average Index Score of 75.0 points or greater across all indices included in the SFY 2019 Quality Withhold Program; and
  2. At least 90.0% of CPC practices with MCP members attributed during the measurement year must remain in good standing on applicable quality and efficiency metrics. In order to remain in good standing, CPC practices must pass at least 50% of applicable quality metrics and at least 50% of applicable efficiency metrics. This determination will be made by ODM.

The Bonus Pool will be divided in proportion to each qualified MCP's net MMC premium and delivery payments made for the measurement year.

- b. **SFY 2020 Quality Withhold Payout Determination.** The Department will use the MCPs' self-reported audited HEDIS data submission for the purpose of evaluating performance related to the Quality Withhold Program.
- i. **Frequency.** MCP performance will be assessed annually (i.e., ODM will issue one assessment and payment, if applicable, per MCP for SFY 2020).
  - ii. **Quality Indices & Measures.** Performance will be assessed on four equally weighted Quality Indices. The Quality Indices used in the Quality Withhold program for SFY 2020 (measurement year 2019) are: (1) Chronic Condition: Cardiovascular Disease; (2) Chronic Condition: Diabetes; (3) Behavioral Health; and (4) Healthy Children. Each index is composed of multiple quality measures which are assigned different weights. The index measures and weights are described in *ODM's Quality Indices and Scoring Methodology*.
  - iii. **Report Period.** The measurement year for the measures used in the Quality Indices is CY 2019.
  - iv. **Index Score.** Indices will be scored according to *ODM's Quality Indices and Scoring Methodology*. A separate Index Score will be calculated for each Index.
  - v. **Potential Payout.** The potential payout for this determination is equal to the amount withheld during CY 2019, i.e., ODM will withhold 2.0% of the capitation and delivery payments from January, 2019 through December, 2019.



- vi. **Calculation.** After adjusting for specific components of the MCP capitation rates as described below, ODM calculates the MCP’s maximum potential payout for the Quality Indices and divides this equally among the indices used in the Quality Withhold Program. The MCP is then awarded a percentage (0-100) of the potential payout allotted to each Quality Index. This determination is made on an index-by-index basis, using the MCP’s Index Score for each Quality Index in comparison to Table 3 below.

**Table 3. SFY 2020 Quality Withhold Payout Table**

SFY 2020 Quality Withhold Program Payout Table	
Index Score	Percent of Potential Payout Awarded
>= 75	100%
70.0 – 74.9	95.0%
65.0 – 69.9	91.0%
60.0 – 64.9	87.5%
55.0 – 59.9	84.5%
50.0 – 54.9	81.8%
45.0 – 49.9	79.3%
40.0 – 44.9	77.0%
35.0 – 39.9	75.0%
30.0 – 34.9	50.0%
25.0 – 29.9	25.0%
< 25.0	0%

*In recognition of requirements in this Agreement, specified components of the MCP’s capitation rate will be automatically assigned a payout award of 100%. These items include the HIC Franchise Fee, MCP Hospital Incentive Program, Enhanced Maternal Program, and CICIP.*

- vii. **SFY 2020 Bonus Pool Determination.** The SFY 2020 Bonus Pool will be funded by the unreturned SFY 2020 Quality Withhold Program dollars. If \$0 are unreturned, then there will be no bonus pool. Unclaimed Bonus Pool dollars will not carry over to the next year. In order to qualify for a share of the bonus pool, MCPs must achieve the following:
  1. An average Index Score of 75.0 points or greater across all indices included in the SFY 2020 Quality Withhold Program; and
  2. At least 90.0% of CPC practices with MCP members attributed during the measurement year must remain in good standing on applicable quality and efficiency metrics. In order to remain in good standing, CPC practices must pass at least 50% of applicable quality metrics and at least 50% of applicable efficiency metrics. This determination will be made by ODM.

The Bonus Pool will be divided in proportion to each qualified MCP’s net MMC premium and delivery payments made for the measurement year.

