THE OHIO DEPARTMENT OF MEDICAID
NEXT GENERATION MYCARE OHIO PROVIDER AGREEMENT
FOR MYCARE OHIO PLAN

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INTRODUCTION

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

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

        i. Focus on the individual;

        ii. Improve individual and population wellness and health outcomes;

        iii. Create a personalized care experience;

        iv. Support providers in continuously improving care;

        v. Improve care for individuals with complex needs to promote independence in the community; and

        vi. Increase program transparency and accountability.

    b. The Next Generation MyCare Ohio Plan (MCOP) must perform its responsibilities and deliver services under this Agreement in a manner consistent with achieving these goals.

2. **Next Generation MyCare Ohio Program**

    a. The MyCare Ohio program began as a demonstration project (MyCare Ohio duals demonstration) in which the Centers for Medicare & Medicaid Services (CMS) and Ohio, under CMS' Financial Alignment Initiative, partnered to test an integrated care model for dual eligible recipients aged 18 and older. Launched on May 1, 2014, the MyCare Ohio duals demonstration is expected to end no later than December 31, 2025, and convert to the Next Generation MyCare Ohio program.

    b. ODM envisions its Next Generation MyCare Ohio program to be one in which ODM and the MCOPs coordinate and collaborate to achieve health care excellence by integrating the coordination, provision, and payment of Medicare and Medicaid funded services for dual eligible members, providers, and system partners.

    c. Key features of the Next Generation MyCare Ohio program include:

        i. Eligibility — Dual eligible recipients age 21 and over who meet the eligibility criteria for the Next Generation MyCare Ohio program.

        ii. Choice — Dual eligible recipients eligible for the Next Generation MyCare Ohio program may elect to receive both their Medicare and Medicaid benefits from the MCOP ("dual benefit member") or elect to receive only their Medicaid benefits from the MCOP ("Medicaid only member").

        iii. Exclusively aligned enrollment — Dual eligible recipients who meet the criteria for MyCare Ohio and who elect to enroll in an MCOP for their Medicare benefits will be enrolled in the MCOP for both their Medicare and Medicaid benefits.

iv. Default enrollment — Subject to meeting the requirements in 42 CFR 422.66(c)(2), individuals who are enrolled in an ODM-contracted MCOP who become eligible for MyCare Ohio and do not choose to receive their Medicare benefits through another Medicare payer will be deemed to have elected the MCOP for both their Medicare and Medicaid benefits.

v. Integration requirements — Additional MCOP requirements that promote care integration and improved experience for dual benefit members include:

1. Providing a single point of contact for members regarding their Medicare and Medicaid benefits.
2. Providing integrated member materials.
3. Offering a unified appeals and grievances process.
4. Coordinating Medicare and Medicaid benefits and care to include acute care, behavioral health, long-term services and supports (LTSS), dental, vision, home health, durable medical equipment, and supports to address members' health-related social needs.
5. Improving access and care coordination for behavioral health services.
6. Simplifying and improving member access to non-emergency transportation.

vi. Statewide service area — MCOPs will be required to serve members statewide. This will expand the availability of integrated care to members residing in areas not served under the MyCare Ohio duals demonstration and minimize the need for enrollment changes and resulting care disruptions to members who move within the state.

d. To reduce provider burden and promote consistency across the Next Generation MyCare Ohio program, ODM has retained the administrative responsibilities for centralized claims submissions, provider enrollment, and for credentialing and re-credentialing.

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

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

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

provider network management (PNM) system is the State's system of record for Medicaid provider data.

3. **Population Health Approach**

   a. ODM seeks to advance ODM's population health approach through its Next Generation MyCare Ohio program. ODM's population health approach requires the MCOP to use the following population health management principles to address health inequities and disparities to achieve optimal outcomes for the holistic well-being of the populations it serves:

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

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

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

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

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

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

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

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

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

      iii. Ensuring health equity in all policies, practices, and operations; and

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

   c. The MCOP must demonstrate congruence with these principles and strategies in all aspects of MCOP performance under this Agreement, including executing MCOP responsibilities, coordinating with other ODM-contracted managed care entities, collaborating with community stakeholders, supporting providers, and delivering services to members.

4. **MCOP Service Area**

a. Under this Agreement, the MCOP is responsible for providing covered services (see Appendix B, Coverage and Services) to members, described in Ohio Administrative Code (OAC) rule 5160-58-02, in every county in the state of Ohio. ODM intends to implement the Next Generation MyCare Ohio program in two phases:

i. **Phase 1:** By January 1, 2026, the MCOP will be expected to implement the Next Generation MyCare Ohio program in the 29 counties in which the MyCare Ohio duals demonstration operated, as identified below.

Butler	Delaware	Lake	Montgomery	Trumbull
Clark	Franklin	Lorain	Ottawa	Union
Clermont	Fulton	Lucas	Pickaway	Warren
Clinton	Geauga	Madison	Portage	Wayne
Columbiana	Greene	Mahoning	Stark	Wood
Cuyahoga	Hamilton	Medina	Summit	

ii. **Phase 2:** The MCOP will be expected to expand implementation of the Next Generation MyCare Ohio program to all remaining counties across the state. ODM anticipates phase 2 expansion to be completed within the first year of this Agreement.

DEFINITIONS AND ACRONYMS

1. General

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

2. Definitions

Abuse – As defined in Ohio Administrative Code (OAC) rules 5160-58-01 and 5160-26-01, provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary, or that fail to meet professionally recognized standards for health care. Abuse also includes member practices that result in unnecessary cost to the Medicaid program.

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

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

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

Advance Directive – As defined in OAC rules 5160-58-01 and 5160-26-01, written instructions such as a living will or durable power of attorney for health care relating to the provision of health care when an adult is incapacitated.

Adverse Benefit Determination – As defined in OAC rules 5160-58-01 and 5160-26-01, a Next Generation MyCare Ohio Plan's (MCOP's):

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

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

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

d. Failure to provide services in a timely manner as specified in OAC rule 5160-58-03.1;

e. Failure to act within the resolution timeframes specified in OAC rule 5160-58-08.4; or

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

Appeal – As defined in OAC rules 5160-58-01 and 5160-26-01, a member's request for an MCOP's review of an adverse benefit determination.

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

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

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

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

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

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

Care Management – A collaborative, team-based and person-centered approach that encompasses the full spectrum of care coordination activities, ranging from short-term assistance to meet care gaps to longer-term, intensive, and holistic care coordination for members with the most intense needs, designed to assist members and their support systems in managing medical conditions and social determinants of health (SDOH) more effectively.

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

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

Certificate of Authority (COA) – Document issued by the Ohio Department of Insurance (DOI) pursuant to Ohio Revised Code (ORC) section 1751.05 that recognizes the MCOP as a health insuring corporation (HIC) with the powers as articulated in ORC section 1751.06.

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

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

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

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

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

Comprehensive Assessment – Consistent with OAC rule 5160-58-01, a comprehensive evaluation of an individual's medical, behavioral health, long-term services and supports (LTSS), and social needs. Results of the assessment process are used to develop the member's person-centered care plan.

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

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

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

Covered Services – The set of services to be covered by the MCOP. Refer to Appendix B, Coverage and Services.

Critical Incident – As further defined in OAC rule 5160-44-05, the following alleged or suspected events: abuse, neglect, exploitation, misappropriation, unnatural or accidental death, health or welfare of the individual at risk due to the individual being lost or missing, and certain prescribed medication issues.

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

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

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

Default Enrollment – An enrollment process in accordance with 42 CFR 422.66(c)(2) that allows the MCOP, following approval by ODM and the Centers for Medicare & Medicaid Services (CMS), to enroll — unless the individual chooses otherwise — either (1) a member of an affiliated Next Generation MCO into its fully integrated dual eligible special needs plan (FIDE SNP) when that member becomes newly eligible for Medicare or (2) a member into its FIDE SNP for Medicare enrollment when the member becomes newly eligible for Medicare when the MCOP was already covering the member's Medicaid benefits.

Dual Benefit Member – A member who receives both Medicaid and Medicare benefits from the MCOP.

Dual Eligible Recipient – An individual who is entitled to, or enrolled for, benefits under Part A of Title XVIII of the Social Security Act and enrolled for benefits under Part B of Title XVIII of such Act, and is eligible for medical assistance under the Ohio Medicaid state plan under Title XIX of such Act or under a waiver of such plan.

Dual Eligible Special Needs Plan (D-SNP) – In accordance with 42 CFR 422.2, a specialized Medicare Advantage plan for special needs individuals who are entitled to Ohio Medicaid that (1) coordinates the delivery of Medicare and Medicaid services for individual who are eligible for such services; (2) may provide coverage of Medicaid services, including LTSS and behavioral health services for individuals eligible for such services; (3) has a contract with ODM consistent with 42 CFR 422.107 that meets the minimum requirements in paragraph (c) of such section; and (4) satisfies one or more of the following criteria for the integration of Medicare and Medicaid benefits: (i) meets the additional requirement specified in 42 CFR 422.017(d) in its contract with the state Medicaid agency; (ii) Is a highly integrated D-SNP; or (iii) Is a fully integrated D-SNP.

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

Eligible Individual – Any dual eligible recipient who is eligible for enrollment in MyCare Ohio as provided in OAC rule 5160-58-02.

Emergency Medical Condition – As defined in OAC rules 5160-58-01 and 5160-26-01, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or their unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Emergency Services – As defined in OAC rules 5160-58-01 and 5160-26-01, covered inpatient services, outpatient services, or medical transportation that are provided by a qualified provider and are needed to evaluate, treat, or stabilize an emergency medical condition. Providers of emergency services also include physicians or other health care professionals or health care facilities not under employment or under contractual arrangement with an MCOP.

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

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

Financial Management Service (FMS) – Consistent with the definition in OAC rule 5160-58-01, a support that is provided to MyCare Ohio Home- and Community-Based Services (HCBS) Waiver participants who direct some or all of their waiver services. When used in conjunction with the employer authority, this support includes, but is not limited to, operating a payroll service for participant employed workers and making required payroll withholdings. When used in conjunction with the budget authority, this support includes, but is not limited to, paying invoices for waiver goods and services and tracking expenditures against the participant-directed budget.

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

Fraud – As defined in OAC rules 5160-58-01 and 5160-26-01, any intentional deception or misrepresentation made by an individual or entity with the knowledge that the deception could result in some unauthorized benefit to the individual, the entity, or some other person. This includes any act that constitutes fraud under federal or state law. Member fraud means the altering of information or documents in order to fraudulently receive unauthorized benefits or to knowingly permit others to use the member's identification card to obtain services or supplies.

Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) – In accordance with 42 CFR 422.2, a D-SNP that: (1) provides dual eligible recipients access to Medicare and Medicaid benefits under a single entity that holds both a Medicare Advantage contract with CMS and a Medicaid managed care organization contract under Section 1903(m) of the Act with ODM; (2) whose capitated contract with ODM requires coverage of primary and acute care, including Medicare cost-sharing; behavioral health services; LTSS; coverage of nursing facility services for a period of at least 180 days during the plan year; home health services; and medical supplies, equipment, and appliances; (3) coordinates the delivery of covered dual services using aligned care management and specialty care network methods for high-risk members; (4) employs policies and procedures approved by CMS and the state to coordinate or integrate member materials, enrollment, communications, grievance and appeals, and quality improvement (QI); (5) has exclusively aligned enrollment; and (6) whose capitated contract with ODM covers the entire services area for the D-SNP.

Grievance – As defined in OAC rules 5160-58-01 and 5160-26-01, a member's expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include but are not limited to the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the MCOP to make an authorization decision.

Healthcare Effectiveness Data and Information Set (HEDIS®[1]) – Set of standardized performance measures developed, supported, and maintained by the National Committee for Quality Assurance (NCQA) designed to allow reliable comparison of MCOP performance.

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

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

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

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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

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

Health Plan Management System (HPMS) – A system that supports contract management for Medicare health plans and prescription drug plans and supports data and information exchanges between CMS and health plans. Current and prospective Medicare health plans submit applications, information about provider networks, plan benefit packages, formularies, and other information via the HPMS.

HealthTrack – Database operated by ODM that tracks member and provider complaints.

Home- and Community-Based Services (HCBS) Waiver – Waiver under Section 1915(c) of the Social Security Act that allows the state to cover home and community services and provide programs that are designed to meet the unique needs of individuals with disabilities who qualify for the level of care (LOC) provided in an institution but who, with special services, may remain in their homes and communities.

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

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

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

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

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

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

Long-Term Services and Supports (LTSS) – Nursing facility care and a range of home and community services and supports designed to meet a member's needs as an alternative to long-term nursing facility care to enable a person to live as independently as possible.

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

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

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

Medicaid – As defined in OAC rules 5160-58-01 and 5160-26-01, medical assistance as defined in ORC section 5162.01 and OAC rule 5160-26-01.

Medicaid Fraud Control Unit (MFCU) – Consistent with OAC rules 5160-58-01 and 5160-26-01, the unit of the Ohio Attorney General's Office responsible for the investigation and prosecution of fraud and related offenses within Medicaid.

Medicaid Only Member – A member who does not receive Medicare benefits from the MCOP and receives Medicare benefits through fee-for-service (FFS) Medicare and a standalone Part D Plan or a Medicare Advantage/Medicare Advantage Part D plan (MA/MA-PD) and only receives Medicaid services through the MCOP.

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

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

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

    iii. Meets generally accepted standards of medical practice;

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

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

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

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

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

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

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

Medicare – As defined in OAC rules 5160-58-01 and 5160-26-01, the federally financed medical assistance program defined in 42 USC Subchapter XVIII.

Medicare Advantage – The Medicare managed care options that are authorized under Title XVIII as specified at Part C and 42 CFR Part 422.

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

Member – An eligible individual who is enrolled in an MCOP.

Member Enrollment Mix Adjustment (MEMA) – The MEMA utilizes the particular waiver enrollment and nursing facility placement of the nursing facility LOC member to provide more revenue to MyCare Ohio plans that have a greater proportion of high-risk/cost members and, conversely, less revenue to MyCare Ohio plans that have a lower proportion of high-risk/cost beneficiaries. The adjustment is budget neutral.

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

Member Materials – Items developed by or on behalf of the MCOP to fulfill MCOP 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 MCOP and which do not include any reference to the MCOP are not considered to be member materials.

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

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

Minimum Data Set (MDS) – A clinical screening system, mandated by federal law for use in nursing facilities, which assesses the key domains of function, health, and service use. MDS assessment forms include the MDS-HC for home care and the MDS 3.0 for nursing facility residents.

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

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

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

Next Generation MyCare Ohio (MyCare Ohio) – The name for Ohio's integrated managed care program that coordinates physical health, behavioral health, and long-term care services for dual eligible recipients age 21 and over who meet the eligibility criteria for the program.

Next Generation MyCare Ohio Plan (MCOP) – An entity that meets the requirements of 42 CFR 438.2 and 422.2 and is a HIC licensed in Ohio that enters into a MyCare Ohio provider agreement and a state Medicaid agency contract (SMAC) with ODM.

Notice of Action – In accordance with 42 CFR 438.404 and 422.570, the written notice an MCOP must provide to members when an MCOP adverse benefit determination has occurred or will occur.

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

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

Ombudsman – The entity designated by the state, and independent of ODM, that advocates and investigates on behalf of MyCare Ohio members to safeguard due process and to serve as an early and consistent means of identifying systematic problems with the program.

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

Pending Member – Consistent with OAC rules 5160-58-01 and 5160-26-01, an eligible individual who has selected or been assigned to an MCOP but whose MCOP membership is not yet effective.

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

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

Person-Centered Care Plan – Consistent with OAC rule 5160-58-01, an integrated, individualized, person-centered care plan developed by the member and their Trans-Disciplinary Care team that addresses clinical and non-clinical needs identified in the assessment and includes goals, interventions, and expected outcomes.

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

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

Post-Stabilization Care Services – As defined in OAC rules 5160-58-01 and 5160-26-01, covered services related to an emergency medical condition that a treating provider views as medically necessary after an emergency medical condition has been stabilized in order to maintain the stabilized condition, or under the circumstances described in 42 CFR 422.113 to improve or resolve the member's condition.

Preadmission Screening and Resident Review (PASRR) – Federal requirement that helps ensure that individuals are not inappropriately placed in nursing homes for long-term care. PASRR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for mental illness and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and 3) receive the services they need in those settings, described in 42 CFR 483.100-138.

Primary Care Provider (PCP) – As defined in OAC rules 5160-58-01 and 5160-26-01, an individual physician (M.D. or D.O.), a physician group practice, an advanced practice registered nurse as defined in section 4723.01 of the Revised Code, an advanced practice nurse group practice within an acceptable specialty, or a physician assistant who meets the requirements of OAC rule 5160-4-03 contracting with an MCOP to provide services as specified in OAC rule 5160-58-03.1. Acceptable PCP specialty types include family/general practice, internal medicine, pediatrics, and obstetrics/gynecology (OB/GYNs).

Program of All-Inclusive Care for the Elderly (PACE) – A comprehensive service delivery and financing model that integrates medical and LTSS under dual capitation agreements with Medicare and Medicaid. The PACE program is limited to individuals age 55 and over who meet the nursing-facility LOC criteria and reside in a PACE service area.

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

Provider – As defined in OAC rules 5160-58-01 and 5160-26-01, a hospital, health care facility, physician, dentist, pharmacy, or otherwise licensed or certified appropriate individual or entity that is authorized to or may be entitled to reimbursement for health care services rendered to an MCOP's member.

Provider Agreement – As defined in OAC rules 5160-58-01 and 5160-26-01, a formal agreement between ODM and an MCOP for the provision of medically necessary services to Medicaid members.

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

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

Provider Network or Network – Consistent with "Provider Panel" as defined in OAC rules 5160-58-01 and 5160-26-01, the MCOP's contracted providers available to the MCOP's members.

Provider Occurrence – As defined in OAC rule 5160-45-06, any alleged, suspected or actual performance or operational issue by a provider furnishing ODM-administered waiver services that does not meet the definition

of an incident as set forth in OAC rule 5160-44-05. Provider occurrences include, but are not limited to, alleged violations of provider eligibility and/or service specification requirements, provider conditions of participation, billing issues including overpayments, and Medicaid fraud.

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

a. Is identified in the Ohio Medicaid state plan;

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

c. Has a negative consequence for the beneficiary;

d. Is auditable; and

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

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

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

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

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

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

QAPI Template – The ODM template that MCOPs submit annually to demonstrate the content of their QAPI program and describe how they have executed ODM's QI requirements.

Quality Improvement Culture – Shared beliefs, perceptions, norms, values, and expectations of individuals and the organization regarding QI and customer satisfaction. When a quality culture is achieved, all employees, from

senior leadership to frontline staff, have infused QI into the way they do business daily. Employees continuously consider how processes can be improved, and QI is no longer seen as an additional task but a frame of mind in which the application of QI is second nature. The components of a sustainable QI culture include: leadership commitment, a QI infrastructure, employee empowerment, a customer (e.g., member, provider, stakeholder) focus, teamwork, and collaboration, and a focus on continually learning and improving.

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

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

Self-Direction – Consistent with the definition of "participant direction" in OAC rule 5160-58-01, the opportunity for a MyCare Ohio HCBS Waiver member to exercise choice and control in identifying, accessing, and managing waiver services and other supports in accordance with their needs and personal preferences.

Service Area – As defined in OAC rules 5160-58-01 and 5160-26-01, the geographic area specified in the MCOP's provider agreement where the MCOP agrees to provide Medicaid services to members residing in those areas.

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

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

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

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

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

Subcontract – As defined in OAC rules 5160-58-01 and 5160-26-01, a written contract between an MCOP and a third party, including the MCOP's parent company or any subsidiary corporation owned by the MCOP's parent company, or between the third party and a fourth party, or between any subsequent parties, to perform a specific part of the obligations specified under the MCOP's provider agreement with ODM.

Subcontractor – As defined in OAC rules 5160-58-01 and 5160-26-01, any party that has entered into a subcontract to perform a specific part of the obligations specified under the MCOP's provider agreement with ODM. A network provider is not a subcontractor by virtue of the network provider contract with the MCOP.

Supplemental Benefits – Consistent with 42 CFR 422.2, 422.100, and 422.102, additional benefits offered by the MCOP to dual benefit members that are not covered by FFS Medicare.

Trans-Disciplinary Care Team – A team made up of the member, the member's managed care team, other professionals, and informal supports chosen by the member. The MCOP must provide the member's care manager (and/or waiver service coordinator if the member is enrolled on the MyCare Ohio HCBS Waiver) and internal support staff, such as social workers, mental health and/or SUD licensed independent professionals, gerontologists, housing specialists, transportation specialists, and community health workers, to support the care manager.

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

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

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

Waiver Service Plan – Consistent with OAC rule 5160-58-01, a component of the person-centered care plan that identifies specific goals, objectives, and measurable outcomes for a MyCare Ohio HCBS Waiver-enrolled member's health and functioning expected as a result of HCBS provided by both formal and informal caregivers, and that addresses the physical and medical conditions of the individual. At a minimum, the waiver services plan shall include: (1) essential information needed to provide care to the member that assures the member's health and welfare; (2) signatures indicating the member's acceptance or rejection of the waiver services plan. If the member is unable to provide the signature when the services plan is initially developed, the individual will submit an electronic signature or standard signature via regular mail, or otherwise provide a signature in no instance any later than at the next face-to-face visit with the case manager; and (3) information that the Waiver service plan is not the same as the physician's plan of care.

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

Waste – As defined in OAC rules 5160-58-01 and 5160-26-01, payment for or the attempt to obtain payment for items or services when there may be no intent to deceive or misrepresent, but poor or inefficient billing or treatment methods result in unnecessary costs.

Written Translation – Translation in writing of MCOP documents and materials into the primary language of an eligible individual or member with LEP.

3. Acronyms

ABD	Aged, Blind, and Disabled
ADAMH	Alcohol, Drug Addiction, and Mental Health
AMA	American Medical Association
API	Application Programming Interface
APM	Alternative Payment Model

APRN	Advanced Practice Registered Nurse
ASAM	American Society of Addiction Medicine
BC-DR	Business Continuity and Disaster Recovery
BCRC	Benefits Coordination and Recovery Center
CAHPS®[2]	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CDJFS	County Department of Job and Family Services
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CIO	Chief Information Officer
CMHSP	Community Mental Health Services Provider
CME	Care Management Entity
CMO	Chief Medical Officer
CMS	Centers for Medicare & Medicaid Services
COA	Certificate of Authority
COB	Coordination of Benefits
COBA	Coordination of Benefits Agreement
CPSE	Claims Payment Systemic Error
CY	Calendar Year
DBA	Doing Business As
D-SNP	Dual Eligible Special Needs Plan
eCQM	Electronic Clinical Quality Measure
EDI	Electronic Data Interchange
EHR	Electronic Health Record
EQRO	External Quality Review Organization
EVV	Electronic Visit Verification
FDR	First Tier, Downstream, and Related Entities
FFS	Fee-for-Service
FIDE SNP	Fully Integrated Dual Eligible Special Needs Plan
FMS	Financial Management Service
FQHC	Federally Qualified Health Center
FTP	File Transfer Protocol
HCBS	Home- and Community-Based Services
HCP-LAN	Health Care Payment Learning and Action Network
HEDIS	Healthcare Effectiveness Data and Information Set
HIC	Health Insuring Corporation
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HPMS	Health Plan Management System
IDSS	Interactive Data Storage System
ILOS	In Lieu of Service
IMD	Institution for Mental Disease
IMS	Incident Management System
ISCA	Information Systems Capabilities Assessment
LISW	Licensed Independent Social Worker

[2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

LOC	Level of Care
LPCC	Licensed Professional Clinical Counselor
LSW	Licensed Social Worker
LTSS	Long-Term Services and Supports
MAGI	Modified Adjusted Gross Income
MARS-e	Minimum Acceptable Risk Standards for Exchanges
MAT	Medication Assisted Treatment
MCOP	Next Generation MyCare Ohio Plan
MDS	Minimum Data Set
MFCU	Medicaid Fraud Control Unit
MHPAEA	Mental Health Parity and Addiction Equity Act
MLR	Medical Loss Ratio
MPS	Minimum Performance Standards
MSR	Member Services Representative
MTM	Medication Therapy Management
NAIC	National Association of Insurance Commissioners
NCPDP	National Council for Prescription Drug Programs
NCQA	National Committee for Quality Assurance
NIST	National Institute of Standards and Technology
NPI	National Provider Identifier
OAC	Ohio Administrative Code
ODI	Ohio Department of Insurance
ODM	Ohio Department of Medicaid
OMHAS	Ohio Department of Mental Health and Addiction Services
OMES	Ohio Medicaid Enterprise System
ORC	Ohio Revised Code
PACE	Program of All-Inclusive Care for the Elderly
PASRR	Preadmission Screening and Resident Review
PCP	Primary Care Provider
PDN	Private Duty Nursing
PDSA	Plan-Do-Study-Act
PHI	Protected Health Information
PIP	Performance Improvement Project
PMF	Provider Master File
PMPM	Per Member Per Month
PNM	Provider Network Management
PROD	Production
QAPI	Quality Assessment and Performance Improvement
QI	Quality Improvement
RHC	Rural Health Clinic
RN	Registered Nurse
SDOH	Social Determinants of Health
SFTP	Secure File Transfer Protocol
SFY	State Fiscal Year
SIU	Special Investigative Unit
SMAC	State Medicaid Agency Contract
SMART	Specific, Measurable, Achievable, Relevant, and Time-Bound
SPBM	Single Pharmacy Benefit Manager
SUD	Substance Use Disorder
TPL	Third Party Liability
UM	Utilization Management
US	United States

USC	United States Code
USCDI	United States Core Data for Interoperability

BASELINE PROVIDER AGREEMENT

This Provider Agreement (hereinafter "Agreement") is entered into this first day of January, 2026, at Columbus, Franklin County, Ohio, between the state of Ohio, the Ohio Department of Medicaid, (hereinafter referred to as ODM) whose principal office is located in the City of Columbus, County of Franklin, state of Ohio, and _____, MyCare Ohio Plan (hereinafter MCOP), an Ohio corporation, whose principal office is located in the city of_____, County of _____, state of Ohio.

The MCOP is licensed as a Health Insuring Corporation by the state of Ohio, Department of Insurance (hereinafter referred to as ODI), pursuant to Chapter 1751 of the Ohio Revised Code (ORC) and is organized and must operate as prescribed by Chapter 5167 of the ORC, Chapter 5160-58 of the Ohio Administrative Code (OAC), Section 333.320 of Am.Sub.H.B. No.33 (135th General Assembly), and other applicable portions of the ORC and OAC as amended from time to time. Upon request, the MCOP must submit to ODM any data submitted to ODI to establish the MCOP has adequate provisions against the risk of insolvency as required under 42 Code of Federal Regulations (CFR) 438.116 and to ensure that neither members nor ODM shall be liable for any MCOP debts, including those that remain in the event of MCOP insolvency or the insolvency of any subcontractors.

The MCOP is an entity eligible to enter into this Agreement in accordance with 42 CFR 438.3 and is engaged in the business of providing the comprehensive services described in 42 CFR 438.2 through the managed care program for the dual eligible population described in Ohio Administrative Code (OAC) rule 5160-58-02 along with any other Medicaid-eligible populations authorized by the Centers for Medicare & Medicaid Services (CMS). The MCOP must meet state and federal requirements to qualify as a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) and contract with CMS with a unique Medicare contract number specific to and only including the MyCare Ohio line of business to operate an MCOP as a FIDE SNP in Ohio throughout the duration of this Agreement.

The goal of MyCare Ohio is for MCOPs to manage the full continuum of Medicare and Medicaid benefits for their members, providing coordination of long-term care, behavioral health, and physical health services to streamline care and improve outcomes of dual members. Dual benefit members are defined in OAC rule 5160-58-01 as individuals enrolled in an MCOP for whom the MCOP is responsible for the coordination and payment of both Medicare and Medicaid benefits. Medicaid only members are defined in OAC rule 5160-58-01 to include individuals enrolled in an MCOP for whom the MCOP is responsible for coordination and payment of only Medicaid benefits. This Agreement applies to both dual benefit members and Medicaid only members, unless otherwise specified herein.

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 MCOP services for the benefit of certain Medicaid recipients. In doing so, the MCOP has provided and must continue to provide proof of the MCOP'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 MCOP pursuant to the federal contracting provisions of 42 CFR 434.6 and 438.6 in which the MCOP must provide or arrange for comprehensive Medicaid services through the managed care program as provided in ORC Chapter 5167 and OAC Chapter 5160-58, assuming the risk of loss, and at all times complying with federal and state laws and regulations, federal and state Medicaid program requirements, and other requirements as specified by ODM. In accordance with 42 CFR 438.3(f)(1), this includes without limitation: Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the

Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990 as amended; and Section 1557 of the Patient Protection and Affordable Care Act.