- c. **SFY 2021 Quality Withhold Payout Determination.** The Department will use the MCPs’ self-reported audited HEDIS data submission for the purpose of evaluating performance related to the Quality Withhold Program.
  - i. **Frequency.** MCP performance will be assessed annually (i.e., ODM will issue one assessment and payment, if applicable, per MCP for SFY 2021).
  - ii. **Quality Indices & Measures.** Performance will be assessed on four equally weighted Quality Indices. The Quality Indices used in the Quality Withhold program for SFY 2021 (measurement year 2020) are: (1) Chronic Condition: Cardiovascular Disease; (2) Chronic Condition: Diabetes; (3) Behavioral Health; and (4) Healthy Children. Each index is composed of multiple quality measures which are assigned different weights. The index measures and weights are described in *ODM’s Quality Indices and Scoring Methodology*.
  - iii. **Report Period.** The measurement year for the measures used in the Quality Indices is CY 2020.
  - iv. **Index Score.** Indices will be scored according to *ODM’s Quality Indices and Scoring Methodology*. A separate Index Score will be calculated for each Index.
  - v. **Potential Payout.** The potential payout for this determination is equal to the amount withheld during CY 2020, i.e., ODM will withhold 2.0% of the capitation and delivery payments from January, 2020 through December, 2020.
  - vi. **Calculation.** After adjusting for specific components of the MCP capitation rates as described below, ODM calculates the MCP’s maximum potential payout for the Quality Indices and divides this equally among the indices used in the Quality Withhold Program. The MCP is then awarded a percentage (0-100) of the potential payout allotted to each Quality Index. This determination is made on an index-by-index basis, using the MCP’s Index Score for each Quality Index in comparison to Table 4 below.

**Table 4. SFY 2021 Quality Withhold Payout Table**

SFY 2021 Quality Withhold Program Payout Table	
Index Score	Percent of Potential Payout Awarded
>= 75	100%
70.0 – 74.9	95.0%
65.0 – 69.9	91.0%
60.0 – 64.9	87.5%
55.0 – 59.9	84.5%
50.0 – 54.9	81.8%
45.0 – 49.9	79.3%
40.0 – 44.9	77.0%
35.0 – 39.9	75.0%
30.0 – 34.9	0%
25.0 – 29.9	0%
<25	0%

*In recognition of requirements in this Agreement, specified components of the MCP's capitation rate will be automatically assigned a payout award of 100%. These items include the HIC Franchise Fee, MCP Hospital Incentive Program, Enhanced Maternal Program, and CICIP.*

- vii. **SFY 2021 Bonus Pool Determination.** The SFY 2021 Bonus Pool will be funded by the unreturned SFY 2021 Quality Withhold Program dollars. If \$0 are unreturned, then there will be no bonus pool. Unclaimed Bonus Pool dollars will not carry over to the next year. In order to qualify for a share of the bonus pool, MCPs must achieve the following:
1. An average Index Score of 75.0 points or greater across all indices included in the SFY 2021 Quality Withhold Program; and
  2. At least 90.0% of CPC practices with MCP members attributed during the measurement year must remain in good standing on applicable quality and efficiency metrics. In order to remain in good standing, CPC practices must pass at least 50% of applicable quality metrics and at least 50% of applicable efficiency metrics. This determination will be made by ODM.

The Bonus Pool will be divided in proportion to each qualified MCP's net MMC premium and delivery payments made for the measurement year.

### 3. **Additional Operational Considerations.**

- a. **Timing of P4P Incentive System and Quality Withhold Program Determinations.** ODM will issue results for each P4P Incentive System and Quality Withhold Program determination to participating MCPs within six months of the end of each established report period. Given that unforeseen circumstances may impact the timing of this determination, ODM reserves the right to revise the time frame in which the P4P Incentive System or Quality Withhold program determination is issued (i.e., the determination may be made more than six months after the end of the contract period).
- b. **Agreement Termination, Nonrenewal, or Denial.** Upon termination, nonrenewal, or denial of the MCP Agreement, the incentive or withhold amount will be retained or awarded by ODM, in accordance with Appendix P, *MCP Termination/Non-renewal*, of this Agreement.
- c. **P4P or Quality Withhold Measures, Requirements, and Measurement Years.** ODM reserves the right to revise P4P or Quality Withhold measures, standards, benchmarks, requirements, and measurement years, as needed, due to unforeseen circumstances. Unless otherwise noted, the most recent report or study finalized prior to the end of the contract period will be used in determining the MCP's overall performance level for that contract period.
- d. **P4P Potential Payout Amounts – Status Determination.** In the event the MCP's performance cannot be evaluated on a particular P4P measure, ODM in its sole discretion will award or retain 100% of the incentive or withhold amount (potential payout) allocated to that particular measure or index. This determination will be based on the circumstances involved (e.g., for SFY 2016, if a HEDIS measure was assigned an audit result of "Not Report" on the MCP's Final Audit