ARTICLE I – GENERAL

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

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

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

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

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

ARTICLE II – TIME OF PERFORMANCE

A. Upon approval by the Director of ODM, this Agreement is in effect from the date executed through December 31, 2028, subject to the MCOP having a Medicare Advantage contract with CMS as a FIDE SNP as described below, unless this Agreement is terminated pursuant to Article VIII of the Baseline Provider Agreement on or prior to this Agreement expiration date, or otherwise renewed or amended pursuant to Article IX of the Baseline Provider Agreement. Termination of this Agreement does not relieve the MCOP of any ongoing obligations as set forth in this Agreement, including those obligations associated with the transition plan described in Appendix O, MCOP Termination and Non-Renewal.

B. The MCOP must be approved by CMS to offer a FIDE SNP throughout the term of this Agreement. The MCOP must provide documentation to ODM and to CMS that demonstrates that the entity responsible for coverage of the Medicaid benefits described in Appendix B, Coverage and Services, is the same legal entity as the entity holding the Medicare Advantage contract with CMS for the Dual Eligible Special Needs Plan (D-SNP) covered under this Agreement, consistent with Attachment 1, Agreement Between Ohio Department of Medicaid and [insert named MCOP].

ARTICLE III – REIMBURSEMENT

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

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

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

ARTICLE IV – RELATIONSHIP OF PARTIES

A. ODM and the MCOP agree that, during the term of this Agreement, the MCOP must be engaged with ODM solely on an independent contractor basis, and neither the MCOP nor its personnel may, at any time or for any purpose, be considered as agents, servants, or employees of ODM or the state of Ohio. The MCOP is therefore responsible for all the MCOP's business expenses, including but not limited to employees' wages and salaries, insurance of every type and description, and all business and personal taxes, including income and Social Security taxes and contributions for Workers' Compensation and Unemployment Compensation coverage, if any. Pursuant to ORC section 145.038, ODM must provide individuals and business entities with fewer than five employees the Independent Contractor Acknowledgment (Form PEDACKN). This form requires the MCOP to acknowledge that ODM has notified the MCOP 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 MCOP, its employees, or its subcontractors for these services. If the MCOP is a business entity with fewer than five employees, the MCOP must ensure that each employee completes the PEDACKN form.

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

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

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

ARTICLE V – CONFLICT OF INTEREST; ETHICS LAWS

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

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

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

D. The MCOP must ensure that any such person who acquires an incompatible, compromising, or conflicting personal or business interest, on or after the effective date of this Agreement, or who involuntarily acquires any such incompatible or conflicting personal interest, immediately discloses their interest to ODM in writing. Thereafter, the MCOP must ensure that they must not participate in any action affecting the services under this Agreement unless ODM determines in its sole discretion that, in the light of the personal interest disclosed, their participation in any such action would not be contrary to the public interest. The MCOP must provide written disclosure of such interest to ODM.

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

ARTICLE VI – NON-DISCRIMINATION OF EMPLOYMENT

A. The MCOP must not discriminate in the performance or employment under this Agreement of an individual who is qualified and available to perform the services under this Agreement on the basis of race, color,

religion, gender, gender identity, sexual orientation, age, disability, national origin, veteran status, military status, health status, genetic information, or ancestry. For purposes of this article, "members" does not include individuals whose sole connection with the MCOP is the receipt of services through a health care program offered by the MCOP. The MCOP, its officers, employees, members, and subcontractors hereby affirm current and ongoing compliance with all federal civil rights laws, including:

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

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

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

D. In addition to requirements imposed upon subcontractors in accordance with OAC Chapter 5160-58, the MCOP must hold all subcontractors and persons acting on behalf of the MCOP in the performance of services under this Agreement responsible for adhering to the requirements of paragraphs (A) through (C) above. The MCOP must include the requirements of paragraphs (A) through (C) above in all contracts and agreements that result from this Agreement.

ARTICLE VII – RECORDS, DOCUMENTS, DATA, AND INFORMATION

A. The MCOP must ensure that all records, documents, data, or other information produced or used by the MCOP under this Agreement are treated in accordance with OAC rules 5160-58-01.1 and 5160-26-06 and must be provided to ODM or its designee at no cost if requested. The records, documents, data, and information must be provided by the MCOP in a format solely determined by ODM, which may include the analysis of any data and documentation the MCOP is required to maintain. The MCOP must maintain an appropriate record system for services provided to members. The MCOP must retain all records in accordance with 42 CFR 438.3(u) and comply with the audit and inspection rights of those records in accordance with 42 CFR 438.3(h).

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

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

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

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

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

G. The MCOP must not use any information, systems, or records made available to it for any purpose other than to fulfill the duties specified in this Agreement. The MCOP must be bound by the same standards of confidentiality that apply to the employees of ODM and the state of Ohio, including without limitation the confidentiality requirements found in 42 CFR Part 431 Subpart F and ORC section 5160.45, as well as 42 CFR Part 2 and ORC section 5119.27 as applicable. The terms of this section must be included in any contracts

and agreements executed by the MCOP for services under this Agreement. The MCOP must implement procedures to ensure that in the process of coordinating care, each member's privacy is protected consistent with the confidentiality requirements cited above, as well as those set forth in 45 CFR Part 160 and 164.

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

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

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

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

ARTICLE VIII – TERMINATION AND NON-RENEWAL

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

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

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

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

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

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

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

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

I. The MCOP understands that availability of funds to fulfill the terms of this Agreement is contingent on appropriations made by the Ohio General Assembly and the US government for funding the Medicaid program. If sufficient funds are not available from the Ohio General Assembly or the US government to make payments on behalf of a specific population (e.g., Aged, Blind, and Disabled; Modified Adjusted Gross Income) to fulfill the terms of this Agreement, the obligations, duties, and responsibilities of the parties with respect to that population will be terminated, except as specified in Appendix O, MCOP Termination and Non-Renewal, as of the date funding expires. If the Ohio General Assembly or the US government fails at any time to provide sufficient funding for ODM or Ohio to make payments due under this Agreement, this Agreement will terminate as of the date funding expires without further obligation of ODM or Ohio.

ARTICLE IX – AMENDMENT AND RENEWAL

A. This Agreement, together with the appendices, Attachment 1, and any other instruments to be executed and delivered pursuant to this Agreement, constitutes the entire Agreement between the parties with respect to all matters herein. This Agreement may be amended only by a writing signed by both parties. Any written amendments to this Agreement must be prospective in nature. ODM, in its sole discretion, may amend this Agreement discretion based upon the best interests of the program, its members, or the state. ODM will take into consideration the feedback of the MCOP before implementing any amendment. Any amendment to this Agreement will be applied to all ODM-contracted MCOPs.

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

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

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

E. This Agreement may be renewed each fiscal year after December 31, 2028, upon satisfactory performance hereunder, appropriation of funds by the Ohio General Assembly, and at the sole discretion of ODM. ODM will issue a notice to the MCOP if ODM decides to renew this Agreement. The MCOP must not obligate resources in anticipation of a renewal until such notice is provided and includes direction to begin obligating resources to the renewal year.

ARTICLE X – LIMITATION OF LIABILITY

A. The MCOP must (1) pay for the defense (if requested by ODM) of ODM and Ohio and any of its agencies, and (2) indemnify and hold ODM, Ohio, and any of its agencies harmless and immune from any and all claims for injury or damages resulting from the actions or omissions of the MCOP in the fulfillment of this Agreement or arising from this Agreement that are attributable to the MCOP's own actions or omissions, or of those of its trustees, officers, employees, members, agents, subcontractors, suppliers, third parties utilized by the

MCOP, or joint ventures. For purposes of this article, "members" does not include individuals whose sole connection with the MCOP is the receipt of services through a health care program offered by the MCOP. Such claims must include but are not limited to any claims by providers or Medicaid recipients, any claims made under the Fair Labor Standards Act or under any other federal or state law involving wages, overtime, or employment matters, and any claims involving patents, copyrights, trademarks, and applicable public records laws. The MCOP is responsible for and must pay all legal fees, expert and consulting fees, expenses, and costs associated with defending ODM, Ohio, and Ohio agencies against these claims, regardless of whether those legal fees, fees, costs, or expenses are incurred by the MCOP or Ohio, ODM, or other Ohio agencies. In any such litigation or claim, ODM, Ohio, and its agencies have the right to choose their own legal counsel and any experts and consultants, subject only to the requirement that legal, expert, and consulting fees must be reasonable.

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

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

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

ARTICLE XI – CHANGE IN ORGANIZATIONAL STRUCTURE

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

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

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

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

ARTICLE XII – ASSIGNMENT

A. The MCOP may not transfer Medicaid members to another MCOP without the prior written approval of ODM. Even with ODM's prior written approval, ODM reserves the right to offer such members the choice of MCOPs outside the normal open enrollment process and implement an assignment process as ODM determines is appropriate. The MCOP must submit any member transfer request to ODM for ODM's approval 120 calendar days prior to the desired effective date. ODM will use reasonable efforts to respond to any such request for approval within the 120-calendar day period. Failure of ODM to act on a request for approval within the 120-calendar day period does not act as an approval of the request. ODM may require a receiving MCOP to successfully complete a readiness review process before the transfer of members under this Agreement.

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

C. The MCOP must not assign any interest in subcontracts of this Agreement and must not transfer any interest in the same (whether by assignment or novation) without the prior written approval of ODM and subject to such conditions and provisions as ODM may deem necessary. The MCOP must submit any such assignments of subcontracts to ODM for ODM's approval 30 calendar days prior to the desired effective date.

ARTICLE XIII – CERTIFICATION MADE BY THE MCOP

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

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

C. The MCOP certifies that neither the MCOP nor any principals of the MCOP (e.g., director, officer, partner, or person with beneficial ownership of more than 5% of the MCOP's equity) is presently debarred, suspended, proposed for debarment, declared ineligible, or otherwise excluded from participation in transactions by any federal agency. The MCOP also certifies that it is not debarred from consideration for contract awards by the Director of the Department of Administrative Services, pursuant to either ORC section 153.02 or ORC section

125.25. The MCOP also certifies that the MCOP has no employment, consulting, or any other arrangement with any such debarred or suspended person for the provision of items or services, or services that are significant and material to the MCOP's contractual obligation with ODM. This certification is a material representation of fact upon which reliance was placed when this Agreement was entered into. federal financial participation (FFP) is not available for amounts expended for providers excluded by Medicare, Medicaid, or State Children's Health Insurance Program (SCHIP), except for emergency services. If it is ever determined that the MCOP knowingly executed this certification erroneously, then, in addition to any other remedies, this Agreement will be terminated pursuant to Article VIII of the Baseline Provider Agreement, and ODM must advise the secretary of the appropriate federal agency of the knowingly erroneous certification.

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

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

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

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

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

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

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

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

L. The MCOP must comply with the Federal Acquisition Regulation for Combating Trafficking in Persons, 48 CFR Part 22 Subpart 22.17, in which "the United States Government has adopted a zero-tolerance policy regarding trafficking in persons." The provisions found in 48 CFR Part 52 Subpart 52.2, specifically Subpart 52.222-50, are hereby incorporated into this Agreement by reference. ODM reserves the right to immediately and unilaterally terminate this Agreement if any provision in this section is violated and ODM may implement Section 106(g) of the Trafficking Victims Protection Act of 2000, as amended (22 USC 7104), see 2 CFR Part 175.

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

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

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

ARTICLE XIV – CONSTRUCTION

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

ARTICLE XV – INCORPORATION BY REFERENCE

A. OAC Chapters 5160-58 are hereby incorporated by reference as part of this Agreement, having the full force and effect as if specifically restated herein. The MCOP must subscribe to the appropriate distribution lists for notification of all OAC rule clearances, and final rules published with medical assistance letters, member handbook transmittal letters, and other transmittal letters affecting MyCare Ohio requirements. The MCOP is solely responsible for submitting its names and email addresses to the appropriate distribution lists and for ensuring the validity of any email addresses maintained on those distribution lists. Email distribution lists include RuleWatch Ohio at https://www.rulewatchohio.gov/; ODM Rule Notification at

https://medicaid.ohio.gov/wps/portal/gov/medicaid/stakeholders-and-partners/legal-and-contracts/; and ODM news and information at https://medicaid.ohio.gov/home/govdelivery-subscribe.

B. Appendices A through P, any additional appendices, and Attachment 1 are hereby incorporated by reference as part of this Agreement having the full force and effect as if specifically restated herein. Appendix O, MCOP Termination and Non-Renewal, and any other applicable obligations set forth in this Agreement will survive the termination or non-renewal of this Agreement.

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

D. In accordance with the terms and conditions of request for applications (RFA) number ODMR-2425-0008 the MCOP is bound by the responses the MCOP has submitted through that process. Accordingly, the MCOP's responses to RFA number ODMR-2425-0008 are incorporated by reference in this Agreement and have the full force and effect as if specifically restated herein.

E. In the event of inconsistency or ambiguity between the provisions of OAC Chapter 5160-58 and this Agreement, the provisions of OAC Chapter 5160-58 will be determinative of the obligations of the parties unless such inconsistency or ambiguity is the result of changes in federal or state law, as provided in Article IX of the Baseline Provider Agreement, in which case such federal or state law will be determinative of the obligations of the parties. In the event OAC Chapter 5160-58 is silent with respect to any ambiguity or inconsistency, this Agreement (including appendices and Attachment 1) will be determinative of the obligations of the parties other than as specifically provided in federal or state law. In the event that a dispute arises that is not addressed in any of the aforementioned documents, the parties must make every reasonable effort to resolve the dispute, in keeping with the objectives of this Agreement and the budgetary and statutory constraints of ODM.

ARTICLE XVI – NOTICES

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

ARTICLE XVII – HEADINGS

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

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

MCOP NAME:

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

THE OHIO DEPARTMENT OF MEDICAID:

BY: _____ DATE: _____
MAUREEN M. CORCORAN, DIRECTOR
50 West Town Street, Suite 400, Columbus, Ohio 4321

APPENDIX A – GENERAL REQUIREMENTS

1. General Administrative Requirements

a. Inclusive Agreement

i. The MCOP acknowledges and agrees that the RFA Number ODMR-2425-0008, all attachments, written addenda to the RFA, the MCOP's accepted proposal, the questions and answers posted during the inquiry period of the RFA Number ODMR-2425-0008 are hereby incorporated into this Agreement.

b. Certificate of Authority

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

c. National Committee for Quality Assurance Accreditation

i. The MCOP must hold and maintain or must obtain National Committee for Quality Assurance (NCQA) Health Plan and Case Management accreditation, for the MCOP's Ohio Medicaid and Medicare lines of business. If the MCOP does not have NCQA Health Plan and Case Management accreditation for the MCOP's MyCare Ohio line of business as of the effective date of this Agreement, the MCOP must achieve NCQA Health Plan and Case Management accreditation within 18 months of the effective date of this Agreement.

ii. The MCOP must achieve and maintain a minimum status of "Accredited" for Health Plan and Case Management.

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

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

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

d. MCOP Implementation and Readiness Review Activities

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

ii. The MCOP must fully partner, support, and cooperate in implementation and readiness review activities as directed by ODM. The MCOP must respond to ODM requests related to implementation and readiness promptly (i.e., within the timeframe specified by ODM). Such

requests may include but are not limited to operations, information technology, data, communications, or any other area of responsibility under this Agreement.

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

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

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

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

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

3. Terminate this Agreement; or

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

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

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

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

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

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

e. Local Presence

i. *Administrative Office*

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

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

ii. *Member and Provider Services Call Center*

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

iii. *Out-of-State Functions*

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

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

f. Contract Communications

i. *Key Contacts*

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

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

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

ii. *Communication Process*

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

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

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

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

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

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

iii. *Timeframes for Responding to Requests for Information*

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

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

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

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

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

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

iv. *Electronic Communications*

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

v. *Meeting Attendance*

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

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

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

vi. *Program Input from MCOP*

1. The MCOP must respond on a timely basis to MyCare Ohio program input opportunities, including:

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

b. Commenting on MyCare Ohio program policy and procedural changes; and

c. Reviewing MyCare Ohio program updates and discussing program issues with ODM staff.

vii. *Performance and Compliance Feedback*

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

g. Program Modifications

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

2. Eligibility, Enrollment, Transfers, and Enrollment Termination

a. MCOP Eligibility and Enrollment

i. The MCOP must comply with the MCOP eligibility and enrollment requirements in OAC rule 5160-58-02.

ii. An eligible individual's decision to enroll in the MCOP for Medicare benefits shall be choice-based. An eligible individual's decision to enroll in the MCOP for Medicare benefits will result in the individual's enrollment in the MCOP for both Medicare and Medicaid benefits.

b. Default Enrollment

i. Subject to meeting the requirements in 42 CFR 422.66(c)(2), individuals who are enrolled in an MCOP or ODM-contracted MCO with an affiliated MCOP who become eligible for MyCare Ohio and do not decline default enrollment to choose to receive their Medicare benefits through another Medicare payer will be deemed to have elected the MCOP for both their Medicare and Medicaid benefits.

c. Auto-Assignment Algorithm

i. Eligible individuals and members who do not exercise their right to choose an MCOP and who are not subject to default enrollment will be assigned to the MCOP through an ODM-approved auto-assignment algorithm.

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

iii. Member choice will not be impacted by an auto-assignment adjustment or stoppage.

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

d. MyCare Ohio HCBS Waiver Enrollment

i. The MCOP will receive requests for MyCare Ohio HCBS Waiver enrollment directly from members or from the Ohio Benefits LTSS (OBLTSS) agencies.

ii. The MCOP must submit MyCare Ohio HCBS Waiver eligibility updates through the ODM-designated system within two business days of the eligibility determination. Waiver eligibility approval and denial notices with hearing rights will be generated from the eligibility system designated by ODM.

iii. For reconciliation of existing waiver enrollees to the MyCare Ohio HCBS Waiver, the MCOP must report to ODM any MyCare member with an active waiver span indicated on the 834 file that documents any waiver but the MyCare Ohio HCBS Waiver. The MCOP must submit waiver enrollment information to ODM as specified in Appendix P, Chart of Deliverables, and participate in an annual waiver enrollment reconciliation process at the end of each waiver year.

e. MCOP Membership Acceptance, Documentation, and Reconciliation

i. *Medicaid Consumer Hotline Contractor*

1. The MCOP must provide ODM prior-approved MCOP materials and directories to the Medicaid Consumer Hotline contractor for distribution to eligible individuals who request additional information about the MCOP.

ii. *Monthly Remittance Advice*

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

iii. *Enrollment and Monthly Capitation Reconciliation*

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

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

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

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

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

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

iv. *Change in Member Circumstance*

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

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

v. *Termination of Enrollment*

1. The MCOP must comply with the MCOP termination of enrollment requirements in OAC rule 5160-58-02.1 and transition of care requirements applicable to a member's termination of MCOP enrollment as specified in Appendix D, Care Coordination.

2. As determined by ODM, the MCOP may be required to provide a defined period of continued enrollment and eligibility to members experiencing a loss of Medicaid or Medicare eligibility.

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

1. *General*

a. The MCOP must comply with change in enrollment requirements pursuant to OAC rule 5160-58-02.1.

2. *Responsibilities of Disenrolling MCOP*

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

b. The disenrolling MCOP must notify the hospital/inpatient facility that it will remain responsible for the inpatient facility charges through the date of

discharge and must notify the treating providers that it will remain responsible for provider charges through the date of disenrollment.

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

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

3. *Responsibilities of Enrolling MCOP*

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

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

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

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

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

f. If a member is admitted to a hospital prior to the first day of Medicaid eligibility and retroactive eligibility does not apply, the MCOP is responsible for reimbursement of the inpatient hospital claim for the days the member is enrolled in the MCOP. The days prior to Medicaid eligibility would be considered non-covered days, and the claim should be processed for payment based upon partial eligibility.

vii. *Just Cause Requests*

1. Pursuant to OAC rule 5160-58-02.1, the MCOP must assist in resolving member-initiated just cause disenrollment requests.

viii. *Eligible Individuals*

1. If an eligible individual contacts the MCOP, the MCOP must provide member-required, MCOP-specific, MyCare Ohio program information.

2. The MCOP must not attempt to assess the eligible individual's health care needs. However, if the eligible individual inquires about continuing/transitioning health care services, the MCOP must provide an assurance that all MCOPs must cover all medically necessary covered health care services and assist members with transitioning their health care services.

ix. *Pending Member*

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

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

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

x. *Direct Member Reimbursement*

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

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

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

f. MyCare Ohio Quarterly Enrollment Files

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

ii. Details regarding specifications for these enrollment files can be found in ODM's MyCare Ohio Plan Quarterly Enrollment Data File Specifications.

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

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

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

g. Notification of Voluntary Membership for Indians

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

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

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

3. Privacy Compliance Requirements

a. General

i. The MCOP must safeguard confidential information in accordance with state and federal requirements, including but not limited to: the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191); 45 CFR parts 160 and 164, 42 CFR 431, Subpart F; 42 CFR Part 2; 42 CFR Part 457; 42 CFR Part 438; and ORC sections 5101.26, 5101.27, and 5160.45 through 5160.481.

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

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

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

b. Data Security Agreement with Board of Pharmacy

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

c. Reporting of Disclosures

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

d. Mitigation Procedures

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

e. Incidental Costs

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

f. System Access Requests

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

4. Member Requirements

a. Health Equity

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

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

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

iv. The MCOP's health equity efforts must align with the requirements in Appendix C, Population Health and Quality.

v. The MCOP must participate in ODM's health equity initiatives as requested by ODM.

b. Member Information

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

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

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

iv. The MCOP must provide written information to members describing how to request language or disability accommodations and how to file a grievance with both the MCOP and the HHS Office of Civil Rights. The MCOP must comply with the following information requirements for eligible individuals and members, in accordance with applicable federal and state law, including 42 CFR 438.10 and OAC rules 5160-58-01.1, 5160-58-03.1, 5160-26-05, and 5160-26-05.1:

1. *Oral Interpretation*

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

2. *Written Translation*

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

3. *Written Materials*

    a. The MCOP must make written materials that are critical to obtaining services available to its members. Such materials include, at a minimum, marketing materials, HIPAA privacy notices, provider directories, member handbooks, care coordination materials provided to the member, grievance and appeal notices, denial and termination notices, and any other materials identified by ODM. Written material must be provided in a manner, format, and language that may be easily understood by individuals with limited English proficiency and those with cognitive impairments.

    b. The MCOP's written materials must include taglines to the extent required by federal law in the prevalent non-English languages, as identified by ODM, and in conspicuously visible font size (in at least 12-point font, Times New Roman or equivalent) explaining the availability of written translations or oral interpretation free of charge to understand the information provided. Upon receiving a request for written materials in a prevalent non-English language, the MCOP must translate written materials that are critical to obtaining services in the member's prevalent non-English language on a standing basis.

    c. The MCOP must make all written member materials available in alternative formats and provide auxiliary aids and services when requested or otherwise learning of the member's need at no expense to eligible individuals and members.

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

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

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

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

    f. The MCOP must ensure that all member materials are clearly legible (written materials in at least 12-point font, Times New Roman or equivalent) and use person-centered, trauma-informed, and easily understood language and format.

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

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

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

4. *MCOP Provider Requirements*

   a. The MCOP must educate providers through a variety of means (e.g., provider alerts, provider manual, provider website) about provider requirements to communicate with individuals with LEP and persons with disabilities and the resources available to help providers comply with those obligations.

   b. The MCOP must ensure that all providers understand and comply with provider communication requirements.

   c. The MCOP must ensure the statewide availability of providers and interpreters or translators to meet provider communication requirements for individuals with LEP and persons with disabilities.

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

   a. If, in accordance with OAC rules 5160-58-01.1 and 5160-26-05.1, the MCOP is financially responsible for providing oral translation, oral interpretation, or sign language services to members while receiving services from a network provider, the MCOP must give preference to contracting with local agencies to provide such services.

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

6. *Centralized Communication Database*

   a. The MCOP must develop a centralized database to record:

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

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

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

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

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

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

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

c. Member Rights

i. In accordance with 42 CFR 422, Subpart C, 42 CFR 438.100 and OAC rules 5160-58-01.1 and 5160-26-08.3, the MCOP must comply with all federal and state laws that pertain to member rights and ensure its employees and contractors adhere to such laws when furnishing services to its members under this Agreement.

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

d. Advance Directives

i. The MCOP must:

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

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

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

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

ii. The MCOP's policies concerning the implementation of those rights, including a clear and precise statement of any limitation regarding the implementation of advance directives as a matter of conscience;

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

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

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

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

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

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

e. MCOP Member and Family Advisory Council

i. The MCOP must convene a statewide MCOP Member and Family Advisory Council (council) at least quarterly and must develop a process for that committee to provide input to the governing board. The council must operate independently from Member and Family Advisory Councils formed for other lines of business and focus solely on the Next Generation MyCare Ohio program. The MCOP must offer meeting attendance in person, by phone, or by webinar.

ii. The MCOP must ensure that the council meets both the Medicaid managed care requirements in 42 CFR 438.110 and the Medicare D-SNP requirements in 42 CFR 422.107(f).

iii. The MCOP, through council support and activities, must engage members in such a way as to elicit meaningful input into the MCOP's population health and quality improvement (QI) strategies, and strengths and challenges with serving members. The MCOP must ensure that the composition of the council includes members, family members, and caregivers. Member composition on the council must be diverse and representative of the MCOP's current membership with respect to the members' race, ethnic background, primary language, age, disability, and health status; enrollment in the MyCare Ohio HCBS Waiver, dual benefit member, and Medicaid only member; members with disabilities; and members receiving HCBS and nursing facility services.

iv. The MCOP must offer and provide reasonable accommodations, interpreter services, and other resources as needed to support member, family member, and caregiver participation in council meetings and activities.

v. The MCOP must actively ensure the council's membership reflects the diversity of its enrolled population.

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

1. A list of attending members during the prior quarter for each council;
2. Meeting dates, agenda, and the minutes from each council meeting that occurred during the prior quarter;
3. Improvement recommendations developed by each council;
4. The MCOP's response to or implementation of the council's improvement recommendations; and
5. The MCOP's method for determining the council's membership reflects the diversity of the MCOP's enrolled population.

f. Ombudsman

i. The Ohio Office of the State Long-Term Care Ombudsman Program provides core ombudsman services to members, including outreach, member empowerment through education, complaint investigation, person-centered complaint resolution, and collects and reports casework data to CMS on a quarterly basis. Ombudsman representatives will be accessible to the MCOP Member and Family Advisory Council and other member advisory boards and will participate in all statewide stakeholder and oversight activities. The Ombudsman will maintain access to and will coordinate with CMS and ODM representatives responsible for oversight of this Agreement.

5. Grievance and Appeal System

a. General

i. The MCOP must develop and implement written policies and procedures for a grievance and appeal system for members.

1. For dual benefit members:

a. The MCOP must provide an integrated appeals and grievance system that processes grievances and appeals in compliance with 42 CFR 422.629 – 422.634 and OAC rule 5160-58-08.4. This includes:

i. Grievance and appeal systems that meet the standards described in 42 CFR 422.629;

ii. An integrated grievance process that complies with 42 CFR 422.630;

iii. A process for making integrated organization determinations consistent with 42 CFR 422.631;

iv. Continuation of benefits while an integrated reconsideration is pending consistent with 42 CFR 422.632;

v. A process for making integrated reconsiderations consistent with 42 CFR 422.633; and

vi. A process for effectuation of decisions consistent with 42 CFR 422.634.

b. For timeframes or notice requirement standards that are not consistent between 42 CFR 422.629-634 and OAC rule 5160-58-08.4, the MCOP must implement the standard(s) that is most advantageous to the dual benefit member.

2. For Medicaid only members, the MCOP must develop and implement written policies and procedures for a grievance and appeal system in compliance with the requirements of OAC rule 5160-58-08.4 and 42 CFR 438 Subpart F.

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

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

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

v. The MCOP must provide information about the MCOP’s grievance, appeal, and state hearing processes to all providers and subcontractors at the time they enter into a contract or written agreement.

vi. The MCOP is prohibited from delegating the appeal or grievance process to another entity unless prior approved by ODM.

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

b. <u>State Hearing Process</u>

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

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

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

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

    a. In this event, the MCOP must attempt to contact the member to initiate the MCOP appeal process unless the timeframe for a member to file an appeal with the MCOP has been exhausted in accordance with OAC rule 5160-58-08.4.

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

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

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

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

i. The MCOP must log and keep records of grievances, appeals, and state hearings documenting MCOP performance of all state and federal requirements (e.g., timely acknowledgement, continuation of benefits when applicable) and in accordance with 42 CFR 438.416 and 42 CFR 422.629 must include:

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

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

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

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

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

6. If applicable, the date of the resolution; and

7. If applicable, the date the MCOP notified the member of the resolution.

d. Grievance and Appeal System Reporting

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

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

6. Provider Requirements

a. Provider Training

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

ii. The MCOP must submit its Calendar of Provider and Subcontractor Required Training as specified in Appendix P, Chart of Deliverables, for ODM's review.

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

iv. The MCOP must represent, warrant, and certify to ODM that such provider and subcontractor training has occurred and provide a summary of the training completed and the number of providers and subcontractors that completed the training as specified in Appendix P, Chart of Deliverables.

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

b. Provider Feedback

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

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

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

c. Notification of MCOP Policy Changes

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

d. Provider Manual

i. The MCOP must customize, distribute, and maintain a provider manual specific to the MCOP program, using ODM-provided template and required model provider manual language.

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

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

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

e. Billing Guides

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

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

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

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

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

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

ii. The MCOP must provide ODM with updates to the pharmacy reference guide, that provides billing and other pharmacy-related information, as specified in Appendix P, Chart of Deliverables.

f. Additional Support for Independent Providers of Long-Term Services and Supports

i. In addition to the training, provider manual, and guidance documents above, the MCOP must develop desk aids or concise training materials in plain language specifically designed

for independent providers of long-term services and supports (LTSS) that provide instruction about how to enroll and contract with the MCOP and how to submit a claim.

ii. The MCOP must dedicate provider relations staff to provide support to independent LTSS providers.

g. Information for ODM-Designated Providers

i. The MCOP must share specific information with federally qualified health centers (FQHCs)/rural health clinics (RHCs), qualified family planning providers, hospitals, and if applicable, certified nurse midwives, certified nurse practitioners, and free-standing birth centers as defined in OAC rule 5160-18-01 member utilization information. The information must be shared within the first month after the MCOP has been awarded a Medicaid provider agreement and annually thereafter.

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

a. The information's purpose;

b. Claims submission information, including the MCOP's Medicaid provider number (this information must only be provided to out-of-network FQHCs/RHCs, qualified family planning providers, certified nurse midwives, certified nurse practitioners, and hospitals). Claims submission information must include 30 calendar day advance notice to providers of any new edits or system changes related to claims adjudication or payment key processing;

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

d. A picture of the MCOP ID card (front and back) for dual benefit members and for Medicaid only members;

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

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

h. Provider Claim Dispute Resolution

i. *Provider Claim Dispute Resolution Process*

1. Provider claim disputes are any provider inquiries, complaints, or requests for reconsiderations ranging from general questions about a claim to a provider disagreeing with a claim denial. While these disputes can come in through any avenue (e.g., provider services call center, provider advocates, MCOP's provider portal), they do not include inquiries that come through ODM's ProviderWeb portal (HealthTrack).

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

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

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

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

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

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

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

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

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

    g. Resolve and provide written notice to the provider of the disposition of all claim disputes, except for claim disputes resulting from the MCOP's decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity, within 15 business days of receipt of the dispute. Written notice is not required if the claim dispute was resolved with an initial phone call or in-person contact;

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

    i. When required, the written notice must include:

        i. The nature of the dispute;

ii. The claim dispute tracking number;

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

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

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

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

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

ii. *Provider Claim Dispute Resolution Tracking and Reporting*

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

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

    b. Upon request, the MCOP must submit any system documentation and additional data requests to ODM within seven business days.

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

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

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

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

        i. Dispute category;

        ii. Claim number;

        iii. Received date;

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

v. Provider type; and

vi. Resolution date.

i. External Medical Review

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

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

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

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

ii. Decisions subject to external medical review include an adverse benefit determination in response to a service authorization request or claim payment denial due to lack of medical necessity. Service authorization requests and claim payments that are denied for reasons other than lack of medical necessity and for which no clinical review was completed by the MCOP are not subject to external medical review.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

xi. For reversed decisions associated solely with provider payment (i.e., the service was already provided to the member), the MCOP must pay for the disputed services within the

timeframes established for claims payment in Appendix L, Payment and Financial Performance.

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

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

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

j. Provider Web Portal Complaints

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

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

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

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

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

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

ii. A call reference number if applicable;

iii. The method(s) of contact;

iv. The person that made the contact; and

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

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

a. Provider contact must include:

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

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

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

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

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

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

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

ii. The method or methods of contact;

iii. The name of the individual or individuals contacted;

iv. The findings shared with the provider;

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

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

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

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

ii. Document the MCOP's outreach to the provider in HealthTrack, including the date of the provider contact, the name(s) of the individual(s) contacted, the requested extension date, and the justification for the delay in resolution.

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

k. Provider Advisory Council

i. The MCOP must establish a provider advisory council.

ii. The MCOP must hold provider advisory council meetings no less than on a semi-annual basis. The MCOP must offer meeting attendance in person, by phone, or by webinar.

iii. The MCOP must ensure that the provider advisory council is composed of a wide array of provider types.

iv. The purpose of the provider advisory council is for the MCOP to gather input, discuss and learn about issues affecting providers, identify challenges and barriers, problem-solve, share information, and collectively find ways to improve and strengthen the health care service delivery system.

v. The MCOP's provider advisory council must be chaired by the MCOP's Administrator/Chief Executive Officer (CEO)/Chief Operating Officer (COO) or designee.

vi. The MCOP must invite ODM to attend provider advisory council meetings and provide an agenda to ODM in advance of the meetings.

vii. The MCOP must report on its provider advisory council activities (Provider Advisory Council Activity Report) as specified in Appendix P, Chart of Deliverables, including meeting dates, provider advisory council attendees, provider advisory council recommendations, and MCOP responses or follow-up activities to provider advisory council recommendations.

7. Call Center Requirements

a. General

i. The MCOP must ensure access to medical advice, behavioral health crisis, care management support, and prior authorization, coverage determination and appeals services through centralized, toll-free 24 hour, seven days a week (24/7) call-in systems available nationwide.

ii. The MCOP must ensure its call center systems have the capabilities to meet all performance and reporting requirements as specified in this Agreement.

iii. The MCOP must maintain a log for the 24/7 call center systems that include at a minimum the:

1. Identification of the caller and the member;
2. Date and time of call;
3. Reason for and disposition of the call;
4. PCP or another provider relevant to the call; and
5. Name and title of person taking the call.

iv. The MCOP's call center systems must have services or capabilities available to assist individuals with communication needs and disabilities, including individuals with hearing impairments and individuals with limited English proficiency.

v. The MCOP must ensure that call center staff are knowledgeable about the MyCare Ohio program and have appropriate access to information pertaining to MyCare Ohio membership (e.g., membership status, covered benefits, provider network, person-centered care plans, etc.).

vi. The MCOP must implement procedures to ensure emergent issues are identified and assigned the highest priority.

vii. The MCOP must meet the call center standards as identified below. If access to call center systems is facilitated through a single call center service line with auto-prompts to transfer the caller, the MCOP must have a process to measure call center standards from the time of selecting the auto prompt. If the MCOP uses the member services line to answer all call center contacts (i.e., the MCOP does not offer an auto prompt to transfer), then call center standards for member services apply. ODM will inform the MCOP of any changes to call center standards.

viii. The MCOP must report the MCOP's performance in meeting the call center standards identified below for its medical advice line; behavioral health crisis line; care management support services line; prior authorization, coverage determinations, and appeals call center line; member services line; provider services line; and pharmacy technical health call center line by submitting a MyCare Call Center Report to ODM as specified in Appendix P, Chart of Deliverables. The MCOP must report call center performance standards more frequently if required by ODM.

ix. The MCOP must use information from its call center systems and interactions to inform improvements to the MCOP's operations and service delivery system.

b. Medical Advice, Behavioral Health Crisis, and Care Management Support Services

i. The MCOP must ensure 24/7 call-in access for medical advice, behavioral health crisis, and care management support services. The MCOP's call center systems for medical advice, behavioral health crisis, and care management support services must be staffed by appropriately qualified medical and behavioral health professionals whose scope of practice and licensure permits them to perform the required functions associated with the services.

ii. The MCOP must ensure an appropriately qualified health professional is the caller's first point of live contact to answer the call, triage the issue, and determine an immediate course of action (e.g., warm transfer to care manager or local behavioral health crisis services, provide intervention, or offer medical advice). The MCOP must not require members to contact their PCP or any other entity prior to contacting the 24/7 call center systems for advice or direction concerning emergency or after-hours services. The MCOP must only use one auto-prompt to get the caller to a live contact.

iii. *Medical Advice Line*

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

2. The MCOP must meet the current Utilization Review Accreditation Commission (URAC) health call center standards for call center abandonment rate, blockage rate, and average speed of answer for its medical advice line.

iv. *Behavioral Health Crisis*

1. The MCOP must have an after-hours system to route emergent and crisis behavioral health calls directly to Ohio Department of Mental Health and Addiction Services' (OMHAS') statewide crisis line, 988, outside of the MCOP's member services hours of operation.

2. The MCOP must meet the current Accreditation Commission for Health Care (ACHC) health call center standards for call center abandonment rate, blockage rate, and average speed of answer for its behavioral health crisis call-in system.

v. *Care Management Support Services*

1. For the purposes of meeting the requirement for care management support services, the calls must be answered and/or forwarded to the member's MCOP care manager or other team members designated to act on behalf of the care manager.

2. The MCOP must ensure if a care manager designee is used the designee is an appropriately trained, qualified health professional who is able to access the member's records, assess the member's issues, and provide an appropriate course of action (e.g., medical advice, direct the member to an appropriate care setting, referral to a member of the Trans-Disciplinary Care team).

3. The MCOP must ensure that the care manager or designee has access to, and is familiar with, the member's person-centered care plan.

4. The MCOP must ensure the member's health, welfare, and safety is considered when determining the resolution and completion timeframe, including the provision of in-person support if warranted.

5. The MCOP must meet the current ACHC/URAC health call center standards for call center abandonment rate, blockage rate, and average speed of answer for its care management support services call-in system.

c. Prior Authorization, Coverage Determinations, and Appeals Call Center Requirements

i. The MCOP must ensure that its 24/7 call-in systems for prior authorization, coverage determinations, and appeals provides access to live customer service representatives available to respond to providers or members for information related to requests for covered benefits, services, and appeals during the normal business hours of 8:00 am to 8:00 pm Eastern Time, Monday through Friday. Normal business hours do not include Saturdays, Sundays, and federal holidays, with the exception of New Year's Day, Martin Luther King Jr. Day, and President's Day.

ii. The MCOP must accept requests for covered benefits, services, and appeals outside of normal business hours, but is not required to have live customer service representatives available to accept such requests outside normal business hours. The MCOP must allow providers and members to submit prior authorization requests electronically. The MCOP may use voicemail outside of normal business hours provided the message:

1. Indicates that the mailbox is secure;

2. Lists the information that must be provided so the request can be processed (e.g., provider identification, member identification, type of request [coverage determination or appeal], physician support for an exception request, and whether the member or provider is making an expedited or standard request);

3. For coverage determination calls (including exceptions requests) related to Part D or Medicaid covered drugs, articulates and follows a process for resolution within twenty-four (24) hours of calls for expedited and standard requests; and

4. For appeals calls related to Part D or Medicaid covered drugs, articulates the process information needed and provides for a resolution within 72 hours for expedited appeal requests and seven calendar days for standard appeal requests.

iii. The MCOP must meet the current URAC health call center standards for call center abandonment rate, blockage rate, and average speed of answer for its call-in systems for prior authorization, coverage determinations, and appeals call centers.

d. Member Services Call Center

i. *Member Services Hours of Operation*

1. The MCOP must ensure its member services call center and member services staff are available nationwide to provide assistance to members through a toll-free call-in system during the normal business hours of 8:00 am to 8:00 pm Eastern Time, Monday through Friday.

2. The MCOP may use alternative call center technologies on Saturdays, Sundays, and federal holidays with the exception of New Year's Day, Martin Luther King Jr. Day, and President's Day so long as the interactive voice response (IVR) system or similar technology records messages from incoming callers and such messages are returned within one business day. For the federal holiday exceptions identified above, the MCOP must ensure its member services call center and member services staff are available during normal business hours.

3. The MCOP must specify member services closure days in the MCOP's member handbooks, member newsletter, or other written communication to MCOP members and on the MCOP's website at least 30 calendar days in advance of the closure.

ii. *Member Services Telephone System*

1. The MCOP's member services telephone system must have services or capabilities available to assist:

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

b. Members and eligible individuals using auxiliary aids and services, including TTYs and all forms of Federal Communication Commission-approved telecommunications relay systems, when using automated-attendant systems; and

c. Members and eligible individuals with limited English proficiency in the primary language of the member.

2. The MCOP must have the capability for ODM or its designee to monitor calls remotely.

3. The MCOP must have the capability to capture "audio signatures" for any required forms or requests that require the member's/prospective member's signature.

4. The MCOP must measure and monitor the accuracy of responses provided by MCOP member services staff and take corrective action as necessary to ensure the accuracy of responses by staff.

iii. *Member Services Representatives*

1. The MCOP must maintain employment standards and requirements (e.g., education, training, and experience) for member services staff and provide a sufficient number of staff to meet ODM's and the MCOP's defined performance objectives.

2. The MCOP must employ and train member services representatives (MSRs) to perform member services responsibilities to assist members and eligible individuals consistent with the requirements of 42 CFR 422.111(h) and 423.128(d).

3. The MCOP must ensure MSRs understand and demonstrate sensitivity to cultural needs, including the disability culture and independent living philosophy.

4. The MCOP must ensure MSRs are trained to address the needs of callers who are hard of hearing, have limited English proficiency, and/or require auxiliary aids and services, including TTYs and all forms of Federal Communication Commission-approved telecommunications relay systems.

5. The MCOP must ensure MSRs are able to effectively and efficiently access and navigate member services systems, including the MCOP's member database and electronic provider directory, to assist callers.

iv. *Member Services Responsibilities*

1. The MCOP must develop and implement member services call center policies and procedures that address staffing; training; hours of operation; performance standards; transfer and referral protocols, including referrals from all sources; monitoring of calls via recording or other means; translation/interpretation; and compliance with call center standards.

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

a. Understanding the requirements and benefits of the MCOP;

b. Understanding the benefits of having the same MyCare plan for Medicare and Medicaid;

c. Resolving concerns, questions, and problems;

d. Assisting members and eligible individuals with cognitive impairments to ensure written materials are understood (e.g., provide and explain written materials in simple, clear, and understandable language);

e. Providing a means to identify disability and communication needs for the MCOP to ensure the member's reasonable accommodation and communication needs are addressed;

f. Assisting members and eligible individuals to access oral interpretation services and written materials in prevalent languages and alternative formats free of charge;

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

h. Accessing covered services and other available services or resources, including whether any service may be obtained directly or through referral or prior authorization;

i. Assisting with the identification, location, qualification, and availability of providers;

j. Obtaining or understanding information about the MCOP's policies and procedures;

k. Assisting members to understand their rights and responsibilities;

l. Informing members about the procedures to change MCOPs or to choose to receive their Medicare benefits through another Medicare payer;

m. Informing and assisting members with the procedures of filing grievances and appeals as specified in OAC rule 5160-58-08.4, 42 CFR 422.629-634, and 42 CFR 438 Subpart F;

n. Obtaining information about state hearing rights;

o. 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; and

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

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

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

b. Notify each dual benefit member with an MCOP-assigned PCP of the ability within the first month of initial MCOP membership to change the MCOP-selected PCP effective on the date of contact with the MCOP;

c. Explain to dual benefit members that PCP change requests after the initial month of MCOP membership must be processed according to the procedures outlined in the MCOP member handbook for dual benefit members; and

d. Encourage Medicaid only members enrolled in another Medicare Advantage plan to reach out to their Medicare Advantage plan regarding the network status of the PCP.

v. *Member Services Call Center Performance Standards*

1. The MCOP must meet or exceed the following call center standards for its member services call center:

   a. 90% of calls answered within 30 seconds after the interactive voice response (IVR) system, touch-tone response system, or recorded greeting interaction, before reaching a live person;

   b. Disconnect rate not to exceed 5%. The disconnect rate is defined as the number of calls unexpectedly dropped divided by the total number of calls made to the member services call center;

   c. Hold time not to exceed 30 seconds. Hold time is defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system, or recorded greeting, before reaching a live person;

   d. Availability of interpreters for 80% of incoming calls requiring an interpreter within eight minutes of reaching the MSR at no cost to the caller;

   e. Connection of 80% of incoming calls requiring TTY services to a TTY operator within seven minutes;

   f. All inquiries that require a call back returned within one business day of receipt; and

   g. A minimum 70% of all calls resolved during the first call.

2. The MCOP must have a process to measure the time from when the call is answered to the point at which a member reaches a MSR capable of responding to the member's question in a manner that is sensitive to the member's language and cultural needs.

3. The MCOP must comply with any changes or updates to ACHC and/or URAC call center standards that result in more stringent member services call center performance standards.

e. Provider Services Call Center

i. *General*

1. The MCOP must comply with provider services requirements pursuant to OAC rules 5160-58-01.1 and 5160-26-05.1.

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

ii. *Provider Services Hours of Operation*

1. The MCOP must ensure its provider services call center and provider services staff are available nationwide to provide assistance to providers through a toll-free call-in system during the normal business hours of 8:00 am to 8:00 pm Eastern Time, Monday through Friday.

2. The MCOP may use alternative call center technologies on Saturdays, Sundays, and federal holidays with the exception of New Year's Day, Martin Luther King Jr. Day, and President's Day so long as the interactive voice response (IVR) system or similar technology records messages from incoming callers and such messages are returned within one business day. For the federal holiday exceptions identified above, the MCOP must ensure its provider services call center and provider services staff are available during normal business hours.

iii. *Provider Services Call Center Performance Standards*

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

a. 90% of calls answered within 30 seconds after the interactive voice response (IVR) system, touch-tone response system, or recorded greeting interaction, before reaching a live person;

b. Disconnect rate not to exceed 5%. The disconnect rate is defined as the number of calls unexpectedly dropped divided by the total number of calls made to the provider services call center;

c. Hold time not to exceed 30 seconds. Hold time is defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system, or recorded greeting, before reaching a live person;

d. Availability of interpreters for 80% of incoming calls requiring an interpreter within eight minutes of reaching the provider services call center representative at no cost to the caller;

e. Connection of 80% of incoming calls requiring TTY services to a TTY operator within seven minutes;

f. All inquiries that require a call back must be returned within one business day of receipt; and

g. A minimum 70% of all calls to the provider services call center are resolved during the first call.

2. The MCOP must have a separate telephone line and phone number for its provider services call center under this Agreement.

3. The MCOP must comply with any changes or updates to ACHC and/or URAC call center standards that result in more stringent provider services call center performance standards.

iv. *Provider Representatives*

1. The MCOP must designate provider representatives with the training and knowledge to promptly and accurately respond to inquiries and resolve problems raised by providers of all types and in all areas of the state.

f. Pharmacy Technical Health Call Center

i. The MCOP must operate a centralized 24 hours per day, seven days a week (24/7) toll-free call-in system, available nationwide to respond to inquiries from pharmacies and providers regarding members' prescription drug benefits. Inquiries may pertain to operational areas such as claims processing, benefit coverage, claims submissions, and claims payment. During non-business hours, this requirement may be met through the use of on-call pharmacists or by contracting with the MCOP's pharmacy benefit manager as long as the individual answering the call is able to address the call at that time.

ii. The MCOP must meet the current ACHC health call center standards for call center abandonment rate, blockage rate, and average speed of answer for its pharmacy technical health call center.

8. MCOP Website Requirements

a. General

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

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

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

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

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

vi. The MCOP must indicate it is responsible for serving the entire state, identify the counties the MCOP is actively serving, and provide information about service expansion to remaining counties, consistent with requirements in the Introduction section of this Agreement.

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

viii. The MCOP's website must have a link to ODM's Preferred Drug List, a link to the MCOP's PBM's website as applicable, and provide information about how members can access pharmacy services, including how to request prior authorization, how to access the pharmacy provider directory, and the MCOP's PBM's toll-free member services call center as applicable.

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

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

xi. The MCOP must include additional information on its website as determined necessary by ODM.

b. Online Member Website

i. *Member Information*

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

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

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

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

c. The ODM-approved MCOP member handbooks, MyCare Ohio HCBS waiver handbook, self-direction member handbook, Quick Guide, recent newsletters, and announcements:

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

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

e. The MCOP's internet-based provider directory;

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

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

    i. Change of address (County);

    ii. Grievance and appeal forms;

    iii. Change of PCP;

    iv. Authorized representative;

    v. Advanced Directive; and

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

h. A list of services requiring prior authorization;

i. A 30-calendar days' advance notice of changes to the list of all services requiring prior authorization, as well as the ODM's Preferred Drug List and list of drugs requiring PA;

    i. The MCOP must provide a hard copy of the notification of any prior authorization changes upon request.

j. The toll-free telephone numbers for the 24/7 MCOP call centers available to members specified in this appendix;

k. A statement that the MCOP does not discriminate on the basis of race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, ancestry, genetic information, health status, or need for health services in the receipt of health services; and

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

3. The MCOP must ensure that toll-free 24/7 call-in systems; statewide and local behavioral health crisis response lines; member and provider services call centers; and transportation scheduling telephone numbers are easily identified on either the

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

ii. *Secure Member Portal*

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

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

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

    c. For dual benefit members, request a change in PCP; and

    d. Access the following information:

        i. Member's Medicaid redetermination date;

        ii. Authorized services;

        iii. A copy of the MCOP's Authorized Representative request form;

        iv. The member's current PCP for dual benefit members;

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

        vi. Explanation of benefits;

        vii. Community resources; and

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

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

3. The MCOP must offer members the option to "opt in" to receive information from the MCOP via email or text message.

c. Online Provider Website

i. *Secure Provider Portal*

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

    a. Access relevant member information to:

        i. View member eligibility and enrollment;

ii. View whether a member is a dual benefits member or a Medicaid only member, specifically using those terms;

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

iv. Access claims and utilization history.

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

c. Submit and receive responses to prior authorization requests (an email process is an acceptable substitute if the website includes the MCOP's email address for such submissions).

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

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

ii. *Publicly-Available Provider Page*

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

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

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

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

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

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

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

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

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

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

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

i. Links to MyCare Ohio requirements in the Ohio Administrative Code and Ohio Revised Code.

9. Staffing Requirements

a. General Requirements

i. The MCOP must employ the identified qualified key and organizational staff, sufficient in number, to meet performance and compliance expectations as set forth in this Agreement. The MCOP must establish and maintain the interdepartmental structures and processes to support the operation and management of its MyCare Ohio line of business in a manner that fosters integration of physical health, behavioral health, and LTSS services and the integration of Medicare and Medicaid services for dual benefit members.

ii. The MCOP must provide ODM with an MCOP Organizational and Functional Chart that identifies key staff, organizational staff and reporting lines as specified in Appendix P, Chart of Deliverables. The MCOP must submit the organizational chart to ODM on an annual, and ad hoc basis when changes occur, or as directed by ODM and include senior and mid-level managers for the MCOP.

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

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

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

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

b. Key Staffing Requirements

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

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

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

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

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

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

c. Key Staff

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

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

ii. *Medical Director/Chief Medical Officer*

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

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

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

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

c. Developing, implementing, and interpreting medical policies and procedures, including service authorization, claims review, discharge planning, and medical reviews performed through the MCOP's grievance and appeal system;

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

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

iii. *Chief Financial Officer*

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

iv. *LTSS Director*

1. The LTSS Director must be an Ohio licensed nurse, Licensed Independent Social Worker (LISW); or have a Master's degree in a health-related field. The LTSS Director must have at least five years of experience in home- and community-based services.

2. The primary functions of the LTSS Director include but are not limited to:

a. Implementing and overseeing all clinical management functions for members receiving LTSS, including but not limited to assessments; service planning; care coordination; transition planning; member appeals and state hearings; and member and caregiver education and training;

b. Implementing and overseeing all provider management functions for providers of LTSS services including but not limited to: (i) provider enrollment, orientations and monitoring and (ii) operation of an incident management, investigation and response system; and

c. Implementing and overseeing all program management functions including but not limited to:

i. Compliance with program requirements, rules, and regulations;

ii. Implementation and management of program policies and procedures and protocols that are aligned with federal and state requirements;

iii. Member grievance process; and

iv. Community education.

v. *Behavioral Health Administrative Director*

1. The Behavioral Health Administrative Director must possess an independent, current, and unrestricted Ohio license to provide behavioral health services in the state of Ohio (medical doctor, doctor of osteopathic, registered nurse with advance practice registered nurse [APRN] licensure, psychologist, licensed independent social worker [LISW], professional clinical counselor [PCC], independent marriage and family therapist) with a minimum of five years of experience in the provision and supervision of treatment service for mental illness and substance use disorders. The Behavioral Health Administrative Director must demonstrate knowledge and understanding of Ohio's overall behavioral health system that includes mental health, alcohol and drug addiction, and developmental disabilities services. The responsibilities of the Behavioral Health Administrative Director include but are not limited to:

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

    b. Ensuring access to behavioral health services;

    c. Ensuring overall integration of behavioral health services in the MCOP member treatment plans;

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

    e. Promoting preventive behavioral health strategies;

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

    g. Participating in management and program improvement activities with other key staff for enhanced integration with primary care and coordination of behavioral health services and achievement of outcomes; and

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

vi. *Behavioral Health Clinical Director*

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

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

Behavioral Health Clinical Director must have expertise in behavioral health activities and QI projects.

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

    a. Play a lead role in monitoring the overall safety of members with a behavioral health, with a special focus on safe prescribing of psychotropic medications as well as all controlled substances;

    b. Have expertise in the care of individuals with substance use disorders, including the American Society of Addiction Medicine levels of care;

    c. Serve as a key clinical lead in developing and implementing evidence-based clinical policies and practices at both the MCOP and the clinical practice levels. This will necessarily require the integration of relevant pharmacy and social data to inform clinical policies and practices;

    d. Participate in regulatory/accreditation reviews; and

    e. Assume key roles in quality improvement initiatives, care management activities, and member safety activities (e.g., incident management).

4. Other duties and responsibilities of the Behavioral Health Clinical Director staff must include:

    a. Overseeing utilization management of behavioral health services to ensure members receiving timely, appropriate, and medically necessary behavioral health care in the most cost-effective setting;

    b. Engaging in oversight and quality improvement activities associated with care management activities;

    c. Providing guidance to behavioral health network development and recruitment in conjunction with provider relations, value-based contracting, support of episodes of care, and full integration of behavioral health services;

    d. Assisting in the review of utilization data to identify variances in patterns, and providing feedback and education to MCOP staff and providers as appropriate;

    e. Representing the MCOP as the behavioral health clinical liaison to members, providers, and ODM; and

    f. Ensuring whole person care by fully integrating physical and behavioral health throughout the care continuum and actively managing transitions of care.

vii. *Pharmacy Director*

1. The MCOP must have a Pharmacy Director who is a registered pharmacist in the state of Ohio with experience in state and federally funded health care programs, preferably with pharmacy benefit management experience.

2. The primary roles and responsibilities of the Pharmacy Director include:

    a. Overseeing the MCOP's responsibilities related to pharmacy benefits;

    b. Coordinating with the MCOP's PBM;

    c. Coordinating with ODM to provide input in the review of new drugs to market, changes to ODM's Preferred Drug List, and ODM's prior authorization criteria for pharmacy benefits;

    d. Overseeing the MCOP's medication therapy management programs;

    e. Monitoring, managing, and coordinating the care of the MCOP's members as it relates to utilization of prescription drugs; and

    f. Participating in ODM's Pharmacy and Therapeutics Committee, the Drug Utilization Review Committee, the Drug Utilization Review Board, and any other committee or board as requested by ODM.

viii. *Population Health Director*

1. The Population Health Director must:

    a. Hold a master's degree or other advanced degree in nursing, social work, health services research, health policy, information technology, or other relevant field;

    b. Have at least five years of progressively responsible professional experience in population health, service coordination, ambulatory care, community public health, case or care management, or coordinating care across multiple settings and with multiple providers; and

    c. Report directly to the MCOP's Medical Director/CMO or Administrator/CEO/COO.