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Report and the “Not Report” designation was determined to be the result of a material bias caused by the MCP, ODM will retain 100% of the incentive or withhold amount [potential payout] allocated to that measure).

- e. **P4P Performance Standards and Quality Withhold Program Benchmarks – Retrospective Adjustment.** ODM uses a uniform methodology, as needed, for the retrospective adjustment of any P4P Incentive or Quality Withhold Standard or Benchmark. This methodology will be implemented at ODM’s sole discretion.

For a comprehensive description of the standard adjustment methodology, see *ODM Methods for the Retrospective Adjustment of Quality, P4P, and Quality Withhold Measure Standards, which may be amended if necessary upon agreement of the parties.*

The sanctions for noncompliance with requirements in this appendix are listed in Appendix N of this Agreement.

## APPENDIX P

### PLAN TERMINATIONS/NONRENEWALS

1. **MCP-Initiated Terminations/Nonrenewals.** If the MCP provides notice of the termination/nonrenewal of this Agreement to ODM, pursuant to Article VIII of the agreement, the MCP will be required to comply with the following:
  - a. **Fulfill Existing Duties and Obligations.** The MCP agrees to fulfill all duties and obligations as required under Ohio Administrative Code (OAC) Chapter 5160-26 and any provider agreements related to the provision of services for the Medicaid population during periods of time when the MCP was under contract with ODM. Such duties and obligations include, but are not limited to, the submission by the MCP of any previously reported appeals and grievances data which were unresolved for the Medicaid population after the termination/nonrenewal date, resolution of provider and consumer complaints for the Medicaid population served by the MCP for the MCP provider agreement time periods, and provision of data to support audits related to the Medicaid population served by the MCP for the MCP's provider agreement time periods.
  - b. **Refundable Monetary Assurance.** The MCP will be required to submit a refundable monetary assurance. This monetary assurance will be held by ODM until such time that the MCP has submitted all outstanding monies owed, data files, and reports, including, but not limited to, grievance, appeal, encounter and cost report data related to time periods through the final date of service under this Agreement. The monetary assurance shall be in an amount of either \$50,000 or 5 % of the capitation amount paid by ODM in the month the termination/nonrenewal notice is issued, whichever is greater.

The MCP shall remit the monetary assurance in the specified amounts via separate electronic fund transfers (EFT) payable to Treasurer of State, State of Ohio (ODM). The MCP shall contact their 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 shall be included with each EFT to ensure monies are deposited in the appropriate ODM Fund account. In addition, the MCP shall send copies of the EFT bank confirmations and copies of the invoices to their Contract Administrator.

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

- c. **Bonus Amount.** The bonus amount in the managed care program performance payment fund will be retained by ODM.
- d. **Final Accounting of Amounts Outstanding.** The MCP shall submit to ODM a final accounting list of any outstanding monies owed by ODM no later than six (6) months after the

termination/nonrenewal date. Failure by the MCP to submit a list of outstanding items will be deemed a forfeiture of any additional compensation due to the MCP. ODM payment will be limited to only those amounts properly owed by ODM.