2. The primary roles and responsibilities of the Population Health Director are to:

    a. Oversee the MCOP's strategic design, implementation, and evaluation of population health initiatives based on a deep understanding of scientific population health principles;

    b. Sponsor and champion MCOP and system-wide initiatives, including cultivating the support necessary to achieve the desired operational objectives for each initiative;

c. Liaison with ODM and other ODM-contracted managed care entities on population health activities; and

d. Develop and implement operational plans that address the market opportunities/challenges and align with the established population health goals.

ix. *Health Equity Director*

1. The Health Equity Director must:

a. Hold at least a bachelor's degree from a recognized college or university and a minimum of five years professional work experience, preferably in public health, social/human services, social work, public policy, health care, education, community development, or justice;

b. Have demonstrated community and stakeholder engagement experience; and

c. Have experience in actively applying or overseeing the application of science-based quality improvement methods to reduce health disparities.

2. The primary roles and responsibilities of the Health Equity Director are to:

a. In close coordination with the Population Health Director, oversee the MCOP's strategic design, implementation, and evaluation of health equity efforts in the context of the MCOP's population health initiatives;

b. Inform decision-making around best payer practices related to disparity reductions, including the provision of health equity and social determinant of health resources and research to leadership and programmatic areas;

c. Inform decision-making regarding best payer practices related to disparity reductions, including providing MCOP teams with relevant and applicable resources and research and ensuring that the perspectives of members with disparate outcomes are incorporated into the tailoring of intervention strategies;

d. Collaborate with the MCOP's Chief Information Officer to ensure the MCOP collects and meaningfully uses race, ethnicity, and language data to identify disparities;

e. Coordinate and collaborate with members, providers, local and state government, community-based organizations, ODM, and other ODM-contracted managed care entities to impact health disparities at a population level; and

f. Ensure that efforts addressed at improving health equity, reducing disparities, and improving cultural competence are designed collaboratively with other ODM-contracted managed care entities to have a collective

impact for the population and that lessons learned are incorporated into future decision-making.

x. *Quality Improvement Director*

1. The QI Director must:

    a. Be an Ohio-licensed RN, physician, or physician's assistant, or be certified as a Certified Professional in Health Care Quality (CPHQ) by the National Association for Healthcare Quality (NAHQ), Certified QI Associate by the American Society for Quality, and/or Certified in Health Care Quality and Management (CHCQM) by the American Board of Quality Assurance and Utilization Review Providers prior to employment or within six months of the date of hire;

    b. Have experience in quality management and quality improvement as specified in 42 CFR 438.206 through 438.370; and

    c. Report directly to the Medical Director/CMO.

2. The primary functions of the QI Director are to:

    a. Develop and manage the MCOP's portfolio of improvement projects, including ensuring impact at a population level and identifying and prioritizing initiatives to align with ODM's Quality Strategy;

    b. Oversee MCOP improvement teams and coordinate QI training for MCOP staff;

    c. Reinforce the application of QI tools and methods within MCOP improvement projects and initiatives; and

    d. Ensure that learning from all improvement projects and initiatives are shared with ODM and ODM's contracted managed care entities.

    e. The QI Director must also be responsible for:

        i. Overseeing all QI activities related to members, ensuring compliance with all such activities, and maintaining accountability for the execution of, and performance in, all such activities;

        ii. Maintaining an active role in the MCOP’s overall QI structure;

        iii. Ensuring availability of staff with appropriate expertise in all areas, as necessary for the execution of QI activities including, but not limited to, the following:

            1. Physical and behavioral health care;

            2. Pharmacy management;

            3. Care management;

4. Long-term services and supports;
5. Financial;
6. Statistical/analytical; and
7. Information systems.

xi. *Care Coordination Director*

1. The Care Coordination Director must be an Ohio-licensed RN or an Ohio-licensed independent social worker in good standing, preferably with a designation as a Certified Case Manager from the Commission for Case Manager Certification. The Care Coordination Director must have experience in the activities of care management as specified in 42 CFR 438.208. The Care Coordination Director must report through the Medical Director/CMO.
2. The primary functions of the Care Coordination Director position are to:
    a. Oversee the day-to-day operational activities of the Care Coordination Program in accordance with state guidelines. The Care Coordination Director is responsible for ensuring the functioning of care coordination activities across the continuum of care (assessing, planning, implementing, coordinating, monitoring, and evaluating);
    b. Implement mechanisms for identifying, assessing, and developing treatment plans for members with special health care needs;
    c. Ensure access to primary care, behavioral health, LTSS, and coordination of health care services for all members;
    d. Ensure continuity of care for member transitions of care as specified in Appendix D, Care Coordination;
    e. Develop and implement processes and resources for providing support to non-MyCare Ohio HCBS Waiver members who opt out of care coordination;
    f. Coordinate services furnished to the member with the services the member receives from any other health care entity;
    g. Ensure care coordination and disease management is part of population health and QI activities, when appropriate;
    h. Ensure that all care coordination staff, including waiver service coordinators, meet initial and ongoing training requirements;
    i. Ensure that care coordination staff and waiver service coordinators meet conflict-free care management standards; and
    j. Ensure care coordination caseload ratios meet minimum ODM requirements.

xii. *Utilization Management Director*

1. The Utilization Management Director must:

    a. Be an Ohio-licensed registered nurse or a physician with a current unencumbered license through the Ohio State Medical Board with experience in the activities of utilization management, in accordance with 42 CFR 438.210;

    b. Preferably be certified as a Certified Professional in Health Care Quality by the NAHQ and/or CHCQM by the American Board of Quality Assurance and Utilization Review Providers; and

    c. Report through the Medical Director/CMO.

2. The Utilization Management Director's primary responsibilities are to:

    a. Oversee the day-to-day operational activities of the Utilization Management Program in accordance with state guidelines;

    b. Develop written policies and procedures regarding authorization of services and monitor to ensure that these are followed;

    c. Ensure the consistent application of review criteria for authorization decisions;

    d. Ensure that decisions to deny or reduce the amount of services are made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease;

    e. Ensure MCOP Notices of Adverse Action are provided in accordance with 42 CFR 438.404;

    f. Ensure that all authorization decisions are made within the specified allowable timeframes; and

    g. Evaluate under and over utilization information for impact on member quality of care and outcomes, including access to care.

xiii. *Network Development Director*

1. The Network Development Director is responsible for network development, network sufficiency, and network reporting functions. This position ensures network adequacy and appointment access, develops network resources in response to identified unmet needs and oversees network provider workforce development activities.

xiv. *Provider Services Director*

1. The Provider Services Director acts as the primary point of accountability to ODM to address escalated provider issues.

2. The primary functions of the Provider Services Director are to:

    a. Meet provider services requirements under this Agreement;

    b. Supply provider education and develop and deliver provider training;

    c. Ensure that network providers impacted by population health initiatives, such as QI projects, are included on project teams to identify provider perceived barriers and provide input on design and intervention test that may impact providers;

    d. Ensure that network provider perspectives and feedback are included in evaluations of improvement initiative successes;

    e. Collaborate with other ODM-contracted managed care entities to simplify provider requirements and remove administrative barriers; and

    f. Develop and implement the MCOP's provider claim dispute resolution process as described in this appendix.

xv. *Claims and Encounter Administrator*

1. The Claims and Encounter Administrator is responsible for:

2. Ensuring prompt and accurate provider claims processing and that encounter reporting requirements are met. Sufficient staffing under this position must be in place to ensure the timely and accurate processing of original claims, resubmissions, and overall adjudication of claims and the submission of timely, accurate, and complete encounter data to ODM. The primary functions of the Claims and Encounter Administrator are to:

    a. Develop and implement claims processing systems capable of paying claims in accordance with state and federal requirements;

    b. Develop processes for cost avoidance;

    c. Ensure minimization of claims recoupments; and

    d. Ensure claims processing timelines and encounter reporting requirements are met.

xvi. *Chief Information Officer*

1. The Chief Information Officer (CIO) must be fully dedicated to the work under this Agreement and authorized to prioritize change orders and allocate the resources necessary to develop and maintain an information system that meets the performance expectations under this Agreement.

2. The CIO must have the necessary training and experience in information systems, data processing, and data reporting to oversee all information systems functions supporting this Agreement.

3. The primary functions of the CIO are to:

    a. Ensure that multiple MCOP data systems are able to connect and coordinate so that fields housed in one system (e.g., updated contact information) can readily inform other systems;

    b. Ensure that information related to data systems, analytical methods, and analysis results is communicated in a way that allows optimal usage by all MCOP programmatic areas;

    c. Ensure that program areas are aware of, and understand how to use data resources (e.g., files received from ODM, health information exchanges, electronic health records, and data from MCOP contractors) and integrate those resources with programmatic data when necessary;

    d. Ensure that member and provider facing websites and portals are easily navigable by the general public, members, and providers by obtaining and incorporating feedback from these stakeholders;

    e. Ensure that information technology projects are implemented timely and correctly, as specified by ODM;

    f. Coordinate with other ODM-contracted managed care entities and ODM to create a seamless view of the Ohio Medicaid interface with the public, members, and providers, resulting in all members interacting with Ohio Medicaid having a uniform way to access information; and

    g. Support program areas to integrate information contained within multiple data systems for use in improvement activities.

xvii. *Grievance and Appeal Director*

1. The primary functions of the Grievance and Appeal Director are to:

    a. Establish and implement a grievance and appeals system pursuant to OAC rule 5160-58-08.4 and in accordance with 42 CFR Part 438, Subpart F and 42 CFR 422.630 – 422.634;

    b. Ensure the MCOP's grievance and appeals system functions in two ways:

        i. As an essential process to remediate member access to care and quality concerns; and

        ii. As a source of information that serves as indicators of health care system issues and concerns.

    c. Share and review grievance and appeal system data with other operational areas, such as population health/quality management, utilization management, network management, member services, and program integrity to collectively develop and monitor interventions to correct system deficiencies.

xviii. *Member Services Director*

1. The Member Services Director is responsible for coordinating communications with members, resolving member inquiries and problems, and meeting member service requirements as required in this Agreement. The Member Services Director must also:

    a. Ensure that members impacted by population health initiatives, such as QI projects, are included on the project team to identify member perceived barriers and to assist with the design and testing of interventions impacting members;

    b. Ensure that member perspectives and feedback are included in evaluations of improvement initiative success; and

    c. Ensure that pertinent knowledge obtained through the MCOP's population health improvement initiatives is incorporated into member services.

xix. *Chief Compliance Officer*

1. The Chief Compliance Officer is responsible for developing and implementing a compliance program and policies and procedures designed to ensure compliance with the requirements in this Agreement.

2. The Chief Compliance Officer must report to the Administrator/CEO/COO and the MCOP's Board of Directors, and must be solely dedicated to ensuring MCOP compliance with this Agreement.

xx. *Lead Investigator (Special Investigative Unit)*

1. The Lead Investigator must hold either:

    a. A bachelor's degree with a minimum of two years of experience in the healthcare field working in fraud, waste, and abuse investigations and audits; or

    b. An associate's degree, with a minimum of four years of experience working in health care fraud, waste, and abuse investigations and audits.

2. The Lead Investigator must be proficient in their ability to understand and analyze health care claims and coding, and must be solely dedicated to Special Investigative Unit (SIU) responsibilities required under this Agreement.

3. The primary responsibilities of the Lead Investigator are to:

    a. Identify risk, and guard against fraud, waste, and abuse throughout the MCOP's service delivery system;

    b. Actively monitor for aberrant providers;

    c. In a timely manner, refer potential fraud, waste, and abuse to ODM as required in Appendix G, Program Integrity; and

d. Actively participate in any meetings identified by ODM, including but not limited to Managed Care Program Integrity Group meetings, the biweekly Home Health Care Fraud Referral meeting, and quarterly Special Investigation Unit lead meetings.

xxi. *MCOP Contract Administrator*

1. The MCOP Contract Administrator must serve as the primary point of contact for all MCOP operational issues.

2. The primary functions of the MCOP Contract Administrator include but are not limited to:

    a. Ensuring the MCOP's compliance with the terms of this Agreement, including coordinating the tracking and submission of all deliverables in this Agreement;

    b. Overseeing all activities by the MCOP and its first tier, downstream, and related (FDR) entities. The MCOP is ultimately responsible for meeting program requirements, ODM will not discuss MCOP issues with the MCOP's FDR entities unless the MCOP is also participating in the discussion;

    c. Attending all meetings and events designated by ODM that require mandatory attendance;

    d. Ensuring the availability to ODM upon either's request, of those members of the MCOP's staff who have appropriate expertise in administration, operations, finance, management information systems, Claims processing and payment, clinical service provision, quality management, member services, utilization management, provider network management (PNM), and benefit coordination;

    e. Coordinating requests and activities among the MCOP, all FDR entities, and ODM;

    f. Fielding and coordinating responses to ODM inquiries in time frames and formats reasonably acceptable to the parties;

    g. Promptly resolving and issues or identified noncompliance related to this Agreement identified by the MCOP or ODM;

    h. Meeting with ODM at the time and place requested by ODM if ODM determines that the MCOP is not in compliance with the requirements of this Agreement; and

    i. Coordinating, preparing for, and facilitating random and periodic audits and site visits.

xxii. *Transition Coordinator*

1. The Transition Coordinator must serve as the MCOP's primary point of contact for planning and managing all MCOP transition activities, including member transitions of care as identified in Appendix D, Care Coordination, and transitions resulting from MCOP termination and/or non-renewal, as identified in Appendix O, MCOP Termination and Non-Renewal.

2. The primary functions of the Transition Coordinator include:

    a. Coordinating the development and submission of the MCOP's transition plan;

    b. Coordinating the tracking and submission of all transition-related reports and deliverables;

    c. Coordinating MCOP representation and attendance for ODM identified transition meetings;

    d. Coordinating and overseeing all member transition activities to ensure the safe, timely, and orderly transition of members and their care; and

    e. Coordinating the development of submission of MCOP transition plan updates and final report to ODM.

d. MCOP Organizational Staff

i. *Special Investigative Unit Staff*

1. The MCOP must maintain adequate staffing and resources for its Special Investigative Unit (SIU) that includes, at a minimum, one SIU staff person and additional SIU staff persons to maintain a ratio of one SIU staff person per 60,000 members.

2. The MCOP's proposed SIU staffing must be included in the MCOP's fraud, waste, and abuse plan described in Appendix G, Program Integrity.

3. The MCOP must ensure that all SIU staff investigators meet the following qualifications:

    a. A minimum of two years in a health care field working on fraud, waste, and abuse investigations and audits;

    b. A bachelor's degree, or an associate's degree with an additional two years working on health care fraud, waste, and abuse investigations and audits; and

    c. The ability to understand and analyze health care claims and coding.

ii. *Member Services Staffing*

1. MCOP member services staffing must be sufficient to designate at least one member-relations staff position per population health stream to serve as the contact to address barriers identified by members during QI projects aimed at improving member outcomes.

iii. *Provider Services Staffing*

1. MCOP provider services staffing must be sufficient to designate at least one provider -relations staff position per population health stream to serve as the contact to address barriers identified by providers during QI projects aimed at improving member outcomes.

iv. *Other Organizational Staff*

1. The MCOP must employ sufficient organizational staff and appropriately utilize staffing resources to comply with this Agreement. ODM will evaluate staffing adequacy based on the MCO's ability to achieve compliance with this Agreement.

e. MCOP Staff Training Requirements

i. The MCOP must ensure staff have appropriate education and experience, and provide staff training and orientation to enable staff fulfill the requirements of this Agreement.

ii. The MCOP must ensure staff receive training on applicable program requirements commensurate with position responsibilities.

iii. The MCOP must use the most appropriate training methods, which may include instructor-lead and web-based trainings.

iv. The MCOP must submit an MCOP Staff Training Plan, including the topics and frequency of training, to ODM for prior review and approval as specified in Appendix P, Chart of Deliverables. At a minimum, the MCOP training must include:

1. Orientation to the MyCare Ohio program, including roles and responsibilities of the MCOP, Area Agencies on Aging (AAAs);

2. Training on health equity and implicit bias;

3. Training on the identification and report of fraud, waste, and abuse;

4. "Question, persuade, and refer" training for all care coordination and management staff and 24/7 medical advice line staff;

5. Training on subjects including disability competency, access, cultural sensitivity, person-centered care delivery approaches, and independent living philosophies;

6. Training on member health and safety;

7. Training on incident reporting and investigations; and

8. Any additional training topics as directed by ODM.

v. The MCOP must ensure that individuals who develop and deliver training have demonstrable experience and expertise in the topic for which they are providing training.

f. Criminal Record Checks

i. The MCOP must ensure that employees of the MCOP and MCOP's subcontractors who have in-person contact with members in their home comply with criminal record check requirements as specified by ODM.

10. Subcontractual Relationships and Delegation

a. General Requirements

i. The MCOP may delegate administrative services subject to the requirements in this section.

ii. Unless otherwise specified by ODM, administrative services include care management, marketing, utilization management, quality improvement, enrollment, disenrollment, membership functions, claims administration, PNM, and coordination of benefits (COBs).

iii. For any other administrative functions not listed above that could impact a member's health, safety, welfare, or access to covered services, the MCOP must contact ODM to request a determination of whether the function may be included as an administrative service that complies with the provisions listed herein.

iv. With the exception of transportation vendors and the MCOP's pharmacy benefit manager, the MCOP must not publish a delegated entity's general call center number.

v. For purposes of this Agreement, parties to administrative services arrangements and related terms are defined as follows:

1. "First tier entity" means any party that enters into a written arrangement, acceptable to ODM, with the MCOP to provide administrative services for MyCare Ohio eligible individuals.

2. "Downstream entity" means any party that enters into a written arrangement, acceptable to ODM, with a first tier or related entity or below the level of a first tier or related entity to provide administrative services for MCOP-eligible members. These arrangements continue down to the level of the ultimate provider of the administrative services.

3. "Related entity" means any related party to the MCOP by common ownership or control under an oral or written arrangement to perform some of the administrative services under the MCOP's contract with ODM.

4. "FDR" is the collective term for first tier, downstream, and related entities.

5. "FDR agreement" is the written agreement between the MCOP and an FDR to delegate administrative responsibilities or service.

b. First Tier, Downstream, and Related Entities Agreements

i. If the MCOP delegates administrative services under this Agreement to any first tier, downstream, and related entities (FDR), the MCOP must ensure it has an FDR agreement with the FDR to perform administrative services on the MCOP's behalf.

ii. The following requirements apply to all FDR agreements.

1. The MCOP must evaluate the FDR's ability to perform the administrative services before executing or renewing any FDR agreement.

2. The MCOP must notify ODM of a proposed new or amendment of an FDR agreement at least 45 calendar days prior to the execution of the FDR agreement using the ODM-approved notification process so that ODM can review the information provided. ODM, in its sole discretion, may require the MCOP to submit the complete and exact text of the proposed new or amendment of an FDR agreement for ODM review. Unless otherwise specified by ODM, FDR agreements may not be executed until ODM has completed its review of the information contained in the notification, and its review of the FDR agreement as applicable.

3. The MCOP must allow ODM to review the terms of any FDR arrangement upon ODM's request.

4. The MCOP must completely and accurately respond to ODM's questions and requests for information about the FDR and any provisions in the FDR agreement within the timeframes established by ODM.

5. ODM has the right and authority to designate the FDR agreement, or any portion thereof, incompatible with this Agreement; incompatible with the Ohio Medicaid state plan or other federal authorities; incompatible with federal, state, or local regulations and laws; or unacceptable to ODM for any other reason, without limitation.

6. If ODM determines that the FDR agreement as a whole or any part of the FDR agreement is unacceptable or incompatible as stated above, the MCOP must amend the FDR agreement to ODM's satisfaction or seek a new FDR agreement.

7. ODM reserves the ability to review and approve all FDR agreements. Standard form contracts that apply to numerous provider entities, however, are generally excluded from this initial review and prior approval process. If any uncertainty exists regarding whether a potential agreement needs to be disclosed to ODM, the MCOP should seek guidance from ODM.

8. The FDR disclosure, review, and approval processes are subject to change at ODM’s discretion.

c. Transparency Requirements

i. The MCOP must include a term in all FDR agreements that requires the FDR to grant ODM access to documents and other records ODM deems relevant to evaluate the FDR's performance thereunder.

ii. Upon ODM's request, the MCOP must disclose to ODM all financial terms and arrangements for payment of any kind that apply between the MCOP or the MCOP's FDR, and any provider of a Medicaid service, except where federal and state law restricts disclosing the terms and arrangements.

1. If applicable, the MCOP and FDR must narrowly designate portions of any FDR agreement as proprietary information. Portions of any FDR agreement designated as proprietary information must be limited to the following:

a. Portions of the FDR agreement that meet the definition of proprietary information in Article VII.B of the Baseline Provider Agreement; and

b. Portions of the FDR agreement that consist of unique business or pricing structures that a competitor may use to gain an unfair market advantage over the FDR or the MCOP.

2. Proprietary designations in every FDR agreement must be limited, consistent with the foregoing.

3. Every portion of an FDR agreement that is not designated as proprietary may be deemed by ODM to be a public record as defined in ORC 149.43.

d. FDR Agreements for Pharmacy Benefit Management

i. If the MCOP enters into an agreement with a pharmacy benefit manager (PBM) for the provision and administration of pharmacy benefits, the MCOP must utilize a pass-through pricing model for Medicaid-covered drugs and ensure for Medicaid-covered drugs:

1. The PBM uses the same pricing schedule to reimburse pharmacies as is used by the PBM to charge the MCOP. At least semi-annually, the MCOP must review the PBM's pricing structure;

2. Pharmacies are not subject to post-adjudications penalties, clawbacks, adjustments, effective rate reconciliations, or recoupments of paid claims for the purpose of financially benefitting the MCOP or PBM; and

3. The PBM does not retain rebates for medications, devices, or supplies for Medicaid-covered products.

e. Additional Requirements for FDR Agreements with Related Parties

i. "Related party" means any person or entity related to, or otherwise affiliated with, the MCOP by common ownership or control, or aligned financial interests. A related party includes but is not limited to agents, managing employees, individuals with an ownership or controlling interest in the MCOP and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons, or otherwise part of the same corporate family, who has the ability or perceived ability to influence the MCOP in making financial or operating decisions.

ii. Prior to entering into an FDR with a related party, the MCOP must submit to ODM a conflict mitigation plan outlining the protections which will be in place to mitigate any actual, potential, or perceived conflict of interest. The mitigation plan will contain at a minimum a detailed description of the proposed FDR agreement, describe the protections ensuring that the agreement will be negotiated at arms-length and not exploit the relationship for financial gain for either the MCOP or the related party, and describe how the MCOP will ensure the FDR arrangement does not impede members' access to care or free choice of provider. The MCOP may not execute the FDR agreement prior to ODM approving the mitigation plan.

iii. If either prior to its approval of the mitigation plan, or at any point thereafter, ODM determines that the mitigation plan as a whole or any part of the mitigation plan is unacceptable, insufficient, or incompatible as stated above, the MCOP must amend the mitigation plan to ODM's satisfaction or else not contract with the related party, or else terminate the agreement with the related party if the agreement has already been executed.

f. FDR Agreement Provisions

i. The MCOP must ensure all FDR agreements include the following enforceable provisions:

1. A description of the administrative services to be provided by the FDR and any requirements for the FDR to report information to the MCO;

2. The beginning date and expiration date or automatic renewal clause for the arrangement, as well as applicable methods of extension, renegotiation, and termination;

3. Identification of the service area and MyCare Ohio population, either "Medicaid only members", "Medicaid only and dual benefit members", or "dual benefit members" the FDR will serve;

4. A provision stating that the FDR must release to the MCOP and ODM any information necessary for the MCOP to perform any of its obligations under the MCOP's provider agreement with ODM, including compliance with reporting and quality assurance requirements;

5. A provision that the FDR's applicable facilities and records will be open to inspection by the MCOP, ODM, ODM's designee, or other entities as specified under the MCOP's provider agreement with ODM or in OAC rule;

6. A provision that the agreement is governed by and construed in accordance with all applicable state or federal laws, regulations, and contractual obligations of the MCO; and that the agreement is automatically amended to conform to any changes in laws, regulations, and MCOP contractual obligations to ODM without the necessity for written amendment;

7. A provision that members and ODM are not liable for any cost, payment, co-payment, cost-sharing, down payment, or similar charge, refundable or otherwise for services performed, including in the event the FDR or the MCOP cannot or will

not pay for the administrative services. This provision does not prohibit waiver entities from collecting patient liability payments from MCOP members as specified in OAC rule 5160:1-6-07.1;

8. The procedures to be employed upon the ending, non-renewal, or termination of the agreement, including, at a minimum, to promptly supply any documentation necessary for the settlement of any outstanding claims or services;

9. A provision that the FDR must abide by the MCOP's written policies regarding the False Claims Act and the detection and prevention of fraud, waste, and abuse;

10. A provision that requires the FDR to adhere to all screening and disclosure requirements as described in Appendix G, Program Integrity;

11. A provision that the FDR and all employees of the FDR are subject to the applicable provider qualifications in OAC rule 5160-26-05;

12. For an FDR providing administrative services that result in direct contact with a member, a provision that the FDR must meet the member information requirements as stated in this appendix and identify, and where indicated, arrange pursuant to the mutually agreed upon policies and procedures between the MCOP and FDR for the following at no cost to the member or ODM:

    a. Sign language services;

    b. Oral interpretation; and

    c. Auxiliary aids and services.

13. For an FDR providing administrative services that result in the selection of providers, a provision that the MCOP retains the right to approve, suspend, or terminate any such selection;

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

15. A provision stating that all provisions in an FDR agreement must conform to and be consistent with all of the provisions of the MCOP's provider agreement with ODM;

16. A provision that all of the provisions applicable to the FDR under the MCOP's provider agreement with ODM supersede all applicable provisions in the FDR agreement. If a provision in an FDR agreement contradicts or is incompatible with any applicable provision in the MCOP's provider agreement with ODM, the applicable provision in the FDR agreement is rendered null and void, unenforceable, and without effect;

17. A provision stating that all FDRs must fully assist and cooperate with the MCOP in fulfilling the MCOP's obligations under the Next Generation MyCare Provider Agreement;

18. A provision that allows the MCO, ODM, and ODM's designee to obtain and gather data, documents, and information from FDRs for purposes of an audit, evaluation, or inspection of its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members; and states that the right to audit will exist through ten years from the final date of the contract period or from the date of completion of any audit, whichever is later, for the purpose of any audit conducted by Ohio Auditor of State, pursuant to ORC Chapter 117;

19. A provision that requires FDRs to provide all data and information to the MCOP needed for the MCOP to provide complete reporting to ODM for the requirements and standards set forth in Appendix N, Compliance Actions and Appendix P, Chart of Deliverables; and

20. A provision stating that FDRs must provide any information that ODM requests for purposes of compliance assessments as described in Appendix N, Compliance Actions.

g. MCOP Accountability

i. The MCOP is ultimately responsible for meeting all contractual obligations under the MCOP's Provider Agreement with ODM, regardless of delegation.

ii. For all MCOP delegated responsibilities under this Agreement, the MCOP must:

1. Monitor FDR performance on an ongoing basis and conduct a formal review at least annually to identify any deficiencies or areas for improvement;

2. Communicate the results of the performance review to the FDR and impose corrective action on the FDR as necessary;

3. Notify ODM and submit a CAP to ODM if at any time the FDR is found to be in noncompliance with MCOP's delegated contractual obligations;

4. Report the results of the annual performance review and any CAP to ODM via the FDR Oversight Report as specified in Appendix P, Chart of Deliverables; and

5. Ensure there is no disruption in meeting the MCOP's contractual obligations to ODM, if the FDR or the MCOP terminates the arrangement between the FDR and the MCO.

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

iv. The MCOP must report termination of FDR arrangements to ODM no less than 15 calendar days prior to the effective date of the termination. For terminated FDR arrangements, the report to ODM must include:

1. A description of whether the activity previously performed by the FDR will be transitioned to the MCOP or another FDR, or terminated entirely. If the activity will be transitioned to another FDR, the MCOP must indicate the entity that will be

responsible for the activity after termination of the FDR arrangement and submit an FDR agreement notification to ODM as described in this Agreement for the new entity.

2. A transition plan describing how the MCOP will ensure minimal disruption to members as a result of the termination.

v. In accordance with 42 CFR 438.602, the MCOP must post on its website the name and title of individuals included in 42 CFR 438.604(a)(6). For the purposes of this requirement, "subcontractor" is defined as any individual or entity that has a contract with the MCOP that relates directly or indirectly to the performance of the MCOP's obligations under this Agreement, not including a network provider.