- e. **Financial sanctions.** All previously collected refundable financial sanctions shall be retained by ODM.
- f. **Data Files.** In order to assist members with continuity of care, the MCP shall create data files to be shared with each newly enrolling MCP. The data files will be provided in a consistent format specified by ODM and may include information on the following: care management, prior authorizations, inpatient facility stays, PCP assignments, and pregnant members. The timeline for providing these files will be at the discretion of ODM. The terminating MCP will be responsible for ensuring the accuracy and data quality of the files.
- g. **Notification.**
  - i. **Provider Notification.** The MCP shall notify contracted providers at least 55 calendar days prior to the effective date of termination. The provider notification shall be approved by ODM prior to distribution.
  - ii. **Member Notification.** Unless otherwise notified by ODM, the MCP shall notify their members regarding this Agreement termination at least 45 calendar days in advance of the effective date of termination. The member notification shall be approved by ODM prior to distribution.
  - iii. **Prior Authorization Re-Direction Notification.** The MCP shall create two notices to assist members and providers with prior authorization requests received and/or approved during the last month of membership. The first notice is for prior authorization requests for services to be provided after the effective date of termination; this notice will direct members and providers to contact the enrolling MCP. The second notice is for prior authorization requests for services to be provided before and after the effective date of termination. The MCP shall utilize ODM model language to create the notices and receive approval by ODM prior to distribution. The notices will be mailed to the provider and copied to the member for all requests received during the last month of MCP membership.

## 2. ODM-initiated Terminations for Cause under OAC rule 5160-26-10.

- a. If ODM initiates the proposed termination, nonrenewal 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 MCP 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 in the MCP's appeal under ORC Chapter 119.

During this time, the MCP will continue to accrue points and be assessed penalties for each subsequent compliance assessment occurrence/violation specified in Appendix N of this

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Agreement. If the MCP exceeds 69 points, each subsequent point accrual will result in a \$15,000 nonrefundable financial sanction.

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

- i. All notifications of such a proposed MCP membership termination will be made by ODM via certified or overnight mail to the identified MCP Contact.
  - ii. The MCP will be notified by ODM of such a proposed MCP membership termination, and will have three business days from the date of receipt to request reconsideration.
  - iii. All reconsideration requests shall be submitted by either facsimile transmission or overnight mail to the Director, Ohio Department of Medicaid, and received by 3PM Eastern Time on the third business day following receipt of the ODM notification of termination. The address and fax number to be used in making these requests will be specified in the ODM notification of termination document.
  - iv. The MCP will be responsible for verifying timely receipt of all reconsideration requests. All requests shall explain in detail why the proposed MCP membership termination is not justified. The MCP's justification for reconsideration will be limited to a review of the written material submitted by the MCP.
  - v. A final decision or request for additional information will be made by the Director within three business days of receipt of the request for reconsideration. Should the Director require additional time in rendering the final reconsideration decision, the MCP will be notified of such in writing.
  - vi. The proposed MCP membership termination will not occur while an appeal is under review and pending the Director's decision. If the Director denies the appeal, the MCP membership termination will proceed at the first possible effective date. The date may be retroactive if the ODM determines that it would be in the best interest of the members.
- b. **Fulfill Existing Duties and Obligations.** The MCP agrees to 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 MCP was under contract with ODM. Such duties and obligations include, but are not limited to, the submission by the MCP of any previously reported appeals and grievances data which were unresolved for the Medicaid population after the termination/nonrenewal date, resolution of provider and consumer complaints for the Medicaid population served by the MCP for the MCP provider

agreement time periods, and provision of data to support audits related to the Medicaid population served by the MCP for the MCP's provider agreement time periods.

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

The MCP shall remit the monetary assurance in the specified amounts via separate electronic fund transfers (EFT) payable to Treasurer of State, State of Ohio (ODM). The MCP shall contact their 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 shall be included with each EFT to ensure monies are deposited in the appropriate ODM Fund account. In addition, the MCP shall send copies of the EFT bank confirmations and copies of the invoices to their Contract Administrator.

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

- d. **Bonus Amount.** The bonus amount in the managed care program performance payment fund will be retained by ODM.
- e. **Financial sanctions.** All previously collected refundable financial sanctions shall be retained by ODM.
- f. **Final Accounting of Amounts Outstanding.** The MCP shall submit to ODM a final accounting list of any outstanding monies owed by ODM no later than six (6) months after the termination/nonrenewal date. Failure by the MCP to submit a list of outstanding items will be deemed a forfeiture of any additional compensation due to the MCP. ODM payment will be limited to only those amounts properly owed by ODM.
- g. **Data Files.** In order to assist members with continuity of care, the MCP shall create data files to be shared with each newly enrolling MCP. The data files will be provided in a consistent format specified by ODM and may include information on the following: care management, prior authorizations, inpatient facility stays, PCP assignments, and pregnant members. The timeline for providing these files will be at the discretion of ODM. The terminating MCP will be responsible for ensuring the accuracy and data quality of the files.
- h. **Notification.**