11. Comprehensive Disaster/Emergency Response Planning

a. Comprehensive Disaster/Emergency Response Plan

i. As directed by ODM, the MCOP must develop and implement a Comprehensive Disaster/Emergency Response Plan for natural, man-made, health care, or technological disasters and other public emergencies (e.g., floods, extreme heat or cold, and public health emergencies).

ii. The MCOP, as directed by ODM, must collaborate and share information with ODM-contracted managed care entities to address the disaster and implement the emergency response plan.

iii. The MCOP must make the ODM-approved Comprehensive Disaster/Emergency Response Plan available to all staff.

b. Primary Point of Contact

i. As identified in the MCOP staffing requirements in this appendix, the MCOP must designate both a primary and alternate point of contact who will perform the following functions with respect to the MCOP's Comprehensive Disaster/Emergency Response:

1. Be available 24/7 during the time of an emergency;

2. Be responsible for monitoring news, alerts, and warnings about disaster/emergency events;

3. Have decision-making authority on behalf of the MCOP;

4. Respond to directives and emergent requests for information issued by ODM; and

5. Cooperate with the local -and state-level Emergency Management Agencies.

ii. The MCOP must participate in workgroups and processes as required by ODM to establish a state-level emergency response plan that will include a provision for MyCare recipients, and must comply with the resulting procedures.

iii. During the time of an emergency or a natural, technological, or man-made disaster, the MCOP must:

1. 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

2. Distribute the list to local and state emergency management authorities according to the protocol established by ODM.

iv. The MCOP must identify members who are at risk for harm, loss, or injury during any emergency or potential natural, technological, or man-made disaster. MCOP identification of vulnerable members must include populations as identified by ODM, and the MCOP must 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 MCOP's Comprehensive Disaster/Emergency Response Plan.

1. For these members, the MCOP must develop an individual-level plan with the member when appropriate.

2. The MCOP must ensure staff, including care coordination staff, are prepared to respond to and implement the plans in the event of an emergency or disaster.

3. The member-level plan must:

a. 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, nursing services, and assistance with activities of daily living (ADLs);

b. Identify how and when the plan will be activated;

c. Be documented in the member record maintained by the MCOP; and be provided to the member.

APPENDIX B – COVERAGE AND SERVICES

1. Basic Benefit Package

a. Service Coverage Requirements

i. Subject to third-party liability, including Medicare coverage requirements, and pursuant to OAC rules 5160-58-01.1 and 5160-26-09.1, the MCOP must cover and ensure members have timely access to all medically necessary services, including those not covered by Medicare, described in the Ohio Medicaid state plan, OAC rule 5160-58-03 and the MyCare Ohio Home- and Community-Based Services (HCBS) Waiver in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to members under fee-for-service (FFS) Medicaid unless otherwise noted below:

1. Home health, private duty nursing (PDN), and registered nurse (RN) assessment and consultation services in accordance with OAC Chapter 5160-12. Home health and PDN services must be accessed prior to using MyCare Ohio HCBS Waiver services.

    a. For home health and PDN services, the MCOP must prior authorize services in a manner that maximizes the effectiveness of the care provided in accordance with OAC rule 5160-58-03.1. Standardized authorization limitations are not permitted. The MCOP must take into consideration the member's specific health needs when determining the length of time for which to authorize services.

    b. Person-centered care plans, when appropriate, must reflect the member's needs and planned interventions, including services authorized and provided.

2. Nursing facility services as required by 1905 (a)(4)(A) of the Social Security Act and described in 42 CFR 440.40 and 42 CFR 440.155 and ORC Chapter 5165.

    a. If a network nursing facility experiences a change in operator (CHOP), the MCOP must not require the new nursing facility to request a new authorization for members who had a previous authorization that is still current.

3. HCBS Waiver services as currently specified in the MyCare Ohio HCBS Waiver and in OAC 5160-58-04. This includes any current or planned changes to the MyCare Ohio HCBS Waiver.

    a. The MCOP must promote and cover self-directed services as described in the MyCare Ohio HCBS Waiver and OAC 5160-58-04. The MCOP must provide information and assistance as outlined in the MyCare Ohio HCBS Waiver.

        i. The MCOP must require all care managers and waiver service coordinators to participate in initial and at least annual training about self-direction.

ii. The MCOP must include information about self-direction in the waiver member handbook. Upon enrollment and at least annually, the MCOP must discuss the purpose of self-direction, the differences between self-directed and provider-managed services, and the additional responsibilities, as well as the benefits of, self-direction, to all members enrolled in the MyCare Ohio HCBS Waiver.

iii. The MCOP must develop and supply a self-direction member handbook and any other related materials to members who express interest in self-direction.

iv. When a member chooses self-direction, the MCOP must provide Information and Assistance as described in the MyCare Ohio HCBS Waiver. This includes:

1. Orientation to the member, including all topics included in the MyCare Ohio HCBS Waiver and

2. All supporting materials required by ODM.

v. For members who choose to use budget authority:

1. The MCOP must provide the member with current budget amounts at least annually and as needs or care costs change. Budget amounts must include all details required by ODM and must include sufficient detail for the member to make informed decisions about how to manage their care.

b. The MCOP must contract directly with the financial management services (FMS) vendor selected by ODM to successfully transition and provide ongoing services for waiver consumers who have elected self-directed employer authority for authorized waiver services. The contract shall continue for the entire period of this Agreement.

i. The MCOP must reimburse the FMS for administrative duties in support of self-directed services at the rate established by ODM and for self-directed services. The FMS vendor will pay the self-directed caregiver directly for services.

ii. The MCOP must submit service authorizations, including self-directed caregiver wages and billable rates to the FMS within three business days of any additions, updates, or revisions.

c. As specified in Appendix P, Chart of Deliverables, the MCOP must submit the Self-Directed Member's Report.

4. Pharmacy Services and Provider-Administered Drugs.

a. Pharmacy services and provider-administered drugs in accordance with OAC rule 5160-4-12 that are covered by Ohio Medicaid and may not be covered under Medicare Part D. This includes:

   i. Agents when used for the symptomatic relief of cough and colds: cough suppressants only.

   ii. Prescription vitamins and mineral products, except prenatal vitamins and fluoride.

   iii. Nonprescription drugs: cough suppressants, vitamins, antacids, antidiarrheals, stool softeners, laxatives, wound protectants, and artificial tears.

b. The MCOP must utilize ongoing medication reconciliation, employment of advanced practice pharmacy management programs, including medication therapy management, and in-person pharmacy consultation to increase adherence to medication regimens and eliminate contra-indicated drugs.

c. The MCOP may, pursuant to ORC Section 5167.12, implement strategies for the management of drug utilization for Medicaid covered drugs not covered by Medicare Part D. The MCOP may, subject to ODM prior approval, require prior authorization (PA) of certain drug classes, and place limitations on the type of provider and locations where certain drugs may be administered. Concurrently, the MCOP cannot require PA for drugs used to prevent preterm birth nor can they require PA for the location of administration.

d. All proposed pharmacy programs and drug utilization management (UM) programs, such as PA, step therapy, partial fills, specialty pharmacy, pill-splitting, etc. are subject to ODM review and approval.

e. The MCOP must provide members with a printed version of ODM's Preferred Drug List and PA lists upon request.

f. The MCOP must submit the Prior Auth (Rx) Statistics Report (Prior Auth Statistics Report) as specified in Appendix P, Chart of Deliverables.

5. Services of a pharmacist provider.

   a. The services of a pharmacist rendered within a pharmacist's scope of practice when medically necessary may be rendered for the purpose of managing medication therapy, administering immunizations, or administering medications in accordance with OAC rule 5160-8-52.

6. Blood glucometers and blood glucose test strips as specified by ODM.

7. Preventive services covered by Ohio Medicaid program in accordance with Section 4106 of the Affordable Care Act and 42 CFR 440.130(c).

8. All United States (US) Preventive Services Task Force grade A and grade B preventive services and approved vaccines recommended by the Advisory Committee on

Immunization Practices and their administration, without cost-sharing, as provided in Section 4106 of the Affordable Care Act.

9. Screening and counseling for obesity provided during an evaluation and management or preventive medicine visit, as described in OAC rule 5160-1-16.

10. Behavioral health services, including those provided by Ohio Department of Mental Health and Addiction Services (OMHAS)-certified providers, as described in OAC Chapter 5160-27.

11. Durable medical equipment and medical supplies as described in OAC rule 5160-10, including expedited wheelchair fitting, purchase, maintenance and repair, professional evaluation, home assessment, the services of skilled wheelchair technicians, pick-up and delivery, timely repairs, training, demonstration, and loaner chairs.

ii. In accordance with 42 CFR 438.210, the MCOP may exclude or place appropriate limits on service coverage, as specified in this appendix, with the exception of emergency and post-stabilization services. The MCOP must provide coverage and payment for emergency and post-stabilization services, including behavioral health post-stabilization services, in accordance with 42 CFR 422.113, 42 CFR 438.114 and OAC rule 5160-5803.

iii. The MCOP is not required to pay for services not covered by Ohio Medicaid, except as specified in OAC rules 5160-58-03 and 5160-1-61, by Medicare for dual benefit members, and this Agreement.

iv. The MCOP must provide Medicare covered services for dual benefit members and follow Medicare criteria for Medicare covered services. If either Medicare or Medicaid provides more expansive coverage for services than the other program does for a particular condition, type of illness, or diagnosis, the MCOP must provide the more expansive coverage.

v. The MCOP shall implement a provision for members, specifically those with special health care needs, to directly access a specialist (e.g., for an approved number of visits or a standing referral) as appropriate for the member's condition and health care needs. The MCOP shall inform members of their right to directly access a specialist.

b. Ohio Medicaid Services Not Covered by MCOP

i. The MCOP is not required to cover Medicaid pharmacy services for Medicaid only members other than the limited pharmacy services as described in this appendix. All other pharmacy benefits for Medicaid only are covered by Medicare. The MCOP must coordinate and collaborate with the appropriate Medicare payor as necessary to ensure that members receive medically necessary pharmacy services. The MCOP must provide pharmacy services to dual benefit members in accordance with Medicare requirements.

ii. The MCOP is not required to cover targeted case management services as specified in OAC rule 5160-48-01, for individuals with developmental disabilities.

iii. Prior to denying coverage of a service, the MCOP must review applicable OAC rules (e.g., 5160-1-61) and conduct a medical necessity review if appropriate.

c. Provider-Preventable Conditions

i. The MCOP must not use Medicaid funding to pay for a service resulting from a provider-preventable condition as defined in 42 CFR 447.26.

1. In accordance with 42 CFR 438.3(g), the MCOP must identify and report all provider-preventable conditions, regardless of the provider's intention to bill for that event, to ODM in the manner specified by ODM.

2. The MCOP must ensure that the prohibition on payment for provider-preventable conditions does not result in a loss of access to care or services for members.

2. Service-Specific Clarifications

a. Pregnancy Related Services

i. The MCOP must comply with the requirements outlined in OAC rule 5160:1-2-16 related to Pregnancy Related Services.

ii. The MCOP must deliver Healthchek (Ohio's early and period screening, diagnostic, and treatment program) information when the member is identified as pregnant.

iii. The MCOP must inform members about Pregnancy Related Services.

iv. Upon identifying a member as pregnant, the MCOP must deliver a Pregnancy Related Services form as designated by ODM to the member within five calendar days.

v. The MCOP may communicate with the member's local County Department of Job and Family Services (CDJFS) agency for any requests made by the member for county-coordinated services and supports (e.g., social services).

vi. The MCOP must provide the above information on the MCOP's provider website as specified in Appendix A, General Requirements. The MCOP must maintain documentation to verify members and providers were informed of Healthchek and Pregnancy Related Services as specified by ODM.

b. Medication Therapy Management Program

i. The MCOP must implement a medication therapy management (MTM) program.

ii. The MCOP's MTM program must include but not be limited to MTM services focused on polypharmacy, opioids, individuals with dementia, behavioral health, and any other area identified by ODM to support ODM's population health strategy.

1. The MTM services for opioid services must include but are not limited to initiatives focused on the education and safe use of opioids as well as the proper disposal of opioids.

2. The MTM services for older adults must include but are not limited to initiatives focused on polypharmacy, transitions of care, and members with dementia.

3. The MTM services for behavioral health must include but are not limited to initiatives focused on polypharmacy, the use of antipsychotic medications in adult populations, members with dementia, and members that have diabetes with co-morbidities.

4. The MTM services for individuals with chronic conditions must include but are not limited to initiatives focused on those that have diabetes and/or hypertension with co-morbidities and transitions of care.

iii. As requested by ODM, the MCOP must work with other MCOPs, the OhioRISE Plan, MCOs, ODM, and other stakeholders to develop MTM services, including the trigger events and MTM activities.

iv. As specified in Appendix P, Chart of Deliverables, the MCOP must submit an MTM program description for its MTM program. The description must include but not be limited to the MTM triggering events, activity that occurs after a triggering event, how each MTM interaction is documented and reimbursed, and how an action plan will be initiated and monitored.

v. As specified in Appendix P, Chart of Deliverables, the MCOP must provide ODM with MTM program updates of key utilization and financial metrics for its MTM program.

c. Abortion and Sterilization

i. The MCOP is prohibited from providing reimbursements for abortion and sterilization services unless the specific criteria found in federal law and OAC rules 5160-17-01 and 5160--21-02.2 are met.

ii. The MCOP must verify that all of the information on the applicable required forms (ODM 03197, ODM 03199, HHS-687, and HHS-687-1 [SPANISH VERSION]) is provided and that the service meets the required criteria before paying any such claim.

iii. The MCOP must not make payment for associated services such as anesthesia, laboratory tests, or hospital services if the abortion or sterilization itself does not qualify for payment.

iv. The MCOP must educate its providers on the requirements and implement internal procedures, including systems edits. The MCOP must only pay claims when the MCOP has determined that the applicable forms are completed and the required legal criteria are met, as confirmed by the appropriate certification or consent forms. The MCOP must maintain documentation to justify any such claim payments.

v. If the MCOP has determined that the requirements associated with an abortion, sterilization, or hysterectomy were sufficiently met by the provider, then no additional information (e.g., unless otherwise required by law, operative notes, history and physical, and ultrasound) is required from ancillary providers.

d. Moral or Religious Objections

i. In accordance with 42 CFR 438.102, if the MCOP determines that it does not wish to provide, reimburse, or cover a counseling service or referral service due to an objection to

the service on moral or religious grounds, the MCOP must immediately notify ODM to coordinate the implementation of this change.

1. ODM will provide coverage and reimbursement for these services in accordance with ODM policy.

2. The MCOP must notify its members of this change at least 30 calendar days prior to the effective date. The MCOP must include any such services that the MCOP will not cover in the MCOP's member handbook and provider directory, as well as in all marketing materials.

ii. If network hospital elects not to provide specific Medicaid-covered hospital services because of an objection on moral or religious grounds, the MCOP must ensure these hospital services are available to its members through another network hospital in the specified county/geographic area.

e. Boards of Alcohol, Drug Addiction, and Mental Health Services

i. The MCOP must collaborate and coordinate with local Alcohol, Drug Addiction, and Mental Health (ADAMH) Boards to identify and address behavioral health service gaps and needs (e.g., mental health services, addiction services, and recovery supports).

f. Institutions for Mental Disease for Mental Health Stays

i. Federal regulation, 42 CFR 438.6(e), allows for a short-term Institutions for Mental Disease (IMD) stays of 15 calendar days or less for members ages 21 through 64. The MCOP may provide mental health services to members ages 21 through 64 for up to 15 calendar days per calendar month while receiving inpatient treatment in an IMD as defined in Section 1905(i) of the Social Security Act.

ii. The MCOP is not prohibited from contracting with an IMD to provide mental health services to members aged 21 through 64, but ODM will not compensate the MCOP for the provision of such services beyond 15 calendar days per calendar month, either through direct payment or considering any associated costs in Medicaid rate setting.

iii. The MCOP must report IMD stays that exceed 15 calendar days per calendar month (IMD for Extended Stay) to ODM as specified in Appendix P, Chart of Deliverables.

iv. For IMD stays that exceed 15 calendar days per calendar month, ODM will recover a percentage of the MCOP's monthly capitation payment as described in Appendix L, Payment and Financial Performance.

g. Emergency Room Services

i. The MCOP must ensure access to 24-hour emergency services for all members, whether they reside in institutions or in the community, in accordance with 42 CFR 438.114. The MCOP must cover and pay for emergency services regardless of whether the provider that furnishes the services is a network provider.

h. Behavioral Health Crisis Services

i. The MCOP must ensure that member-serving MCOP staff know the continuum of community resources for behavioral health crisis services, including the 988 Suicide & Crisis Lifeline (988).

ii. The MCOP must train MCOP staff who interface with the public or have direct member contact on how to connect (through warm handoffs) members in need of behavioral health crisis services to 988. Staff making warm transfers to 988 must use the National Suicide Prevention Lifeline ten-digit terminal numbers when geolocation based on the member's location cannot be used, such as when the call is being transferred from the MCOP's member call center.

iii. The MCOP must track and document behavioral health crisis contacts from members and ensure that this information is shared as soon as possible and no later than the next business day with the member's MCOP's care coordinator, waiver service coordinator, and/or behavioral health care coordination entity for appropriate follow-up.

iv. The MCOP must work with ODM, OMHAS, and other entities as identified by ODM to develop a robust continuum of behavioral health crisis services.

i. Substance Use Disorder Treatment

i. The MCOP must utilize the American Society of Addiction Medicine (ASAM) level of care criteria, and the MCOP must not add additional criteria when reviewing level of care for substance use disorder (SUD) treatment provided in a community behavioral health center or a hospital billing outpatient hospital behavioral health (OPHBH) services. When making medical necessity determinations for inpatient services for co-occurring behavioral health and physical health conditions or for co-occurring substance use and mental health disorders, the MCOP must also use other clinical criteria (e.g., MCG® or InterQual®) in addition to ASAM criteria, and must authorize services when either ASAM or MCG®/InterQual® indicate the need for inpatient services.

ii. The MCOP must continue to work with ODM in implementing the 1115 SUD demonstration waiver to provide services to members with a SUD diagnosis. Additional work will include developing UM strategies, increasing care coordination efforts, and monitoring network adequacy. Upon implementation of a standardized SUD treatment form, when properly submitted by a provider, the MCOP must accept the identified form to prior authorize SUD services and determine level of care.

j. Emergency Hospitalizations

i. In accordance with ORC section 5122.10 regarding emergency hospitalizations, also referred to as "pink slips", the MCOP must cover initial evaluation for up to 24 hours and stabilization services for up to three court days thereafter.

k. Organ Transplants

i. *Organ Transplant Coverage*

1. Pursuant to OAC rule 5160-2-65, the MCOP must ensure coverage for organ transplants and related services.

2. The MCOP's coverage for all organ transplant services, except kidney transplants, is contingent upon review and recommendation by the "Ohio Solid Organ Transplant Consortium". The review and recommendation for coverage is based on criteria established by Ohio organ transplant surgeons and authorization from the ODM prior authorization unit.

3. Reimbursement for bone marrow transplant and hematopoietic stem cell transplant services, as defined in OAC rule 3701-84-01, is contingent upon review and recommendation by the "Ohio Hematopoietic Stem Cell Transplant Consortium". The review and recommendation for coverage is based on criteria established by Ohio experts in the field of bone marrow transplant and authorization from the ODM prior authorization unit.

4. While the MCOP may require prior authorization for these transplant services, the approval criteria must be limited to confirming the member has been referred to and approved for a transplant by the applicable consortium and authorized by ODM.

5. Pursuant to OAC rule 5160-2-03, the MCOP must cover all services for the organ donor related to covered organ donations to an organ recipient member.

ii. *Prior Authorizations for Transplant Evaluations (Pre-Transplants)*

1. The MCOP is prohibited from requiring prior authorization that may create a barrier to accessing the "Ohio Solid Organ Transplant Consortium" or "Ohio Hematopoietic Stem Cell Transplant Consortium" for review and recommendation (e.g., a member must be able to access pre-transplant services required for consortium review).

2. The MCOP may require providers to submit information for the purposes of assisting members with identifying available providers, initiating care coordination services, and addressing any compensation issues.

3. When identifying available providers that could ultimately impact where the transplant is performed, the MCOP must not solely consider whether the provider is a network provider, but also consider the proximity to a member's residence, the member's support system, and the providers who coordinate the member's care.

l. Gender Transition

i. The MCOP is prohibited from having or implementing a categorical coverage exclusion or limitation for all health services related to gender transition.

ii. The MCOP is not precluded from determining whether a particular health service is medically necessary or otherwise meets applicable coverage requirements in individual cases.

iii. When an individual who has transitioned needs medically necessary services related to their gender at birth, the MCOP must review for medical necessity and cannot categorically deny a service due to gender.

m. Community-Based Palliative Care

i. In accordance with 42 CFR 418.3 and as defined in ORC section 3712.01, palliative care is specialized care provided at any stage of a serious or life-threatening illness by an interdisciplinary team working in consultation with other health care professionals.

ii. The MCOP must cover palliative care services for a target group of members with serious illness as defined by a list of specific conditions and clinical criteria determined by ODM.

iii. Consistent with the aims of palliative care as defined in ORC section 3712.01, covered services must include, but are not limited to:

1. Advance care planning;

2. Physical symptom management including prescription of controlled substances;

3. Comprehensive symptom management provided through an interdisciplinary team; and

4. Care coordination and communication in developing and implementing a plan of care aligned with member's goals.

n. Hospice Services

i. In accordance with Sections 1902(a)(13)(B) and 1905(o)(3)(C) of the Social Security Act, the MCOP must pay room and board payments to the hospice provider instead of the nursing facility if the member resides in a nursing facility and is receiving hospice services.

ii. Hospice room and board payments must be equal to at least 95% of the rate the nursing facility would otherwise be paid.

iii. Leave days are not covered for nursing facility members receiving hospice.

o. Inpatient Hospital Services

i. The MCOP must enforce the three-calendar day roll-in requirements pursuant to OAC rule 5160-2-02.

ii. The MCOP must follow the readmission policies as outlined in OAC Chapter 5160-2 for inpatient hospital stays as follows:

1. For readmissions within 30 calendar days due to complications or other circumstances that arose because of an early discharge and/or other treatment errors, the two inpatient hospital stays must be combined into one claim, and the MCOP must not deny the second admission due to being a readmission.

a. The MCOP must maintain a list of the types of conditions or admissions that are exempt from review to combine claims, including any behavioral health conditions or admissions.

b. The MCOP must exempt behavioral health admissions from readmission considerations unless otherwise approved by ODM.

2. Upon receipt of claims for two admissions, the MCOP must conduct a clinical review to determine whether two admissions must be combined as one claim.

3. The MCOP must not deny a prior authorization request solely based on a readmission request. Prior to making an authorization decision regarding a readmission, the MCOP must conduct a clinical review to determine if the readmission is related to the original admission.

p. Non-Emergency Medical Transportation Services

i. The MCOP must have ODM's prior approval of policies and procedures, and subsequent changes thereto, associated with arranging and providing transportation for members.

ii. The MCOP must arrange and provide transportation to any member requesting transportation when the member must travel 30 miles or more each way from the member's home, regardless of distance, to receive a medically necessary Medicaid-covered service provided by the MCOP and pharmacy services provided by the MCOP, including, for dual benefit members, to obtain Part D drugs. The MCOP must provide information and assistance to members to ensure members receive medically necessary transportation.

iii. The MCOP's member services call center must have a selection for transportation for members. Member services representatives must be trained to respond to transportation requests in accordance with MCOP policies and procedures for arranging and providing transportation services. This must include linkage and coordination with the CDJFS' non-emergency medical transportation services when appropriate.

iv. Even if the transportation is under 30 miles, the MCOP must arrange and provide transportation for members in a manner that ensures that members do not face transportation barriers to attend wellness visits and to receive dialysis, chemotherapy, community behavioral health, and prenatal services.

v. The MCOP is responsible for arranging transportation in cases where transportation of families, caregivers, and sibling (other minor residents of the home) when needed to facilitate the treatment needs of the member and their family.

vi. The MCOP must ensure members can reach a representative at the MCOP for all transportation needs related to a scheduled medical service. This includes request made outside the usual call center operating hours.

vii. The MCOP must ensure transportation vendors have sufficient detail for both pick-up and drop-off locations to ensure the vendor can meet the member's individual needs. This includes but is not limited to member's address, medical provider's address, apartment and/or suite numbers, building names or other identification, and entrance locations. A

transportation vendor must not drop-off or attempt to pick-up a member in a location other than the one identified by the MCOP.

viii. The MCOP must not provide group transportation without prior consent from the members being transported. When providing transportation for more than one member to more than one location, the MCOP must ensure that the total transit time for any single member on the trip does not exceed 60 minutes beyond the member's point-to-point transit time.

ix. The MCOP may not restrict the number of transports in a single day.

x. The MCOP must contract with transportation vendors that have experience serving a dual population. Characteristics of experienced providers include but are not limited to:

1. The ability to help the member transfer between the pick-up location and the vehicle, to enter and exit the vehicle, and to transfer between the vehicle and the destination location safely;

2. Sensitivity to aging adults living with disabilities; and

3. The capacity to meet individual member needs when transporting.

xi. Transportation timeliness:

1. The MCOP must ensure the member is transported to their appointment on time and that transportation pick-up is no more than 15 minutes before nor 15 minutes after the pre-scheduled pick-up time. Members must be notified at least four hours in advance of the scheduled transportation pick-up time.

2. The MCOP must ensure that transportation pick-up is completed no more than 30 minutes after the requested time for pick-up when not pre-scheduled.

3. The MCOP must ensure the transportation vendor attempts to contact the member prior to leaving the pick-up location if the member is not present at the time of pick-up.

4. The MCOP must ensure the transportation vendor does not leave the pick-up location prior to the pre-scheduled pick-up time and must allow the member up to 15 minutes after the scheduled pick-up time once the member has been contacted.

xii. The MCOP and transportation vendor must identify and accommodate any special transportation assistance needs of its members (e.g., door-to-door assistance, attendant support, member-specific timeliness requirements).

1. The MCOP must communicate member-specific needs to the transportation vendor in each transportation request.

2. The MCOP must document any member-specific transportation needs in the member's person-centered care plan, when applicable.

3. The MCOP must ensure specialized transportation for members who have cognitive or behavioral challenges that require different transportation providers or supports than available from counties or standard Medicaid provider network.

4. The MCOP must consider that a longer time period may be necessary if the plan is arranging specialized transportation and must provide exceptions for advance notice requirements for urgent member needs (e.g., for same or next day urgent appointments) and hospital discharges.

xiii. Transportation for members with long-term services and supports (LTSS) needs. The MCOP must contract with providers experienced in transporting members with LTSS needs. Characteristics of LTSS experienced providers include but are not limited to:

1. The ability to help the member transfer between the pick-up location and the vehicle, to enter and exit the vehicle, and to transfer between the vehicle and the destination location safely;

2. Sensitivity to aging adults living with disabilities;

3. The ability to safely operate, secure, and transport a wheelchair or other assistive device;

4. Maintain vehicles equipped with fasteners to secure wheelchairs and prevent movement, and a stable access ramp or hydraulic lift; and

5. The capacity to meet individual member needs when transporting.

xiv. The MCOP must submit a plan to ODM that addresses the provision of transportation services during winter snow and other weather emergencies. The MCOP's plan must describe how the MCOP will identify, triage, and transport members requiring critical services, and notify members of canceled transportation and rescheduling.

1. The MCOP's plan must specify the snow emergency level and any other weather-related criteria that require a change to scheduled transportation.

2. The MCOP must notify the ODM Contract Administrator immediately when the MCOP cancels transportation due to a weather emergency in accordance with the plan.

xv. The MCOP must collaborate with ODM, other ODM-contracted MCOPs, and the counties to improve member experience and access to transportation services, including standardizing the way for members to access transportation services.

xvi. The MCOP must submit a Transportation Performance Report to ODM as specified in Appendix P, Chart of Deliverables. This report must include a description of strategies used by the MCOP to improve transportation performance and member experience.

q. Nursing Facility Services Level of Care Determination

i. For Medicaid covered nursing facility stays, the MCOP must evaluate the member's need for the level of services provided by a nursing facility.

ii. To make this decision, the MCOP must use the criteria for nursing facility-based level of care pursuant to OAC rules 5160-3-06, 5160-3-08, 5160-3-14, and 5160-1-01.

iii. The MCOP must evaluate both intermediate and skilled levels of care concurrently when making a level of care determination.

iv. The MCOP must have processes in place to validate a Preadmission Screening Resident Review (PASRR) level 1 screening via the electronic system designated by ODM in accordance with the requirements set forth in OAC 5160-3-15.1 for all members seeking admission to a Medicaid-certified nursing facility. If the individual has indications of a severe mental illness and/or developmental disability the appropriate State Authority, OMHAS and/or the Ohio Department of Developmental Disabilities (DODD), must issue a non-adverse level II determination for PASRR requirements to be met. Medicaid payment for nursing facility services cannot precede the date PASRR requirements were met.

v. The MCOP must provide documentation of the member's level of care determination to the nursing facility. If properly submitted by a provider, the MCOP must accept the Ohio Medicaid Managed Care/MyCare Ohio Nursing Facility Request Form to prior authorize nursing facility services and determine level of care. The MCOP must maintain a written record documenting that the criteria were met. If the criteria were not met, the MCOP must issue a Notice of Action and maintain documentation that a Notice of Action was issued pursuant to OAC rule 5160-26-08.4.

vi. The Notice of Action must include the specific level of care criteria that were not met (i.e., no determined need for assistance with two or more areas of assistance with daily living, no need for medication administration, no cognitive impairment resulting in a need for 24 hour support to prevent harm, or no need for a skilled nursing service or therapy).

vii. The MCOP must provide ODM a PASRR Report as specified in Appendix P, Chart of Deliverables.

r. COVID-19 Testing and Treatment

i. The MCOP must cover all Medicaid covered COVID-19 testing codes, treatment, and vaccinations without restrictions or cost-sharing. The MCOP must cover each COVID-19 vaccine effective on the date the vaccine is approved by the Centers for Disease Control and Prevention (CDC).

3. Additional Benefits

a. Value-Added Services

i. In accordance with 42 CFR 438.3(e)(1)(i), the MCOP may elect to provide services in addition to those covered under the Ohio Medicaid FFS program.

ii. Before the MCOP notifies potential or current members of the availability of those services, the MCOP must first notify ODM of its plans to make such services available.

iii. The MCOP may provide members debit cards to purchase over-the-counter medications not covered by the Ohio Medicaid program.

iv. The MCOP must demonstrate to ODM's satisfaction that the value-added services are readily available and accessible to members who are eligible to receive them for at least six calendar months, unless otherwise approved by ODM.

v. When determining the types of value-added services, the MCOP elects to provide, the MCOP should consider the population health needs of its membership.

vi. The MCOP may not vary the availability of value-added services by county, except out of necessity for transportation services (e.g., bus versus cab).

vii. If the MCOP offers transportation to its members as a value-added service and the added transportation benefit only covers a limited number of trips, the MCOP must not count the required transportation benefit listed above in this appendix against the trip limit under the added transportation benefit.

viii. If the MCOP offers transportation to members as a value-added service and has a limit on this benefit (e.g., specified number of trips), transportation provided for members to access out-of-network providers for services the MCOP is unable to provide in-network must not be counted toward the transportation benefit limit.

ix. If the MCOP offers transportation to its members as a value-added service, the MCOP must meet the same transportation performance standards and reporting requirements identified above in this appendix for the value-added transportation benefit.

x. The MCOP must obtain ODM approval of any MCOP-initiated change to value-added services that would take effect 90 calendar days prior to open enrollment as well as within 90 calendar days after the completion of open enrollment. Unless approved by ODM, changes will not be accepted from May 2 through November 30.

xi. The MCOP must give advance notice of at least 90 calendar days to ODM and members when decreasing or ceasing any additional benefits. When the MCOP finds that it is impossible to provide 90 calendar days prior notice for reasons beyond its control, as demonstrated to ODM's satisfaction, the MCOP must notify ODM within at least one business day of discovery.

b. Pilot and Trial Incentive Programs

i. The MCOP must submit a description of a proposed pilot, health care quality improvement activity, or trial incentive program to ODM for review and approval prior to implementation. A pilot incentive program is a short-term program in a specified geographic area or with a defined member population that is measured to determine if it meets the specified program goal. A health care quality improvement activity is a structured quality improvement activity meeting the requirements specified in 45 CFR 158.150. A trial incentive program is a time limited monetary or non-monetary reward offered to a member who complies with the intended goals of the program as outlined by the MCOP (e.g., recommended health screenings) in the submission.

ii. The MCOP's proposed pilot or trial incentive program:

1. Must aim to improve health outcomes by engaging members in their own care;

2. May consist of short-term incentives (e.g., one-time flu shot incentive) and time-limited incentive programs, but should also offer long-term projects (e.g., women's health screenings) and other incentives to improve social determinant of health and wellness for MyCare members.

3. Must demonstrate that the MCOP used data to select incentive program goals and priorities; and

4. Must not discriminate against members based on race, national origin, limited English proficiency, gender, disability, chronic disease, whether a person resides or receives services in an institutional setting, frailty, health status, or other prohibited basis. The MCOP must implement incentive programs to ensure equal access for members eligible for the MCOP's proposed incentive program.

iii. The MCOP must not use a medically necessary Medicaid-covered service, or an additional benefit as offered in the MCOP's member handbook as an incentive.

iv. Pilot and trial incentive program requirements described in this section do not apply to quality withhold programs specified in Appendix J, Quality Withhold, of this Agreement or any federally required quality improvement projects.

v. The MCOP must refer to the ODM form 10267 Managed Care & MyCare Ohio Organization Pilot Program Request Template for additional clarification.

vi. The MCOP must ensure that any incentive program or combination of incentive programs complies with state and federal requirements. ODM's approval of a pilot or trial incentive program should not be construed as an assurance that the program meets such requirements.

vii. The MCOP must submit a Pilot and Trial Incentive Program Report to ODM as specified in Appendix P, Chart of Deliverables, which includes incentive program participation levels, measures of success, and the MCOP's proposed plans for improvement or changes for the following year.

c. <u>In Lieu of Services</u>

i. In accordance with 42 CFR 438.3(e)(2), the MCOP may voluntarily propose coverage for services that are in lieu of services (ILOS) covered under the Ohio Medicaid state plan (ILOS).

1. The MCOP's proposal must demonstrate that any ILOS is a medically appropriate and cost-effective substitute for a service covered under the Ohio Medicaid state plan.

2. The MCOP proposal must include a cost-benefit analysis for any ILOS it proposes to provide, including how the proposed service would be a medically appropriate and cost-effective substitute for a service covered under the Ohio Medicaid state plan.

ii. ILOS must be prior approved by ODM in writing, and MCOPs must only provide ILOS that are documented in this Agreement.

iii. The MCOP must not require a member to use an ILOS as an alternative to a service covered under the Ohio Medicaid state plan.

d. Supplemental Benefits

i. Consistent with 42 CFR 422.2, 422.100, and 422.102, ODM may require coverage of the following Medicare supplemental benefits for dual benefit members:

1. Community-based palliative care as described in Appendix B, Coverage and Services, Paragraph 2.m.

2. Additional transportation required under Appendix B, Coverage and Services, Paragraph 2.p.

3. Separate reimbursement for evaluation and management services with International Classification of Diseases (ICD) Z codes for additional rendering providers to be determined by ODM (e.g., pharmacists).

4. A flexible spending card, such as a prepaid Visa, which can be used by the member for items such as food, utilities, and over-the-counter drugs in an amount equaling the largest amount offered by any of the MCOP's corporate family's Medicare Advantage plans within the state of Ohio.

5. Transportation services to and from community activities for MyCare members not enrolled in the MyCare Ohio HCBS Waiver.

6. Coverage of services determined by ODM possibly including dental, eyewear, and hearing aids in an amount specified by ODM.

4. Member Cost-Sharing for Medicaid Services

a. Pursuant to OAC rule 5160-26-05 and 42 CFR 438.108, the MCOP may impose the applicable member co-payment amount for Medicaid dental services, vision services, and/or non-emergency emergency department services.

b. If the MCOP intends to impose a co-payment, the MCOP must notify ODM of the timing of the implementation of imposing the co-payment and obtain ODM's written approval of the MCOP's proposed notice to members.

c. If the MCOP intends to impose a co-payment for a mental health or SUD benefit, the co-payment must comply with parity requirements in 42 CFR 438.910(c). The MCOP must submit documentation to ODM demonstrating that the co-payment complies with parity and receive ODM's approval prior to implementing the co-payment.

d. If ODM determines the MCOP's decision to impose a particular co-payment on its members would constitute a significant change for those members, ODM may require the effective date of the co-payment to coincide with the open enrollment month.

e. Notwithstanding the preceding paragraph, the MCOP must provide an ODM-approved, written notice to all its members 90 calendar days in advance of the date that the MCOP proposes to impose the co-payment.

f. With the exception of member co-payments, the MCOP has elected to implement in accordance with OAC rule 5160-26-05, the MCOP's payment for any covered services constitutes payment-in-

full, and the MCOP must ensure its providers do not charge members or ODM any additional co-payment, cost- sharing, down payment, or similar charge, refundable or otherwise.

g. In accordance with 42 CFR 438.106(b), the MCOP is prohibited from holding a member liable for the cost of services provided to the member in the event that ODM fails to make payment to the MCOP.

h. Pursuant to OAC rule 5160-26-05, the MCOP must ensure that MCOP subcontractors and providers do not bill members any amount greater than would be owed if the entity provided the services directly (i.e., no balance billing).

i. The MCOP may elect to implement co-payments for Medicaid covered drugs but must not charge cost- sharing to members above levels established under the Medicare Part D Low Income Subsidy. Co-payments charged for Medicaid drugs must not exceed the applicable amounts for brand and generic drugs established yearly by CMS under the Medicare Part D Low Income Subsidy, although the MCOP may elect to reduce this cost-sharing for all members to encourage medication adherence.

j. The MCOP may waive Medicaid cost-sharing, subject to applicable regulatory and legal requirements and limitations.

k. Members who are residents of nursing facilities or enrolled in the MyCare Ohio HCBS Waiver may be required to contribute to the cost of nursing facility care that amount of patient liability established by the CDJFS.

    i. Pursuant to the MyCare Ohio HCBS Waiver, following a four-month claims run-out period, the MCOP must provide monthly reconciliation reports, as designated by ODM, to each AAA documenting any month for which the waiver member's actual cost of HCBS waiver services is less than the member's patient liability amount for the same period. For all members except those using the Assisted Living Service, the report must specify the actual payment amount of HCBS waiver services delivered and the patient liability amount for the applicable month. The MCOP must submit the report to each AAA no later than the 15th of the month. If no members meet the reporting criteria, the MCOP must enter 'N/A' in the first row of all columns and submit as instructed.

5. Utilization Management Program

a. <u>General Requirements</u>

    i. The MCOP must develop, implement, and maintain a Utilization Management (UM) program that is National Committee for Quality Assurance (NCQA) accredited and that facilitates the delivery of high quality, cost efficient, and effective care. The MCOP's UM program must be used to inform the MCOP's population health and quality improvement (QI) strategies as outlined in Appendix C, Population Health and Quality.

    ii. The MCOP must monitor its UM program on an ongoing basis and evaluate and update UM program requirements at least annually as a component of the MCOP's QI plan and assessment. Based upon the evaluation and assessment, the MCOP must update the UM program policies, structures, and processes, as necessary. The MCOP's monitoring, and evaluation of its UM program must include:

        1. Monitoring the timeliness of service authorization;

2. Monitoring the consistency of the MCOP's application of service authorization criteria;

3. Assessing to determine whether the MCOP's prior authorization procedures unreasonably limit member access to covered services;

4. Reviewing the MCOP's list of services that are subject to prior authorization to determine whether there is an ongoing need for prior authorization to ensure appropriate utilization of services;

5. Using provider feedback to identify opportunities to standardize and streamline service authorization processes to reduce administrative burden for providers; and

6. Monitoring for updates to ODM clinical coverage criteria, evidence-based nationally recognized medical necessity guidelines, and other professional literature to inform and update the MCOP's clinical coverage policies and criteria.

iii. While the MCOP must have mechanisms in place to ensure that its UM program interfaces with and informs the MCOP's program integrity responsibilities under Appendix G, Program Integrity, the MCOP must demonstrate that the primary function of its UM program is to meet the clinical needs of its members, to meet all state and federal requirements, and to deliver efficient and appropriate services.

iv. In accordance with 42 CFR 438.210(e), the MCOP must ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member.

v. In accordance with 42 CFR 438.210, the MCOP must ensure that required services are not arbitrarily denied or reduced in amount, duration, or scope solely because of diagnosis, type of illness, or condition of the member.

vi. The MCOP must use UM data and other quality information to identify and appropriately address providers who appear to be operating outside peer norms with respect to service utilization, prescribing patterns, and quality of care concerns. The MCOP must report providers who are operating outside of such peer norms, including practices that impact member safety, to ODM.

vii. The MCOP must use information available through the Ohio Board of Pharmacy's prescription drug monitoring program, in addition to other available resources (e.g., claims data), to monitor member utilization and provider prescribing patterns of controlled substances and other drugs.

viii. The MCOP must have the capabilities to receive service authorization requests by EDI or a flat file.

b. Policies and Procedures

i. The MCOP must develop and implement clearly defined UM policies, structures, and processes pursuant to OAC rule 5160-58-03.1 and for Medicare services to dual benefit

members, in compliance with Medicare requirements, including 42 CFR 422.127 and 42 CFR 422.128, to maximize the effectiveness of care provided to members.

ii. The MCOP must implement UM requirements for SUD services as necessary to support Ohio's SUD 1115 demonstration waiver implementation plan. All UM requirements must comply with parity requirements (see section 8 of this appendix).

iii. The MCOP must submit clinical coverage policies and any subsequent proposed changes to ODM for review and approval prior to implementation. The MCOP's submission must include a proposed list of the services and items subject to UM clinical coverage reviews.

1. As part of the MCOP's submission of clinical coverage policies or changes thereto, the MCOP must include a summary of the MCOP's analysis, in the format specified by ODM, that demonstrates that the policy and/or changes thereto comport with the parity requirements in 42 CFR 438.910(d).

2. The MCOP's analysis must demonstrate that the non-quantitative treatment limits resulting from the MCOP's clinical coverage policies for mental health/SUD benefits in all classifications are comparable to and are applied no more stringently than the non-quantitative treatment limits for medical/surgical benefits in the classification.

iv. The MCOP must notify network and out-of-network providers of clinical coverage policies. The communication must include an outline or a summary specifying the changes and their impact on specific providers receiving the policy changes. Changes to policies require 30 days advance notice. Provider notifications must meet the requirements in Appendix A, General Requirements.

v. The MCOP must not implement additional UM requirements for any MyCare Ohio HCBS Waiver services identified and approved through the person-centered service planning process in accordance with OAC rule 5160-44-02.

c. Utilization Management Program Structure

i. The MCOP must structure its UM program to meet requirements in OAC rule 5160-58-03.1.

ii. The MCOP must ensure that the administrative and organizational structure of the MCOP's UM program reports to the MCOP's Chief Medical Officer (CMO).

iii. The MCOP's UM structure must include a UM Committee, chaired by the MCOP's CMO or designee, to review and approve the MCOP's UM program, plan, and annual evaluations, as well as UM policies and procedures. The MCOP must include the Behavioral Health Clinical Director as a member of the UM Committee.

iv. The MCOP must have appropriately qualified UM review staff who are available by telephone from 8:00 am to 5:00 pm Eastern Time, Monday through Friday, (except for the major holidays and two optional closure days as required in Appendix A, General Requirements) to render UM decisions for providers. UM review staff must be available by telephone 24/7 to respond to authorization requests for inpatient admissions, or the MCOP must have policies and procedures that allow for emergency inpatient admissions with authorization the next business day.

v. In addition to having appropriately licensed clinical staff with subject matter expertise to review and make prior authorization decisions as specified in Appendix A, General Requirements, the MCOP must have appropriately licensed clinical professionals to supervise staff making medical necessity decisions.

vi. The MCOP must ensure that MCOP staff performing peer-to-peer consultations as described below in this appendix are health care professionals who have appropriate clinical expertise in treating the member's condition.

d. Authorization Data and Reporting

i. Pursuant to OAC rule 5160-58-03.1, the MCOP must submit information on prior authorization requests as directed by ODM.

The MCOP must submit detailed prior authorization data to ODM for the Utilization Management Tracking Database (UMTD) as specified in Appendix P, Chart of Deliverables.

ii. The MCOP must provide ODM a Service Authorization Report as required in the *ODM Grievance, Appeal, and Service Authorization Reporting Specifications Manual* to ODM as specified in Appendix P, Chart of Deliverables.

iii. The MCOP must conduct root cause analysis of authorization denials and appeals and develop a targeted plan to decrease inappropriate denials and ensure ease of appeal of medical necessity denials.

iv. The MCOP must provide ODM an Unstaffed Home Care Report as specified in Appendix P, Chart of Deliverables. The Unstaffed Home Care Report must include details for any member with a need for aide or nursing service without a provider, as described in the required reporting template. This includes services without a provider at the planned service start date or when a member experiences the loss of a provider after the services were authorized.

v. The MCOP must share with ODM any tasking tool used in developing authorizations for either MyCare Ohio HCBS Waiver services or home health or PDN state plan services.

6. Coverage Requirements

a. Medical Necessity Criteria

i. Pursuant to OAC rule 5160-58-03, the MCOP's coverage requirements and decisions must be based on the coverage and medical necessity criteria published in OAC Chapter 5160 and practice guidelines as specified in OAC rule 5160-26-05.1.

ii. For Medicare services to dual benefit members, the MCOP must comply with Medicare coverage requirements, including 42 CFR 422.101.

iii. The MCOP must have objective, written criteria based on sound clinical evidence to make medical necessity and utilization decisions. The MCOP must involve appropriate providers in the development, adoption, and review of medical necessity criteria. The MCOP's written criteria must meet NCQA standards and must specify procedures for appropriately applying the criteria.

iv. The MCOP must use ODM-developed medical necessity criteria where it exists. In the absence of ODM-developed medical necessity criteria, the MCOP must use clinically-accepted, evidence-informed medical necessity criteria (e.g., InterQual®, MCG®, and ASAM) as approved by ODM.

v. In the absence of ODM-developed medical necessity criteria or ODM-approved, clinically-accepted, evidence-informed medical necessity criteria, the MCOP's adaptation or development of medical necessity criteria must be based upon evaluated, peer reviewed medical literature published in the United States.

1. Peer reviewed medical literature must include investigations that have been reproduced by non-affiliated authoritative sources.

2. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale that is based upon well-designed research and endorsements by national medical bodies or panels regarding scientific efficacy and rationale.

vi. When applying coverage policies and medical necessity criteria, the MCOP must consider individual member needs and an assessment of the local delivery system.

b. Inter-Rater Reliability

i. The MCOP must perform inter-rater reliability testing to ensure consistent application of MCOP medical necessity criteria when making coverage decisions.

ii. At least annually, the MCOP must ensure that all staff performing initial and continuing authorizations and denial reviews participate in inter-rater reliability testing to assess consistency in the application of medical necessity criteria.

iii. The MCOP must establish specific inter-rater reliability thresholds by service or category of service.

iv. The MCOP must not permit staff performing below acceptable thresholds for inter-rater reliability to make independent authorization decisions until such time that staff member can be retrained and monitored and demonstrate performance that exceeds the acceptable threshold.

v. The MCOP must continually monitor performance and implement corrective measures if the MCOP does not meet internal inter-rater reliability benchmarks.

7. Service Authorization

a. General Requirements

i. The MCOP must cooperate with ODM to develop processes and systems necessary to allow providers to submit requests for product or service authorization, and for the MCOP to accept and respond to authorization requests from providers through secure electronic transmission and exchanges with ODM's Ohio Medicaid Enterprise System (OMES). Authorization requests include prior authorizations, concurrent reviews, and retrospective

reviews. The MCOP must require its providers to comply with service authorization submission requirements through ODM's OMES as determined by ODM.

ii. The MCOP must comply with requirements in OAC rule 5160-58-03.1for responding to provider requests for initial and continuing authorization of services.

iii. The MCOP must comply with prior authorization requirements described in the CMS Interoperability and Prior Authorization Final Rule.

iv. The MCOP must establish its PA system so it does not impede member access to medically necessary covered services.

v. The MCOP must comply with the provisions of OAC rule 5160-58-03.1 regarding the timeframes for PA of covered outpatient drugs as applicable for Medicaid covered drugs.

vi. For any service or prior authorization request or decision, ODM may require an additional clinical review or a different clinical review process. The MCOP must cooperate with and assist, as needed, with this additional or different review. ODM retains authority to ultimately decide whether a service should be approved.

vii. The MCOP must comply with service authorization requirements to meet the member transition of care requirements in Appendix D, Care Coordination, and within this Agreement.

viii. The MCOP must permit and facilitate ODM real time, read-only access to the MCOP's service authorization systems, including all approval and denial documentation.

ix. The MCOP must implement ODM expectations to standardize and streamline requirements to reduce administrative burden for providers, including:

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

b. Substance Use Disorder Services

i. The MCOP must make medical necessity determinations for inpatient and outpatient substance use disorder (SUD) treatment authorizations in accordance with the ASAM criteria and guidelines for placements and level of care. When making medical necessity determinations for inpatient services, the MCOP must also use other clinical criteria (i.e., MCG® or InterQual®) in addition to ASAM criteria and must authorize services when either ASAM or MCG®/InterQual® indicates the need for inpatient services.

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

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

iv. Upon medical necessity review and in accordance with ASAM criteria, if a needed level of care for SUD treatment is not available, the MCOP must authorize at the next highest available level of care for SUD treatment. For example, if an authorization request for ASAM 4.0 does not meet clinical criteria for inpatient hospitalization, but the member needs medically monitored withdrawal management at ASAM level 3.7, the MCOP must authorize level 4.0 until access to level 3.7 withdrawal management can be assured.

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

c. Home Health Assessment Service Authorization

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

d. Retroactive Coverage Requirements

i. Pursuant to ORC section 5160.34(C), the MCOP is prohibited from retroactively denying a prior authorization request as a UM strategy. When performing a pre-payment review of a claim, the MCOP may not deny the claim due to medical necessity when the service was prior authorized. In addition, the MCOP must conduct the retrospective review of a claim submitted for a service where prior authorization was required but not obtained in accordance with the criteria in ORC section 5160.34(B)(9).

e. Notification of Authorization Decisions

i. The MCOP must meet Notice of Action requirements pursuant to OAC rule 5160-58-08.4.

1. The MCOP must use the ODM-developed Notice of Action template, and all information included by the MCOP must meet the member information requirements as described in Appendix A, General Requirements.

f. Peer-to-Peer Consultation and Provider Appeals

i. When the MCOP denies a service authorization request from a provider, the MCOP must include and offer the following information to providers in the initial denial notice, via a separate notice, the option to request a peer-to-peer consultation, and a provider appeal, and external medical review. The provider appeal process must satisfy the requirements and timeframes in ORC 5160-34(B)(12).

ii. The MCOP must use accepted clinical guidelines under this Agreement when conducting peer-to-peer consultations and provider appeals.

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

iv. The MCOP must ensure that MCOP staff conducting peer-to-peer consultations and provider appeals are health care professionals who have clinical expertise in treating the member's condition, with the equivalent or higher credentials as the requesting/ordering provider.

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

vi. The MCOP must offer a peer-to-peer consultation within a mutually agreed upon time within 24 hours of a provider's request for a peer-to-peer consultation.

8. Mental Health Parity and Addiction Equity Act Requirements

a. The MCOP must comply with Mental Health Parity and Addiction Equity Act (MHPAEA) requirements outlined in 42 CFR Part 438 Subpart K regarding services provided to managed care members. The requirements apply to the provision of all Medicaid covered benefits and additional services (i.e., value-added and ILOS) to all populations included under the terms of this Agreement.

i. The MCOP must participate in ODM-requested meetings, respond to ODM information requests, work with ODM to resolve compliance risks, and notify ODM of any changes to benefits or limitations that may impact compliance with MHPAEA.

ii. The MCOP must conduct ongoing monitoring to determine compliance with MHPAEA and report compliance analysis and determinations using the MHPAEA Compliance Assessment Tool (MHPAEA Tool) provided and required by ODM.

iii. The MCOP must submit an updated MHPAEA Tool and written attestation of MHPAEA compliance to ODM:

1. At least 30 calendar days prior to the proposed effective date for implementing any new clinical coverage policy or changes to previously approved clinical coverage policies;

2. At least 30 calendar days prior to the proposed effective date to apply a financial requirement (co-payment);

3. At least 30 calendar days prior to the effective date of a change to benefits or limitations that may impact MHPAEA compliance;

4. As specified in Appendix P, Chart of Deliverables; and

5. Upon ODM's request.

iv. The MCOP's annual updated MHPAEA Tool must include an annual summary of self-monitoring activities that describes:

1. The MCOP's processes for reviewing and analyzing changes to benefit packages, service delivery structures, operational requirements, and policies to ensure ongoing parity compliance; and

2. The MCOP's processes for monitoring parity compliance in operation on a regular basis, including:

a. The data/information monitored by the MCOP to identify potential parity compliance concerns, the frequency of the MCOP's review of the data/information;

b. How the MCOP determines when further analysis is necessary; and

c. The process used by the MCOP to conduct further analysis when the data/information suggests the possibility of a parity compliance concern.

v. The MCOP must 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 MCOP.

APPENDIX C – POPULATION HEALTH AND QUALITY

1. Population Health Management

a. General

i. ODM defines "population health management" as an approach to maintain and improve physical and psychosocial well-being and address health disparities through cost-effective, person-centered health solutions that address members' health needs in multiple settings at all points along the continuum of care.

ii. ODM will lead Ohio's Medicaid population health management framework and will identify the respective roles and responsibilities of ODM and the MCOPs, for population health. The MCOP must participate in ODM-led meetings and activities and meet ODM-established population health roles and responsibilities as directed by ODM.

iii. Consistent with the construct of ODM's population health management framework, the MCOP must develop and implement its MCOP-specific Population Health Management Strategy (PHMS), to include the MCOPs role in leading population health efforts across MCOPs, for its members. The MCOP must submit its PHMS to ODM for review and approval as specified in Appendix P, Chart of Deliverables.

iv. The MCOP must continuously evaluate the effectiveness of its PHMS by monitoring performance on key (or ODM-required) outcome and process measures throughout the year. Subsequent submissions of the MCOP's PHMS must include updates to reflect the evaluation of its PHMS as described in Section 5 of this appendix.

b. MCOP Population Health Management Strategy (PHMS) for Covered Populations

i. The MCOP’s PHMS must be structured by ODM-specified population health streams and include how the MCOP is contributing to:

1. The development of an optimal person-centered health system;

2. Improving access to that system;

3. Ensuring that higher risk (sub)populations are identified;

4. Ensuring that all members are provided with best evidenced care and enhanced services to meet their needs; and

5. Maintaining and supporting continuity of care throughout the life course.

ii. The MCOP must submit the above stairstep approach for each population stream along with its PHMS template submission as described in Appendix P, Chart of Deliverables.

iii. The MCOP's PHMS must also describe the following core elements, described in more detail below in this appendix:

1. Population health infrastructure, including the leadership, resources, and information systems needed to support the MCOP's PHMS;

2. Population identification and segmentation to inform population health strategies, including assignment of members in alignment with ODM-identified population streams and the MCOP's risk stratification framework, criteria, and thresholds;

3. Population health approaches, including care coordination, quality improvement (QI), optimal care delivery, value-based purchasing, and other innovative approaches. The MCOP must describe:

    a. The approaches in place to improve the population health within each of ODM-identified population streams, with particular attention to health equity;

    b. Specific initiatives within each of these strategic approaches;

    c. The timelines and milestones for all the initiatives undertaken as part of the MCOP's PHMS; and

    d. Cross-system coordination — how the MCOP will collaborate and coordinate with other entities that impact population health as a result of their involvement in the support, care, and treatment of members, including the OhioRISE Plan and Single Pharmacy Benefit Manager (SPBM).

4. Evaluation — how the MCOP will monitor, evaluate, and refine its population health strategy, including using information obtained through system data, activities related to the MCOP's Quality Assessment and Performance Improvement (QAPI) Program, and External Quality Reviews to inform and improve its PHMS.