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

- c. **Bonus Amount.** The bonus amount in the managed care program performance payment fund will be awarded by ODM in accordance with the pay-for-performance system set forth in Appendix O for the current provider agreement year.
  - d. **Financial sanctions.** All previously collected refundable financial sanctions shall be returned to the MCP.
  - e. **Final Accounting of Amounts Outstanding.** The MCP shall submit to ODM a final accounting list of any outstanding monies owed by ODM no later than six (6) months after the termination/nonrenewal date. Failure by the MCP to submit a list of outstanding items will be deemed a forfeiture of any additional compensation due to the MCP. ODM payment will be limited to only those amounts properly owed by ODM.
  - f. **Data Files.** In order to assist members with continuity of care, the MCP shall create data files to be shared with each newly enrolling MCP. The data files will be provided in a consistent format specified by ODM and may include information on the following: care management, prior authorizations, inpatient facility stays, PCP assignments, and pregnant members. The timeline for providing these files will be at the discretion of ODM. The terminating MCP will be responsible for ensuring the accuracy and data quality of the files.
  - g. **Notification.**
    - i. **Provider Notification.** The MCP shall notify contracted providers at least 55 calendar days prior to the effective date of termination. The provider notification shall be approved by ODM prior to distribution.
    - ii. **Prior Authorization Re-Direction Notification.** The MCP shall create two notices to assist members and providers with prior authorization requests received and/or approved during the last month of membership. The first notice is for prior authorization requests for services to be provided after the effective date of termination; this notice will direct members and providers to contact the enrolling MCP. The second notice is for prior authorization requests for services to be provided before and after the effective date of termination. The MCP shall utilize ODM model language to create the notices and receive approval by ODM prior to distribution. The notices will be mailed to the provider and copied to the member for all requests received during the last month of MCP membership.
4. **Termination or Modification of this Agreement due to Lack of Funding.** Should this Agreement terminate or be modified due to a lack of available funding as set forth in the Baseline of this

Agreement, the MCP has no right to appeal the selection process under ORC Chapter 119 pursuant to ORC section 5164.38 and will be required to comply with the following:

- a. **Fulfill Existing Duties and Obligations.** The MCP agrees to 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(s) during periods of time when the MCP was under contract with ODM. Such duties and obligations include, but are not limited to, the submission by the MCP of any previously reported appeals and grievances data which were unresolved for the Medicaid populations, resolution of provider and consumer complaints for the Medicaid population served by the MCP for the MCP provider agreement time periods, and provision of data to support audits related to the Medicaid population served by the MCP for the MCP's provider agreement time periods.
- b. **Refundable Monetary Assurance.** The MCP will be required to submit a refundable monetary assurance should the Agreement terminate. This monetary assurance will be held by ODM until such time that the MCP has submitted all outstanding monies owed, data files, and reports, including, but not limited to, grievance, appeal, encounter and cost report data related to time periods through the final date of service under the MCP's provider agreement. The monetary assurance shall be in an amount of either \$50,000 or 5 % of the capitation amount paid by ODM in the month the termination notice is issued, whichever is greater.

The MCP shall remit the monetary assurance in the specified amounts via separate electronic fund transfers (EFT) payable to Treasurer of State, State of Ohio (ODM). The MCP shall contact their 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 shall be included with each EFT to ensure monies are deposited in the appropriate ODM Fund account. In addition, the MCP shall send copies of the EFT bank confirmations and copies of the invoices to their Contract Administrator.

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

- c. **Bonus Amount.** The bonus amount in the managed care program performance payment fund will be awarded by ODM in accordance with the pay-for-performance system set forth in Appendix O for the current provider agreement year.
- d. **Financial sanctions.** Previously collected refundable financial sanctions directly and solely related to the termination or modification of this Agreement shall be returned to the MCP.
- e. **Final Accounting of Amounts Outstanding.** The MCP shall submit to ODM a final accounting list of any outstanding monies owed by ODM no later than six (6) months after a termination/nonrenewal date of this Agreement. Failure by the MCP to submit a list of

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outstanding items will be deemed a forfeiture of any additional compensation due to the MCP. ODM payment will be limited to only those amounts properly owed by ODM.