2. Population Health Infrastructure

a. General

    i. The MCOP must provide the infrastructure necessary to support its population health management approach that must include:

        1. The support of senior leadership;

        2. A robust information system and the related analytics; and

        3. Adequate staffing and resources to support each MCOP's strategic initiatives to improve population health and to evaluate and integrate the results of population health's improvement strategies into MCOP practices.

b. Senior Leadership Support

    i. The MCOP's senior leadership must foster and create an ongoing dynamic culture of innovation and health care excellence through its population health management approach. The lead member of the senior QI leadership team must report directly to the MCOP's Chief Executive Officer (CEO).

    ii. The MCOP must ensure that the Medical Director/Chief Medical Officer (CMO) is involved with and provides oversight for all clinically-related population health initiatives.

iii. The MCOP, through its senior leadership, must:

1. Provide direction and oversight of all population health improvement efforts;
2. Promote an MCOP culture that is focused on supporting an optimal health care delivery system through collaborative, cross-system population health management strategies;
3. Ensure a focus on both individual- and system-wide levels of improving the quality of care and reducing health disparities;
4. Ensure that gaps in care are remedied at both the individual and systemic levels;
5. Consistently and frequently use data and analytics strategically to identify improvement opportunities, evaluate the effectiveness of improvement initiatives, and incorporate results and lessons learned into MCOP business processes;
6. Ensure that all MCOP population health initiatives support health equity;
7. Ensure the MCOP shares results of improvement activities with other ODM-contracted managed care entities, community organizations that provide care coordination behavioral health care coordination entities, and ODM to work collaboratively to develop and implement strategies to have a collective impact in improving population health outcomes, including addressing health equity and social determinants of health (SDOH);
8. Ensure relevant staff (e.g., member services, provider relations, utilization management [UM] staff) are engaged in population health improvement efforts (e.g., care coordination and QI efforts) to inform and address barriers to optimal care and health outcomes;
9. Ensure transparent communication and coordination among the leadership team, the CEO and relevant functional areas of the organization;
10. Promote ongoing, rapid-cycle improvement of the quality of care and services provided by the MCOP and its subcontractors and providers; and
11. Engage in high-impact leadership activities as described in the paper High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs.[3]

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

c. Staffing Resource Allocation

i. *General*

1. The MCOP must allocate sufficient staffing to its population health activities to support each strategic initiative and respond to the needs of internal and external stakeholders.

ii. *Analytical Support*

1. The MCOP must have dedicated staff who conduct data analytic activities that include but are not limited to:

    a. Data cleaning and quality assurance;

    b. Data integration and data aggregation;

    c. Population identification and risk stratification;

    d. Descriptive and predictive analyses necessary to support population health strategies (e.g., care coordination, QI efforts, and alternative payment models); and

    e. Collaboration with other ODM-contracted managed care entities and health care system and community stakeholders to ensure that data integration and analysis is optimized for population health improvement.

iii. *Health Equity Staffing*

1. The MCOP must have sufficient health equity staffing resources to:

    a. Actively contribute to QI projects within each of the ODM-identified population streams;

    b. Attend ODM-led meetings and make connections with health equity staff from ODM and other ODM-contracted managed care entities; and

    c. Establish relationships with communities and community-based entities to inform and address local health equity issues.

iv. *Quality Improvement Staffing*

1. The MCOP must use QI activities and initiatives to improve population health outcomes, including the creation of new processes and procedures through iterative testing and evaluation that, at a minimum, incorporate insights from data, research, members, and providers.

2. The MCOP must dedicate sufficient staff to fulfill the MCOP's set of clearly defined QI functions and responsibilities, so that staffing is proportionate to, and adequate for, the planned number and types of QI initiatives.

3. The MCOP must have QI teams composed of MCOP staff fully dedicated to the Ohio Medicaid program that represent the following areas of expertise:

    a. Continuous QI;

    b. Analytics;

    c. Subject matter expertise in clinical and nonclinical improvement topics being addressed through improvement efforts;

    d. Health equity;

    e. MCOP policies and processes related to the improvement topic; and

    f. Member and provider perspectives (may be staff or liaisons with the MCOPs member and provider services).

4. The MCOP must designate at least one member of each QI team as having decision-making authority for testing and evaluating QI team changes to improve MCOP operations, demonstrating that the MCOP's QI teams are empowered to identify and make needed changes.

v. *Care Coordination Staffing*

1. The MCOP must provide the required care coordination staffing resource allocation necessary to support the MCOP's approach to population health management as specified in Appendix D, Care Coordination.

d. Population Health Information System

i. *General*

1. The MCOP must have information systems necessary to integrate and analyze data from multiple data sources to identify population streams, risk levels, individual- and population-level needs and calculate quality performance metrics, including but not limited to Health Care Effectiveness Data and Information Set (HEDIS) measures, as described in 42 CFR 438.242, 422.516(a) and 423.514. Information technology must also allow for monitoring the effectiveness of the MCOP's response to identified needs and its impact on improving outcomes.

ii. *System Capabilities*

1. The MCOP's information system must fully support all components of its PHMS, and comply with the requirements in Appendix K, Information Systems, Claims, and Data. At a minimum, the MCOP's data information system must have the capabilities necessary to support the MCOP in performing the following essential activities:

    a. Integration of multiple data and information sources (e.g., enrollment data, care management data, claims, member services, 24/7 medical advice line, and prior authorization data) to facilitate internal MCOP communication and coordination related to a specific member (e.g., the UM reviewer is able

to see the care coordination risk level and care coordinator assigned to a particular member) or population;

b. Inform population identification, risk assignment, stratification, and assignment of care coordination status;

c. Identification of providers and community-based organization involvement; and

d. House data to support the MCOP's PHMSs, including:

i. MCOP type of care coordination (i.e., care manager or waiver service coordinator);

ii. Identification of the primary entity providing care management and/or coordination;

iii. Identification of the alternative entity providing care management or coordination (e.g., Dual Eligible Special Needs Plan [D-SNP] or Medicare Advantage plan for Medicaid only members)

iv. Person-centered care plan content, including goals, interventions, outcomes, and completion dates;

v. Identification of population health improvement opportunities and choice of an appropriate population health management approach; and

vi. Data needed to monitor the effectiveness and impact of the MCOP's population health strategies.

2. The MCOP must search for and proactively incorporate useful data sources to improve its ability to serve its members, network providers, families, and communities.

3. The MCOP's information system must support the MCOP to perform timely information system improvements, testing, and execution necessary to operationalize MCOP- and ODM-coordinated population health efforts.

4. The MCOP's information system must support the use of health information exchanges (HIEs) and electronic health records (EHRs) necessary for near real-time understanding of member needs and reporting metrics, such as electronic clinical quality measures (eCQMs).

5. The MCOP's data systems must integrate key member information to facilitate internal MCOP communication and care coordination related to a specific member, as well as to inform the MCOP population stream initiatives. Key information includes but is not limited to:

a. Clinical data (including EHR and HIE data);

b. Data provided by community organizations that provide care coordination including behavioral health care coordination entities;

c. Health risk assessments and other assessments whether conducted by the MCOP, providers, or community-based organizations;

d. Enrollment data;

e. Financial data;

f. Utilization data, which may include services like professional, hospital, and pharmacy;

g. Labs;

h. Data from member and provider portals;

i. Programmatic data (e.g., care management, disease management);

j. Improvement project outcome, process, and balancing measures;

k. Survey data (e.g., Consumer Assessment of Healthcare Providers and Systems [CAHPS], Behavioral Risk Factor Surveillance System [BRFSS], Ohio Pregnancy Assessment Survey [OPAS], American Community Survey [ACS]);

l. Registry data (e.g., immunization data);

m. Complaints, grievances, and appeals;

n. Resource information from community-based organizations serving members;

o. Local governmental data (e.g., local health department data, Alcohol, Drug Addiction, and Mental Health [ADAMH] Board data, County Department of Job and Family Services [CDJFS] data, family first councils);

p. Data from MCOP subcontractors and providers (e.g., transportation, home health agencies, HUBS); and

q. Administrative data from ODM (e.g., 834 file).

6. The MCOP's data system must support health equity efforts by:

   a. Allowing for the identification of disparities in areas such as service access, utilization, health outcomes, intervention effectiveness, social risk factors, and survey (e.g., Consumer Assessment of Healthcare Providers and Systems [CAHPS]) results by member characteristics; and

   b. Supporting the monitoring and comparison of process and outcome measures over time to inform disparity reduction efforts.

7. The MCOP's data system must efficiently and securely share data with ODM, community organizations that provide care coordination, behavioral health care

coordination entities, and other community-based organizations, subject to state and federal privacy requirements, including:

a. Data to identify gps in services for members;

b. Attribution file;

c. Risk factors related to SDOH and other relevant information; and

d. Tracking and confirming MCOP referrals to social services.

8. The MCOP's data system must efficiently and securely exchange care coordination data with providers (e.g., primary care providers [PCPs] and behavioral health providers) to facilitate integrated care planning, subject to state and federal privacy requirements. Data sharing must use industry standard formats (Consolidated Clinical Document Architecture and Fast Health Interoperability Resources).

3. Population Identification and Segmentation

a. Population Stream Assignment

i. ODM's population health streams are currently: women and infants, children, and adults with behavioral health conditions, healthy children and adults, members with developmental or chronic conditions, and older adults. The MCOP's assigned population streams must align with the following covered populations within one of ODM's-identified population streams for Next Generation MyCare Ohio which includes: women, adults with behavioral health conditions, healthy adults, members with developmental or chronic conditions, and older adults. The MCOP must stratify populations within its membership to drive the MCOP population health management approach, prioritization of initiatives, and resource allocation and to optimize health outcomes.

ii. The MCOP must incorporate ODM-provided, structured guidance for identifying the population streams as described in ODM's Quality Strategy, located on ODM's website, into the MCOP's PHMS as required by ODM.

iii. The MCOP must, in its PHMS, describe each population stream and include the incidence and prevalence of medical and behavioral health conditions, and considerations that may impact health status, such as:

1. Age, gender, race, ethnicity, geography, language, and other socio-economic barriers;

2. Current and previous trauma experiences that might impact the effective provision of health care services; and

3. Living or caregiver arrangements that might pose challenges for certain members.

iv. The MCOP must integrate information from a variety of data sources, including those referenced in this appendix, to assign members to one of the ODM-identified population streams.

v. The MCOP must assign each member to a population stream based upon the member's age, health care conditions, and needs.

vi. The MCOP must have systems and processes in place to identify and track the population stream assigned to each member.

b. Risk Stratification

i. Within each population stream, the MCOP must establish and assess member risk levels for all members.

ii. The MCOP must develop a risk stratification framework, criteria, and thresholds that must be approved by ODM prior to application as part of its PHMS. The MCOP's risk stratification must be comprised of four tiers (i.e., from lowest to highest: low/monitoring risk [Tier 1], moderate risk [Tier 2], high risk [Tier 3] and intensive risk [Tier 4]). The MCOP must develop ODM-approved criteria and thresholds for each tier to determine member assignments.

1. The MCOP's criteria and thresholds must identify the factors considered when determining a member's risk stratification level.

a. At a minimum, the criteria and thresholds must include the following current and historical factors:

i. Receipt and duration of 1915 (c) Home- and Community-Based Services (HCBS) waiver enrollment or 1915(i) services;

ii. Current risk tier or waiver acuity level;

iii. Change in existing waiver service coordinator or MCOP care manager relationship;

iv. Change in caregiver status/support;

v. Nursing facility or assisted living placement;

vi. Displayed risk factors for being institutionalized (e.g. previous history of institutionalization, enrollment in 1915 (c) waiver);

vii. Acuity and number of chronic conditions;

viii. Substance use and mental health disorders;

ix. Inpatient and emergency department utilization;

x. SDOH; and

xi. Safety risk factors.

b. To determine the needs of the member, the MCOP must consider information from the member's health risk assessment; and

c. Other available information.

2. The MCOP must assign an initial risk stratification tier within the first month of a member's enrollment for members newly enrolled with the MCOP.

3. The MCOP must evaluate a member's stratification tier whenever there is a significant change in the member's needs or circumstances. If the MCOP changes the member's stratification tier as a result of this evaluation, the MCOP must document the change in member's need or circumstances that led to the change in stratification.

4. In coordination with other data sources, the MCOP must use risk stratification to assist in targeting interventions aimed at improving population health, as well as identifying and providing for member needs (e.g., transportation, housing instability, food insecurity).

5. The MCOP, in collaboration with ODM and other ODM-contracted managed care entities, must develop a process to collectively monitor Ohio's high- risk groups (e.g., members with complex nursing needs, substance use disorder [SUD] and behavioral health needs, and SDOH related needs) across the life course to prevent current and future adverse events.

6. The MCOP must submit a file to ODM that contains a risk stratification level for all members (MCOP Risk Stratification Data Submission File), in a file format as required in the *MCOP Risk Stratification Data Submission Specifications* and as specified in Appendix P, Chart of Deliverables.

4. Population Health Approaches

a. General

i. The MCOP's population health improvement strategies must include:

1. Care coordination consistent with the requirements in Appendix D, Care Coordination;

2. Optimizing the delivery system through quality and performance improvement activities, health equity, and the identification and promotion of clinical and payer best practices;

3. Supportive payment structures to promote a system-wide population health management approach; and

4. A range of health and wellness programs and informational material that target specific health needs and risk behaviors identified for the MCOP’s membership.

b. Optimal Delivery System

i. The MCOP must continuously improve all aspects of the care delivery system to optimize the health of members through inclusion of input from members, providers, and other partners across the care continuum into the design, execution, evaluation, and refinement of MCOP service delivery policy and practice.

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

1. *Clinical Best Practice Guidelines*

a. The MCOP must develop and implement clinical practice guidelines that:

i. Are based on valid and reliable clinical evidence or consensus of health care professionals in a particular field;

ii. Consider the needs of members;

iii. Are adopted in consultation with the MCOP's network providers, which may be done through a provider advisory group;

iv. Are reviewed and updated quarterly, or more frequently, if needed;

v. Are provided in an efficient and effective format to all affected providers, members, and potential members;

vi. Incorporate the results of QI projects when applicable; and

vii. Are reported annually within ODM's PHMS Evaluation template.

b. The MCOP must participate in the Regional Quality Improvement (QI) Hub initiative in order to more reliably translate best-evidence care into clinical practice. This initiative, currently focused on diabetes and hypertension, led by the colleges of medicine and health system partners, adds value to Ohio's health system as it is focused on driving more effective care and intentionally addressing health disparities through structured QI interventions. The MCOP must implement QI interventions co-designed with the Regional QI Hub and participating practices, conduct related evaluations as needed, and spread successful interventions.

2. *Payer Best Practices*

a. As a strategy for optimizing the care delivery system, the MCOP must identify and demonstrate best payer practices that optimize member and provider experiences. The MCOP must provide evidence of best practices (e.g., results of intervention testing, pilot, or program evaluations) to ODM upon request. Activities in support of this strategy must include:

i. Incorporating the perspective of members, families, communities and providers;

ii. Obtaining input from network providers on burdens generated by MCOP policies and procedures and efforts to minimize these burdens;

iii. Incorporating feedback from provider and member advisory groups on their needs and barriers to obtaining services to address the needs;

iv. Researching industry standards;

v. Reviewing trade journals and other literature;

vi. Conversing with other lines of business within the MCOP's parent company; and

vii. Testing strategies with members and providers through science-based QI methods and incorporating successful strategies into MCOP operations and policy.

c. Care Coordination

i. The MCOP must provide care coordination consistent with the requirements and principles in Appendix D, Care Coordination.

d. Health Equity

i. The MCOP must participate in and support ODM's efforts to reduce health disparities, address social risk factors, and achieve health equity. The MCOP's health equity efforts must include the following:

1. Identifying disparities in health care access, service provision, satisfaction, and outcomes. This includes:

a. Obtaining data on member demographics and social determinants; and

b. Stratifying MCOP data (e.g., claims, HEDIS, CAHPS, health risk assessment, member-identified race, ethnicity, geography, language, and SDOH) to determine populations with the highest needs.

2. Ensuring the delivery of services in a culturally appropriate and effective manner to all members by promoting cultural humility at all levels of the MCOP and with network providers, including promoting awareness of implicit biases and how they impact policy and processes;

3. Obtaining ongoing input from members within population streams who have disparate outcomes to:

a. Create strategies for reducing disparities that incorporate the perspective of the member;

b. Define metrics, timelines, and milestones that indicate success; and

c. Establish credibility and accountability through active member involvement and feedback.

4. Ensuring that each functional area with outward facing communications tests potential publications with members for understanding and conveyance of the intended message, as well as cultural appropriateness;

5. Collaboratively partnering with members, other ODM-contracted managed care entities, network providers, and internal staff to test, refine, and share successful strategies for reducing disparities;

6. Connecting and engaging with individuals and organizations within the communities the MCOP serves to understand community needs and resources;

7. Partnering with community-based organizations and contributing to solutions addressing SDOH-related needs, such as:

    a. Lack of access to nutritious food (e.g., food insecurity, food deserts, and food swamps);

    b. Employment;

    c. Homelessness and housing instability;

    d. Education;

    e. Transportation;

    f. Interpersonal safety; and

    g. Toxic stress.

8. Ensuring the active referral to and follow-up on identified needs related to SDOH such as those outlined above by:

    a. Providing validated up-to-date community resource lists for member and provider use;

    b. Sharing health risk assessments and other sources identifying SDOH needs, subject to state and federal privacy requirements, with network providers, HUBS, and community health workers;

    c. Allowing provider choice regarding method of referral and follow-up/confirmation;

    d. Reimbursing providers for notification of SDOH needs (e.g., use of the International Classification of Diseases [ICD] Z codes); and

    e. Reimbursing network providers for follow-up after referral to confirm that the member received the service (e.g., HIEs).

9. Identifying dual benefit members who have not seen a PCP in a year or more, assessing their needs and risk stratifying appropriately, making referrals to needed services, and following up to confirm that the member received the services;

10. Staying informed of innovations and research findings that impact the health of populations experiencing disparities; and

11. Tracking data over time and increasing performance targets when milestones are met.

ii. The MCOP must describe how the MCOP meets the requirements for addressing health disparities within ODM's PHMS Evaluation template.

e. MCOP Specialized Services and Resources

i. The MCOP must provide services and resources tailored by population, community, and risk tier along the care continuum from low to intensive risk.

ii. When a need for services or resources is identified through a risk assessment, such as the Pregnancy Risk Assessment Form (PRAF), the MCOP must provide a report as specified in Appendix P, Chart of Deliverables.

iii. As part of its PHMS, the MCOP must include a description of specialized services and other resources (e.g., health and wellness programs, 24/7 medical advice line, care coordination) for each population stream tailored to risk level and communities.

iv. The MCOP must identify community services and resources that can be offered to members and build working relationships with community organizations to refer to and support provision of those services.

1. *Specialized Services for High-Risk Populations*

a. The MCOP must provide or arrange for specialized (or non-traditional) services to be delivered via different models in the community (e.g., home visiting, centering, community hub, community workers) as appropriate for high-risk populations identified by the MCOP, or as required by ODM. High-risk populations include but are not limited to women who are at risk of a preterm birth and those with complex nursing needs such as dialysis dependence, eternal feeds such as tracheostomy, total parenteral nutrition (TPN), or peripherally inserted central catheter (PICC) lines, chronic disease, amputation, or traumatic brain injury (TBI). High-risk members could also include those undergoing treatment for addiction, members involved with the justice system, and individuals with dual mental health/SUD. SDOH concerns such as unstable housing and/or limited familial support, limited English proficiency, those with no backup plan members who reside in outlying or rural areas, and individuals transitioning from a nursing facility or other residential or institutional facility back to the community.

b. The MCOP must assess and enhance specialized programming for each group identified by the MCOP's PHMS using continuous QI principles.

c. The MCOP must ensure that all services provided to high-risk or special populations align with the associated ODM guidance documents for those populations. ODM guidance documents can be found on ODM's website.

d. The MCOP is responsible for ensuring that the community services meet health equity expectations, the member's needs, honor member preference, and do not duplicate other services paid for by the MCOP or ODM.

e. Members who are pregnant or capable of becoming pregnant who reside in a community served by a qualified community hub, as defined in Ohio Revised Code (ORC) section 5167.173(A)(5), may be recommended to receive HUB pathway services (by a physician, advance practice registered nurse, physician assistant, public health nurse, or another licensed health professional specified by the MCOP or ODM). For those members, the MCOP at a minimum must provide for the delivery of the following services provided by a certified community health worker or public health nurse, who is employed by, or works under contract with, a qualified community hub:

i. Community health worker services or services provided by a public health nurse to promote the member's healthy pregnancy; and

ii. Care coordination performed for the purpose of ensuring that the member is linked to employment and educational/training services, housing, educational services, social services, or medically necessary physical and behavioral health services.

iii. The MCOP must support and implement ODM's programs and initiatives for justice-involved individuals as specified in *ODM's Expectations for Managed Care Organizations to Support Justice-Involved Individuals*.

f. Utilization Management

i. The MCOP must monitor health care service under- and over-utilization as outlined in Appendix B, Coverage and Services, and Ohio Administrative Code (OAC) rule 5160-58-03.1 to inform its PHMS. This includes:

1. Analyzing utilization by subpopulation demographics to ensure optimal care for all populations;

2. Analyzing utilization by service areas (service types and geographies) prioritized by the MCOP for UM;

3. Establishing a process for setting thresholds for selected types of utilization (e.g., clinical criteria);

4. Establishing standards for timeliness of UM decisions and MCOP performance against standards;

5. Immediately investigating any identified under-utilization of services in order to determine root cause, corrective action to identified problem areas, and monitoring of data over time to ensure sustained correction of the problem that led to the service under-utilization;

6. Establishing methods to ensure that the MCOP UM decision-making process is as efficient and uncomplicated as possible for the member, provider, and provider's staff;

7. Evaluating the consistency of the application of UM criteria through inter-rater reliability testing, as specified in Appendix B, Coverage and Services; and

8. Communicating identified trends to MCOP staff, ODM, and providers, as appropriate.

ii. In accordance with 42 CFR 438.330, the MCOP must describe its mechanisms to detect both under-utilization and over-utilization of services as part of the QAPI sub-portion of the annual PHMS evaluation. The MCOP must link the utilization analysis to population health outcomes, and incorporate the information obtained through this analysis into the MCOP's PHMS.

g. Community Reinvestment

i. The MCOP must demonstrate a commitment to improving health outcomes in local communities in which it operates through community reinvestment activities. The MCOP's community reinvestment must be used to support population health strategies.

1. The MCOP must not use community reinvestment funding to pay for Medicaid covered services or MCOP administrative expenses.

2. The MCOP must contribute , a specified percentage of its estimated annual after-tax underwriting margin to community reinvestment. The calculation for 2027 will be an estimate provided by ODM based on the projected member months each calendar year (CY). For 2027, ODM will calculate3% of the MCOP’s assumed 1.5% risk margin with the expectation that the MCOP will begin implementation of community reinvestment during CY 2026 following approval of its Community Reinvestment Plan. For 2028, ODM will calculate 4% of the MCOP’s assumed 1.5% risk margin with the expectation that the MCOP will award the community reinvestment amount by June 30, 2029. The actual underwriting margin will be calculated for 2027 and 2028 based on the MCOP’s previous annual cost report with adjustments applied in recognition of taxes, as applicable. If the MCOP’s underwriting margin results are negative or otherwise less than actual community reinvestment spending in 2027 or 2028, ODM will issue a rebate to the MCOP, up to the full amount spent toward community reinvestment activities or the original underwriting margin estimate, whichever is less. If the MCOP’s underwriting margin results are positive or otherwise more than actual community reinvestment spending for 2027 or 2028, the MCOP must add the balance to the next year’s community reinvestment required amount.

a. Beginning in 2029, the actual underwriting margin will be calculated annually based on the same year’s annual cost report with adjustments applied in recognition of taxes, as applicable. The MCOP must contribute 5% of the annually calculated amount to community reinvestment by the end of the following year (e.g., the 202 amount must be awarded by December 31,

2030). Any unspent community reinvestment dollars required in any year will be carried over and added to the required amount for the next year.

3. The MCOP must work collaboratively with the other ODM-contracted MCOPs, MCOs, and the OhioRISE Plan in a geographic area to maximize the collective impact of community reinvestment funding.

4. The MCOP must use available population health data (e.g., opportunity index data, and consider existing local community health assessments [e.g., local health districts and hospital assessments]) to develop its community reinvestment plan.

5. The MCOP must prioritize community reinvestment opportunities generated from community partners.

6. The MCOP must submit the collaborative Community Reinvestment Plan and Evaluation to ODM for ODM approval as specified in Appendix P, Chart of Deliverables. The MCOP's Community Reinvestment Plan must detail the MCOP's anticipated community reinvestment activities and describe how those activities support the MCOP's population health strategies.

7. After the first submission, the MCOP must include a collaborative evaluation of the Community Reinvestment Plan to ODM as part of its Community Reinvestment Plan submission to ODM. The evaluation must describe and quantify the impact of community reinvestment funding on population health improvement.

h. Quality Improvement

i. *General Requirements*

1. The MCOP must establish and implement an ongoing, comprehensive QAPI program in accordance with the requirements in 42 CFR 438.330, 42 CFR 422.152 for dual benefit members, and must meet the quality management and improvement criteria described in the most current National Committee for Quality Assurance (NCQA) Health Plan Accreditation requirements.

2. The MCOP’s QAPI program must employ a deliberate and defined, science-informed approach that is responsive to member and provider needs and incorporates systematic methods for discovering reliable approaches to improving population health and reducing health disparities.

3. The MCOP's QAPI program must encompass all levels of the organization, clearly linking the MCOP’s QI strategy to the MCOP’s and ODM's mission and vision.

4. The MCOP must participate in efforts by the State to prevent, detect, and remediate critical incidents (consistent with assuring member health and welfare pursuant to 42 CFR 441.302 and 441.730(a)) that are based, at a minimum, on the requirements on the State for HCBS waiver programs under 42 CFR 441.302(h).

5. The MCOP must establish internal processes to ensure that the quality program activities for primary, specialty, and behavioral health services, and long-term

services and supports (LTSS) reflect utilization across the MCOP's provider network and included the following elements:

a. A medical record review process, consistent with 42 CFR Part 456, for monitoring provider network compliance with policies and procedures, specifications and appropriateness of care.

6. The MCOP must provide the MCOP's stairstep PHMS framework QI strategy and QI structure as part of its PHMS. The MCOP must report on the execution of its QAPI program to ODM as part of its annual PHMS Evaluation-QAPI described below in this appendix.

7. The MCOP must have mechanisms in place to assess the quality and appropriateness of care furnished to members with special health care needs. The MCOP must follow the guidance in the QAPI submission template when describing and evaluating these aspects of the program.

8. The MCOP must:

    a. Deliver quality care that enables members to stay healthy, get better, manage chronic illnesses and/or disabilities, and maintain/improve their quality of life. Quality care refers to:

        i. Quality of physical health care, including primary and specialty care;

        ii. Quality of behavioral health care focused on recovery, resiliency, and rehabilitation;

        iii. Quality of LTSS including mechanisms to assess the quality and appropriateness of:

            1. Care between settings and a comparison of services and supports received with those in the member's person-centered care plan:

            2. Person-centered care plans, based on comprehensive assessments, and developed with members;

            3. Person-centered care plan that meet members' needs and that are responsive to their wishes for how services and supports will be delivered;

            4. Services in the plan and that they are actually delivered;

            5. Coordinated services (including health services); and

            6. Provider responsiveness to members' changing needs and circumstances.

        iv. Adequate access and availability to primary care, behavioral health care, specialty health care, and LTSS providers and services;

v. Continuity and coordination of care across all care and services settings, and for transitions in care; and

vi. Member experience and access to high quality, coordinated, and culturally competent clinical care and services, inclusive of LTSS across the care continuum.

ii. *Quality Improvement Strategy*

1. As described in this appendix, the MCOP must annually submit a clearly delineated, outcomes-driven QI strategy within the PHMS submission.

iii. *Quality Assessment and Performance Improvement Program Structure and Accountability*

1. *Organizational and Cross-Organizational QI Efforts*

a. The MCOP must integrate QI efforts throughout the organization.

b. The MCOP must ensure that staff at all levels of the organization are fully equipped and committed to improving health outcomes and reducing health disparities.

c. The MCOP must openly communicate the results of successful and unsuccessful QI efforts, internally and externally, to foster a culture of innovation.

d. The MCOP must engage and empower staff across all levels of the organization to seek out the root cause of problems, collaboratively test improvement strategies, and rapidly learn what works to maintain and spread successes.

e. The MCOP must collaborate with ODM and other contracted entities, on QI activities as required by ODM.

2. *Administrative Oversight by Senior Leadership*

a. As part of its population health infrastructure described above in this appendix, the MCOP must establish administrative oversight and accountability for its QI program.

b. The MCOP's oversight must include the assignment of an ODM-approved, senior QI leadership team responsible for the QI program (e.g., QI Director, Medical Director).

c. The MCOP must ensure that the Medical Director/ CMO is involved and provides oversight for all clinically-related improvement projects.

d. The lead member of the senior QI leadership team must report directly to the MCOP's CEO.