- f. **Data Files.** In order to assist members with continuity of care, the MCP shall create data files if requested by ODM. The data files will be provided in a consistent format specified by ODM and may include information on the following: care management, prior authorizations, inpatient facility stays, PCP assignments, and pregnant members. The timeline for providing these files will be at the discretion of ODM. The MCP will be responsible for ensuring the accuracy and data quality of the files.
- g. **Provider Notification.** The MCP shall notify contracted providers within 30 calendar days of notice from ODM of the effective date of termination or modification of this Agreement. The provider notification shall be approved by ODM prior to distribution.

The sanctions for noncompliance with requirements in this appendix are listed in Appendix N of this Agreement.

## APPENDIX Q

### PAYMENT REFORM

On January 9, 2013, Governor John Kasich's Advisory Council on Health Care Payment Reform adopted the Catalyst for Payment Reform (CPR) principles as part of a comprehensive strategy to prioritize and coordinate multi-payer health care payment innovation activities in Ohio. The Ohio Department of Medicaid (ODM) is committed to reforming the health care delivery system by designing and implementing systems of payment that signal powerful expectations for improved health care delivery.

1. **Payment Innovation and Reform.** Improving the delivery of health care, including its quality, efficiency, safety, patient-centeredness, coordination, and outcomes, requires significant changes in existing payment structures and methodologies as well as the environment in which payments are made. The following innovations have been adopted by Ohio Medicaid:
  - a. Payment reforms should promote health by rewarding the delivery of quality, cost effective and affordable care that is patient-centered and reduces disparities;
  - b. Health care payments should encourage and reward patient-centered care that coordinates services across the spectrum of providers and care setting while tailoring health care service to the individuals patient's needs;
  - c. Payment policies should encourage alignment between public and private sectors to promote improvement, innovations and meeting national health priorities, and to maximize the impact of payment decisions of one sector on the other;
  - d. Decisions about payment should be made through independent processes guided by what serves the patient and helps society as a whole, and payment decisions shall balance the perspectives of consumers, purchasers, payers, physicians and other health care providers;
  - e. Payment policies should foster ways to reduce expenditure on administrative processes (e.g., claims payment and adjudications); and
  - f. Reforms to payment should balance the need for urgency against the need to have realistic goals and timelines that take into account the need to change complex systems and geographic and other variations.
2. **ODM's Expectations.** ODM expects the MCP to support and advance initiatives to develop a health care market where payment is increasingly designed to improve and reflect the effectiveness and efficiency with which providers deliver care. In addition, ODM supports the development of MCP members engaged in managing their health, selecting their providers, and maintaining sensitivity to the cost and quality of services they seek. The MCP shall use its best efforts to ensure these commitments and initiatives apply to the benefits offered and services delivered under this provider agreement. The MCP shall achieve progress in the following areas:
  - a. **Value-Oriented Payment.** The MCP shall design and implement payment methodologies with its network providers designed either to cut waste or reflect value. For the purposes of this



5. **Reporting.** The MCP shall submit a quarterly progress report as specified by ODM that addresses progress towards meeting the obligations as outlined above. ODM will provide a report template. The report elements shall include:
  - a. A description of the value-based purchasing strategies;
  - b. Type of provider (s);
  - c. Objective of each value-based purchasing strategy and progress in meeting each objective;
  - d. Type of value-based arrangement (e.g. upside risk or downside risk);
  - e. Sum of total gross payments;
  - f. Sum of total net payments; and
  - g. Unique count of members.
  
6. **Care Innovation and Community Improvement Program (CICIP) Requirements.** CICIP was developed to increase alignment of quality improvement strategies and goals between ODM, the MCP, and both public and nonprofit hospital agencies. The four agencies are large Medicaid safety-net and academic medical centers. CICIP goals align with ODM goals: improve healthcare for Medicaid beneficiaries at risk of or with an opioid or other substance abuse disorder, along with improving care coordination. Implementation of CICIP is contingent on CMS approval.

Before the program period begins, average commercial rate (ACR) will be determined for each participating agency using claims data of the identified qualified practitioners for CY 2016. The composite ACR for all participating agencies will be used each year when calculating the CICIP payments.

Using this information, ODM's actuary will estimate a per member per month (PMPM) amount associated with the CICIP program. This amount will be reduced by a predetermined percentage, with the difference being allocated to annual bonus payments based on adherence to data reporting requirements and achievement of performance improvements. The estimated CICIP payment, less the amount allocated to bonus payments, will be included in the capitation rates effective July 1, 2018. The capitation rates will include a fixed PMPM amount for CICIP, with potential variation by region and rate cell. The MCP monthly payments equal to 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 MCP on the payment amount for each agency based on the agreed upon payment schedule with the agencies.

After the second year of the program, ODM will calculate the bonus payments to the agencies based on the agreed upon value based/ quality measures. ODM will provide the bonus payments to the MCP so it can be distributed to the agencies. All payments to the agencies will be paid up to the calculated ACR, and will never exceed that amount.

As the program moves forward, CICIP PMPM allocations by practice will be reconciled based on actual utilization, and future payments are adjusted based on a semi-annual reconciliation process. The CICIP

payments included in the capitation rates are anticipated to be updated annually, with the option for mid-year amendments.

- a. **Participating Agencies.** For the purpose of this requirement, a participating agency is defined as either a public hospital agency as defined in ORC section 140.01, or a nonprofit hospital agency as defined in ORC section 140.01 that is affiliated with a state university as defined in ORC section 3345.011. For the contract year beginning July 1, 2018, the participating agencies are:
  - i. The MetroHealth System,
  - ii. UC Health,
  - iii. University of Toledo Medical Center,
  - iv. The Ohio State University Wexner Medical Center.
- b. **Qualified Practitioners.** For the purposes of the CICIP program, qualified practitioners include: Physicians, Physician Assistants, Nurse Practitioner (NPs), Clinical Nurse Specialist (CNSs), Certified Registered Nurse Anesthetists (CRNAs), Certified Nurse Midwives (CNMs), Clinical Social Workers (CSWs), Clinical Psychologists, Optometrists, and Dentists. The services for the professionals listed would be billed under one of the Group national provider identifier (NPI) numbers that are affiliated with one of the Participating Agencies and identified by ODM.
- c. **Reporting.** CICIP payments will be based on the HIPAA compliant 820 file. Encounter claims data will be used for the appropriate time period when calculating CICIP payments and reconciling previous payment.
- d. **Quality Measures.** The quality measures that were agreed upon between ODM, the MCP, and the agencies are as follows:
  - i. Rate of Opioid Solid Doses Dispensed (without Suboxone) per patients of practitioners prescribing opiates;
  - ii. Rate of patients receiving opioids also receiving Benzos;
  - iii. Rate of patients receiving greater than 80 mg Morphine Equivalent Dose (MED) of patients with opioid scripts;
  - iv. Rate of Ohio Automated Rx Reporting System (OARRS) queries of those practitioners prescribing opiates;
  - v. Initiation and Engagement of Alcohol and other Drug Dependence (HEDIS);
  - vi. Follow-up after inpatient stay for mental health within 7 days (HEDIS);
  - vii. Emergency Room Utilization Reduction; and



viii. Improve the Opioid Use Disorder (OUD)/maternity measures with a focus on:

1. Timeliness of prenatal care;
2. Live births weighing less than 2,500 grams; and
3. Postpartum care.

CICIP will not have an impact on Comprehensive Primary Care (CPC). The payments to the MCP for CICIP will not be included when calculating CPC.

ODM agrees that the MCP should be held harmless of the 1% Health Insuring Corporations (HIC) Tax. HIC Tax amounts included in the July 2018 capitation rates will be increased to account for the CICIP program.

ODM will provide the MCP advance notice of when the payment will be due and the amount of the payment to the CICIP participating agencies.

The sanctions for noncompliance with requirements in this appendix are listed in Appendix N of this Agreement.