3. *Quality Improvement Capacity Building*

    a. General

        i. The MCOP must provide opportunities for staff training and hands-on application of ODM-approved, QI science tools, methods, and principles in daily work and strategic initiatives in order to build internal MCOP staff QI skills and capacity throughout the organization.

    b. Quality Improvement Training Requirements

        i. To create an organizational foundation with the necessary QI skills and proficiencies, the MCOP must:

            1. Ensure the MCOP's Medical Director, Behavioral Health Clinical Director, LTSS/HCBS Director, Population Health Director, Health Equity Director, QI Director, Dental Director, Pharmacy Director, analytic support staff, and at least one MCOP staff person assigned to each improvement team have completed training that covers the QI training content described below from an ODM-approved entity. The MCOP's QI training is not a substitute for the certification required in Appendix A, General Requirements; and

            2. Document the MCOP's ongoing efforts to build QI expertise and capacity in its annual PHMS Evaluation.

    c. Quality Improvement Training Content

        i. The MCOP's QI training content must include but is not limited to:

            1. The Model for Improvement developed by the Associates in Process Improvement and popularized by the Institute for Healthcare Improvement (IHI);[4]

            2. The Deming System of Profound Knowledge® (SoPK);

            3. Listening to and incorporating information and feedback from members, providers, and other stakeholders;

            4. Process mapping/flow charting;

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

5. Specific, Measurable, Applicable, Realistic, and Timely (SMART) Aim development and the use of key driver diagrams for building testable hypotheses;[5]
6. Gemba walks and other methods for understanding the perspective of members and providers impacted by the improvement project, including barriers related to current MCOP or system processes;
7. Methods for barrier identification and intervention selection (e.g., root cause analyses, Pareto charts, failure mode and effects analysis, and the five whys technique);
8. Selection and use of process, outcome, and balancing measures;
9. Testing change through the use of Plan-Do-Study-Act (PDSA) cycles;
10. Active application of rapid cycle, QI tools and methods;
11. The use of statistical process control, such as the Shewhart control chart; and
12. Tools for spread and sustainability planning.

d. Quality Improvement Training Completion

   i. The MCOP must submit training curricula to ODM for approval prior to start of MCOP operations under this Agreement, and prior to substantive changes to the training curricula.

   ii. The MCOP must submit Evidence of QI Training Completion as specified in Appendix P, Chart of Deliverables.

   iii. Medical Directors with a substantial role in improvement projects or who are accountable for the QAPI program, as well as QI Directors, must complete the course work within six months. Medical and QI Directors are exempt to this requirement if they have evidence of course completion covering the content above within.

e. Applying Quality Improvement Training Concepts

   i. The MCOP must ensure that during and subsequent to QI training, MCOP staff are actively involved as QI team members in at least one

[5] Institute for Healthcare Improvement. Driver Diagram. http://www.ihi.org/resources/Pages/Tools/Driver-Diagram.aspx

improvement project in order to continue to build the QI capacity of the MCOP.

ii. For purposes of this Agreement, "active involvement" means applying QI tools, methods, and concepts to a clinical or nonclinical problem, including the analysis of data to determine opportunities for improvement, root cause determinations, barrier assessment, intervention design, and testing using PDSA cycles, longitudinal measurement, and assessment of intervention impact on outcome measures using statistical process control methods.

iv. *MCOP Clinical and Nonclinical Improvement Projects*

1. The MCOP must design and conduct improvement projects in clinical and nonclinical topic areas that improve population health (including health equity) across the care continuum.

2. The MCOP must self-initiate improvement projects, as well as conduct improvement projects that ODM requires. ODM-required improvement projects may include projects in coordination with other ODM-contracted MCOPs, MCOs, and the OhioRISE Plan (e.g., improvement of medication reconciliation by clinics and hospitals, medication adherence, safety, and quality).

3. MCOP improvement projects must aim to achieve significant and sustained improvement over time in population health outcomes, quality of life, and provider/member satisfaction.

4. In conducting improvement projects, the MCOP must:

    a. Designate a member of the Senior QI Leadership team as project sponsor to ensure that resource needs are met, issues are identified, and elevated on a timely basis, and learning is effectively shared throughout the organization;

    b. Appropriately staff projects as described in this appendix;

    c. Use PDSA cycles, along with frequent and ongoing analysis to quickly determine the effectiveness of interventions;

    d. Use ODM developed templates (e.g., QI meeting template, key driver diagram [KDD] template, PDSA template) to document the MCOP's manual, rapid cycle, and iterative work required, as well as the lessons learned from this process;

    e. Use data to identify improvement opportunities, longitudinally monitor project progress. This includes using data analysis methods such as statistical process control to differentiate common and special cause variation in order to identify improvement, sustained successes, and additional opportunities for improvement;

f. Analyze data to identify disparities in services and/or care and tailoring interventions to specific populations when needed in order to reduce disparities; and

g. Actively incorporate member and provider perspectives into improvement activities.

5. The MCOP must use ongoing analysis, data feedback, and the associated learning to determine improvement subjects and interventions.

6. As required by ODM, the MCOP must share knowledge gained from successful and unsuccessful intervention testing within improvement projects, as well as project outcomes, across MCOPs and with ODM to improve population health planning statewide.

7. *Performance Improvement Projects*

   a. Performance improvement projects (PIPs) are a subset of all MCOP improvement projects that must comply with 42 CFR 438.330. Each year, ODM designates at least one improvement project to serve as the MCOP PIP. As with all other improvement projects, ODM requires that PIPs are conducted using rapid cycle QI science techniques.

   b. The MCOP must initiate, work collaboratively with ODM, and complete PIPs in topics selected by ODM. Potential topics include LTSS, nursing facility care, and/or rebalancing and diversion from nursing facilities.

   c. The MCOP must work with ODM and ODM's external quality review organization (EQRO) to develop and implement at least one PIP designated by ODM.

   d. As part of this process, the MCOP must participate in PIP planning, including assisting in the recruitment of participating practices, determining initial key drivers and interventions.

   e. The MCOP must ensure that all PIPs designed and/or implemented demonstrate improvement, and the MCOP must clearly articulate lessons learned during the course of the initiative.

   f. The MCOP must adhere to ODM-specified reporting, submission, and frequency guidelines during the life of the PIP; establish and implement mechanisms for rapid testing of interventions; and establish mechanisms for spreading and sustaining successful interventions in order to optimize improvement gains.

   g. Upon request, the MCOP must provide longitudinal data demonstrating sustained improvement over the course of the project and during the sustainability phase following final validation of the PIP by ODM's EQRO.

   h. The MCOP must fully cooperate with ODM's EQRO in its PIP validation activities, performed in accordance with 42 CFR Subpart E.

8. *Chronic Care Improvement Program (CCIP)*

    a. In accordance with 42 CFR 422.152(c), the MCOP must develop a chronic care improvement program (CCIP) and establish criteria for participation in the program. The CCIP must be relevant to and target the MCOP's membership and must align with the ODM Population Health Strategy. Although the MCOP has the flexibility to choose the design of its CCIPs, ODM may require the MCOP to address specific topic areas.

v. *Quality Improvement Communication Strategy*

1. The MCOP must develop and use a clearly defined communication strategy for QI activities. The MCOP's communication strategy must include:

    a. Mechanisms for data receipt and exchange, analyzing and interpreting data, and transparently and proactively involving stakeholders and partners in applying data to inform improvement efforts;

    b. A description, including lines and methods of communication, of the internal mechanisms used to frequently, transparently, and proactively communicate improvement status updates across the organization, to executive leadership, and to ODM. Status updates must include lessons learned from intervention testing, advances to the theory of knowledge, and progress on process and outcome measures;

    c. Mechanisms for proactive, regular communication with ODM and EQRO staff regarding improvement opportunities and priorities, intervention successes, lessons learned, and future activities; and

    d. Mechanisms and standards for responding promptly and transparently to data and information requests by ODM or the EQRO Cross-System Collaboration.

i. Cross-System Collaboration

i. The MCOP must facilitate cross-system collaboration and coordination with other entities that impact population health as a result of their involvement in the support, care, and treatment of members. All collaboration and coordination is subject to state and federal privacy requirements. Such entities include but are not limited to:

    1. Care coordination entities, including ODM-funded entities associated with alternative payment models (behavioral health care coordination entities) and conflict free case management agencies;

    2. Other entities within the health care delivery system; and

    3. Other ODM-contracted MCOPs and involved entities (e.g., local health departments, ADAMH Boards, County Job and Family Services, justice system).

ii. Cross-system collaboration and coordination includes:

1. Identification of service gaps and assistance in closing gaps in care (e.g., scheduling appointments, arranging transportation, and facilitating referrals and linkages to MCOP health and wellness programs and MyCare Ohio HCBS waiver services) in order to optimize health outcomes;
2. Data sharing, subject to state and federal privacy requirements;
3. Coordination between involved care coordination entities, waiver service coordinators, and primary care and nursing facility providers;
4. Ensuring seamless care transitions and follow-up as outlined in Appendix D, Care Coordination;
5. Early identification of care needs (e.g., LTSS, lack of preventive care, behavioral health) and connection to services;
6. Promotion of services that facilitate care delivery (e.g., telehealth);
7. Integrating behavioral and physical health; and
8. Addressing SDOH, such as food insecurity, housing instability, and transportation needs.

j. Value-Based Payment

i. Value-Based Payment as described in Appendix H, Value-Based Payment.

5. Evaluation

a. Population Health Management Strategy (PHMS)-QAPI Evaluation

i. The MCOP's annual evaluation of its PHMS must be used to inform the MCOP's PHMS for the upcoming year.

ii. The MCOP's PHMS Evaluation must be submitted using the PHMS Evaluation template as described in Appendix P, Chart of Deliverables.

iii. For each population stream, the MCOP's PHMS Evaluation must assess the effectiveness of the MCOP's PHMS in contributing to:

1. Development of an optimal person-centric health system;
2. Improved access to the health system;
3. Improved identification of higher risk subpopulations;
4. The provision of best-evidenced care and enhanced services; and
5. The maintenance and support of continuity of care over the life course.

iv. For each population stream, the MCOP must assess the MCOP's progress towards meeting the objectives and goals associated with the population health stream-specific strategic aims.

v. The MCOPs PHMS Evaluation must assess data from multiple areas of the system (e.g., claims, health risk assessments, member grievances and appeals, care coordination, Incident Management System [IMS], and HIE) in order to identify patterns (e.g., service utilization patterns) and anticipate problem areas (e.g., unmet SDOH needs) to refine the MCOP's Population Health Strategy for the upcoming year.

vi. The MCOP's PHMS Evaluation must assess the extent to which the input from members, providers, and other partners was included in the design, execution, and refinement of MCOP service delivery policy and practice.

vii. The MCOP's PHMS Evaluation must describe how the MCOP has institutionalized effective policies and practices it has found to be effective so that they are a permanent and sustained part of its operations.

viii. The MCOP must utilize its monitoring of process and outcome measures to inform risk stratification algorithms, as well as its ongoing design or adaptation of strategies and initiatives to better serve the needs of the population.

ix. The MCOP's report of the implementation of the QAPI program, required by 42 CFR 438.330, is reported as part of the PHMS Evaluation and must include:

1. A description of ODM- and MCOP-initiated improvement projects, including the annual PIPs. The description must include:

    a. How the PIP was designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction;

    b. The trended measurement of performance (e.g., outcome measures, measures of success) using objective quality indicators;

    c. Interventions that were undertaken to achieve improvement in the access to and quality of care;

    d. Evaluation of the effectiveness of the interventions based on metrics; and

    e. Planning and initiation of activities for increasing or sustaining improvement.

x. A description of mechanisms the MCOP uses to detect both under-utilization and over-utilization;

xi. A description of mechanisms the MCOP uses to assess the quality and appropriateness of care furnished to members with special health care needs and members receiving LTSS;

xii. A description of mechanisms the MCOP uses to assess the quality and appropriateness of care furnished to members using LTSS, including assessment of care between care settings and a comparison of services and supports received with those set forth in the member's person-centered care plan, if applicable; and

xiii. A description of the MCOP's efforts to prevent, detect, and remediate critical incidents that are based, at a minimum, on requirements for HCBS waiver programs.

b. Quality Improvement Meeting Requirements

i. The MCOP must document project learning using the ODM QI meeting template and submit the template prior to each meeting, as specified in Appendix P, Chart of Deliverables.

1. During the planning phase of an improvement project, the MCOP must support ODM in its efforts to coordinate and lead the QI meetings. The MCOP must provide its QI template that includes, as appropriate to the topic, the following:

a. Detailed and high-level process maps of the MCOP's processes related to the outcome of interest;

b. Results of obtaining member and provider perspectives on the MCOP's processes (e.g., identified barriers and ideas for improvement); and

c. Strategies, timelines, and milestones for next steps (including what must be accomplished before the next meeting).

2. During the active testing stage of an improvement project, the MCOP must ensure its QI template and accompanying meeting reflects the results of the MCOP's weekly or more frequent PDSA cycles as demonstrated by documentation of testing and annotated run or control charts.

3. Once changes have resulted in improvement, the MCOP must begin actively testing in new circumstances for purposes of effectively spreading the improvement.

c. External Quality Review

i. ODM will select an EQRO to provide for an annual external and independent review of the quality, outcomes, timeliness of, and access to services provided by the MCOP.

ii. The MCOP must submit data and information, including member medical records, at no cost to, and as directed by, ODM or its designee for the annual external quality review activities.

iii. The MCOP must participate in an annual external quality review that must include but is not limited to the following activities:

1. A comprehensive administrative compliance review as directed by ODM in accordance with 42 CFR 438.358;

a. In accordance with 42 CFR 438.360 and 438.362, the MCOP, if it is accredited by a national organization approved by the Centers for Medicare & Medicaid Services may request to be exempted (deemed) from certain portions of the administrative compliance review. ODM will inform the MCOP if the MCOP may request a non-duplication exemption.

b. The EQRO may conduct focused reviews of MCOP performance as directed by ODM in the following domains that include but are not limited to the following:

i. Availability of services;

ii. Assurances of adequate capacity and services;

iii. Coordination and continuity of care;

iv. Coverage and authorization of services;

v. Provider selection;

vi. Confidentiality;

vii. Grievance and appeal systems;

viii. Subcontractual relationships and delegation;

ix. Practice guidelines; and

x. Health information systems.

2. Encounter data studies;
3. Validation of performance measurement data;
4. Review of information systems;
5. Validation of PIPs; and
6. Provider surveys and member satisfaction and/or quality of life surveys.

APPENDIX D – CARE COORDINATION

1. MCOP Care Coordination

a. General Requirements

i. The MCOP must develop and implement a high-performing care coordination program that meets the Medicare Model of Care requirements, the care coordination requirements in this appendix, and reflects the guiding principles to optimize the health of the individual members and populations it serves.

ii. Care coordination, for purposes of the requirements in this Agreement, is used in the broadest sense to encompass the full spectrum of care coordination activities, ranging from short-term assistance to meet care gaps to longer-term, intensive, and holistic care coordination for members with the most intense needs. Other terminology used in this appendix is as defined in the Definitions section of this Agreement.

iii. The MCOP must provide care coordination services to all members, including dual benefit and Medicaid only members. Members may opt out of care coordination, except for members enrolled in the MyCare Ohio Home- and Community-Based Services (HCBS) Waiver. The MCOP must continue to monitor members who have chosen to not actively participate in care coordination. In addition, the MCOP must adhere to the following requirements:

1. The MCOP must coordinate a member's Medicaid and Medicare services.

    a. For Medicaid only members, the MCOP must coordinate with the member's Medicare Advantage Plan, if applicable, to reduce gaps or duplication of services.

2. The MCOP must provide identified ODM staff and delegates access, including the ability to enter information, to the MCOP's care coordination system to reduce administrative burden on the MCOP and ODM, and to improve the efficiency of ongoing incident management and other health, safety, and welfare reviews or investigations of reportable incidents in accordance with the Ohio Administrative Code (OAC) rule 5160-44-05.

3. The MCOP's care coordination program must serve as the foundation to ensure that all members have access to quality care coordination, regardless of whether the member is receiving care coordination from the MCOP's staff, a waiver service coordination from an Area Agency on Aging (AAA), or a behavioral health care coordination entity or other behavioral health agency/specialist.

4. The care coordination/Trans-Disciplinary Care team is a team made up of the member, the member's managed care team, and other professionals and informal supports chosen by the member.

    a. The MCOP must provide the member's care coordinator (or waiver service coordinator if the member is enrolled on the MyCare Ohio HCBS Waiver) and have internal support staff to support the care coordinator and

Trans-Disciplinary Care team, including but not limited to social workers, mental health, and/or substance use disorder (SUD) licensed independent professionals, gerontologists, housing specialists, transportation specialists, and community health workers.

5. The MCOP must promote consistency in care coordination assignment.

    a. The MCOP must ensure that a member is able to choose a care coordination lead as appropriate when the member has both an MCOP care coordinator and waiver service coordinator.

6. The MCOP must have partnerships with ODM-designated behavioral health care coordination entities (from this point forward referred to as behavioral health care coordination entities) to the extent they are available and other behavioral health agencies/specialists to meet the needs of members. Either directly or through partnerships/delegates/contracts, the MCOP must have behavioral health expertise to meet member needs.

    a. The MCOP must make referrals to behavioral health care coordination entities or other behavioral health agencies/specialists as appropriate. The MCOP care coordinator and behavioral health care coordination entity or other behavioral health agency/specialist must work collaboratively to support the member in achieving their goals, including recovery and Social Determinants of Health (SDOH) goals.

    b. For those members who qualify for but are not engaged with a behavioral health care coordination entities or who choose not to receive care coordination from a behavioral health care coordination entity, the MCOP must determine assignment to an MCOP care coordinator and attempt to link members with or continue to work with any behavioral health agencies the member might be engaging with for ongoing behavioral health care.

    c. When behavioral health needs are identified by the MCOP and/or delegate, the MCOP must show efforts to refer and link the member with a regular source of ongoing behavioral health care.

    d. The MCOP must have processes for promoting and supporting providers treating behavioral health conditions in the primary care setting.

    e. The MCOP must develop procedures for cross-training and consultation for MCOP care coordinators and behavioral health care coordination entities or other behavioral health agencies/specialists as well as community-based behavioral health providers to facilitate coordination of care for the member.

iv. Members who receive Specialized Recovery Services (SRS) (i.e., recovery management and individualized placement and support — supported employment), are assigned a recovery manager who performs assessments, person-centered planning, and coordination of SRS. Recovery managers are assigned by a Recovery Management agency. The MCOP is not permitted to perform Recovery Management services and must contract with at least one

Recovery Management agency to provide Recovery Management services for all members receiving SRS.

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

2. The MCOP must include the recovery manager as part of the member's Trans-Disciplinary Care team. The MCOP must integrate a member's SRS person-centered care plan into the member's MCOP person-centered care plan.

3. The MCOP's care coordinator must adhere to ODM's incident management requirements specified in OAC rule 5160-44-05. If the MCOP becomes aware of an incident for a member receiving SRS, the MCOP care coordinator must inform the recovery manager. Prevention plans must be jointly developed by the MCOP care coordinator and the recovery manager.

4. The MCOP must refer a member who is potentially eligible for SRS to its contracted Recovery Management agency to initiate the SRS eligibility determination process.

5. The MCOP must adhere to all operational requirements in the 1915(i) state plan amendment and OAC Chapter 5160-43.

6. The MCOP must ensure that contracted Recovery Management agencies comply with operational requirements, including contact and care plan requirements as stated in OAC Chapter 5160-43, the 1915(i) state plan amendment, and the Recovery Management guide.

v. Helping Ohioans Move, Expanding Choice (HOME Choice) is a program designed to assist eligible individuals in moving from institutional settings to community settings. This program works in tandem with other Medicaid services and community supports, including the MyCare Ohio HCBS Waiver. The MCOP must adhere to the following related to HOME Choice:

1. The MCOP can refer members, as appropriate and agreed to by the member, to the HOME Choice Program.

2. MCOP members can access HOME Choice services if they are not duplicative of services provided by the MCOP as part of care coordination . If the HOME Choice program option is pursued by the MCOP for a member, the MCOP must perform required activities to prepare and support the successful transition, such as completion of forms and collaboration with the HOME Choice transition coordinator. Upon notification of HOME Choice enrollment, the MCOP must contact the HOME Choice transition coordinator to discuss transition needs. The MCOP must assist the member to complete a MyCare Ohio HCBS Waiver application upon request from the member, ODM, or the transition coordinator. The MCOP can submit the application prior to the individual securing housing.

3. The MCOP must incorporate HOME Choice goals/activities into the person-centered care for members found to be ineligible for the MyCare Ohio HCBS Waiver.

4. Upon request from HOME Choice staff or their designated entity, the MCOP must submit a level of care assessment request to the local AAA.

5. The MCOP must authorize community transition services for MyCare Ohio HCBS Waiver members as appropriate and needed, in accordance with OAC rule 5160-44-26.

6. The MCOP must reimburse authorized community transition services purchases upon invoicing from the Community Transition Services provider.

vi. The MCOP's care coordination program must safeguard confidential information in accordance with the privacy compliance requirements specified in Appendix A, General Requirements.

b. Guiding Principles

i. The MCOP's care coordination program must reflect the following guiding principles:

1. Care coordination identifies and addresses physical, behavioral, long-term services and supports (LTSS), and psychosocial needs of members.

2. Care coordination supports member goals and choices through a person-centered, trauma-informed, and culturally attuned approach.

3. Care coordination provides care continuity while honoring member experience and choice.

4. The MCOP preserves and collaborates with existing care relationships between members and local behavioral health care coordination entities.

5. The MCOP establishes clear communication and delineation of roles and responsibilities of various entities throughout the care coordination process to minimize the duplication of services and streamline service delivery.

6. The MCOP implements systems capable of efficiently receiving, providing, and exchanging the data and information necessary to effectively coordinate the care of members who are served by multiple entities.

c. MCOP Care Coordination Program Description

i. The MCOP must submit its care coordination program description that includes the MCOP's Medicare Model of Care in writing for ODM approval prior to implementation. Following initial approval, the MCOP must submit any changes to its care coordination program to ODM for approval prior to implementing the change. The MCOP must submit the Care Coordination Program Submission as specified in Appendix P, Chart of Deliverables.

ii. The MCOP's care coordination program submission must describe the following components, described in more detail within this appendix:

1. The MCOP's care coordination staffing including an organizational chart and the number of staff by role, qualifications, and physical location;

    a. The MCOP's contingency plan to assure coverage of critical care coordination functions in the event of staff vacancies.

2. The training topics and frequency of initial and ongoing training provided to MCOP care coordination staff and a description of how staff training is documented and tracked;

3. The MCOP's risk stratification framework, including the criteria and threshold for each tier;

4. The assignment of MCOP care coordination staff, including proposed caseload sizes and assignment methodology;

5. The MCOP's requirements related to contact schedules;

6. The MCOP's roles and responsibilities for performing care coordination activities when the MCOP is exclusively providing care coordination to members (i.e., primary care coordination role);

7. The MCOP's roles and responsibilities when the member receives waiver service coordination or care coordination from a behavioral health care coordination entity or other behavioral health agency/ specialist where these entities have the primary care coordination role and the MCOP is secondary;

8. How the MCOP will notify members of care coordination assignment;

9. The MCOP's data and information systems and how they will be used to support MCOP's responsibilities for care coordination regardless of which entities are providing care coordination;

10. How the MCOP will monitor the care coordination program for individual and systemic improvements; and

11. How the care coordination program will ensure the coordination and integration of Medicaid and Medicare services.

2. Care Coordination Requirements

a. <u>Staffing and Training</u>

i. The MCOP must provide the required care coordination staffing resource allocation necessary to support the MCOP's approach to population health management, as specified in Appendix C, Population Health and Quality.

ii. The MCOP's care coordination staff must include a range of disciplines with complementary skills and knowledge to deliver a comprehensive, integrated care coordination program fully capable of addressing members' physical, behavioral, LTSS, and psychosocial needs.

iii. The MCOP must ensure staff who are performing care coordination functions are operating within their professional scope of practice, appropriate for the member's health care needs, and comply with the state's licensure and credentialing requirements.

iv. The MCOP must ensure individuals conducting training have demonstrable experience and expertise in the topic for which they are providing training.

iv. The MCOP must ensure that care coordination staff and delegates are trained in behavioral health conditions, community behavioral health services and resources, and identifying behavioral health needs.

1. The MCOP must ensure that care coordination staff and delegates have access to behavioral health specialists, including practitioners with advanced degrees and licensure.

v. The MCOP must ensure that individuals who develop and deliver training have demonstrable experience and expertise in the topic for which they are providing training.

vi. The MCOP must provide onboarding and ongoing training for all MCOP care coordination staff, including community health workers, that includes:

1. Health equity and implicit bias;
2. Cultural and disability competency;
3. Person-centered care planning;
4. Trauma-informed care;
5. Motivational interviewing;
6. Fraud, waste, and abuse;
7. Communication;
8. Grievance and appeal processes and procedures;
9. Community resources;
10. Strategies for addressing any disease-specific processes;
11. Incident reporting requirements;
12. Health Insurance Portability and Accountability Act (HIPAA) requirements;
13. Self-direction;
14. Independent living and recovery;
15. Medicare services and coordination of dual services;
16. General behavioral health;

17. Behavioral health crisis training;
18. Wellness principles;
19. Americans with Disabilities Act (ADA)/Olmstead requirements, and
20. Other topics as specified by the state.

vii. The MCOP must ensure that waiver service coordinators attend mandatory annual training for waiver service on the following topics:

1. Cultural competency/diversity training that reflects the diversity of the MyCare member population;
2. Medication management;
3. Level of Care criteria;
4. MyCare Ohio HCBS Waiver;
5. Coordinating dual services;
6. Provider service specifications;
7. Process for requesting home and vehicle modifications and adaptive and assistive equipment;
8. Risk and safety planning — identifying individual risks and the modifications or equipment necessary to maintain a member in their home;
9. Person-centered care planning;
10. Self-direction;
11. Restraints, seclusion, and restrictive interventions;
12. Community resources, including an overview of other service delivery system(s), including developmental disabilities, general behavioral health and crisis care, aging, health, that includes an explanation of the resources available, and training on how to access the services;
13. HIPAA; and
14. Customer service.

viii. The MCOP must annually attest that professional training sessions have been conducted for MCOP care coordinators , Trans-Disciplinary Care Team members, and waiver service coordinators via the Care coordination Training Requirements Attestation.

1. Newly hired care coordinator and new waiver service coordinators must receive training before assignment of any cases.

ix. The MCOP's proposed care coordination program may employ an integrated team approach of clinical and non-clinical staff, whose skills and professional experience complement and support one another performing required care coordination activities. However, the MCOP must ensure a primary point of contact for care coordination.

x. Care coordination activities that require licensed staff must be performed by licensed staff, as required by this Agreement and state law.

xi. The MCOP Care Coordination team must consult with the member's primary care provider (PCP) to support ongoing PCP collaboration; however, timing of PCP communication and engagement should not impede the MCOP's care coordination efforts.

b. Mandatory Training Requirements for Care coordinators who work with Behavioral Health Population

i. The MCOP must ensure staff working with members with behavioral health needs receive training on characteristics of members with behavioral health needs and best practices (including strategies to address trauma) for addressing behavioral health needs of this population.

ii. The MCOP must assure that care coordinators who work with members with behavioral health needs receive training on:

1. Health equity and implicit bias; and

2. "Question, persuade, and refer" training.

iii. When a position's role includes the application of clinical criteria, medical necessity criteria, or similar guidelines or criteria that requires the use of clinical judgement, the MCOP must include:

1. An inter-rater reliability component to the training;

2. A minimum threshold of satisfactory scoring in inter-rater reliability prior to assumption of duties; and

3. No less than annual refresher training, including meeting or exceeding scoring threshold on inter-rater reliability.

c. Conflict Free Care Management

i. The MCOP must abide by the conflict free case management standards set forth in 42 CFR 441.301(c)(1)(vi) and 42 CFR 441.730(b). The MCOP must submit attestation upon ODM request that conflict free case management standards are being followed by all MCOP care coordinators and waiver service coordinators, including any delegated entities.

1. The MCOP must ensure that its care coordination staff and waiver service coordinators 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.

d. Risk Stratification and Care Coordination Ratios

i. In addition to conducting risk stratification for the purposes of population health activities on a population level as described in Appendix C, Population Health and Quality, the MCOP must use individual-level risk stratification as one factor when determining the level of care coordination that is appropriate for each member.

ii. The MCOP must assign a risk tier to each member. The MCOP must develop a risk stratification framework as part of its care coordination program that is comprised of four tiers (i.e., from lowest to highest: low monitoring risk [Tier 1], medium risk [Tier 2], high risk [Tier 3], and intensive risk [Tier 4]). The MCOP's risk stratification framework must include the criteria and thresholds for each tier to determine member assignments.

iii. The MCOP must stratify members according to the risk tiers described below and comply with the following ratios for its care coordination program, including MCOP care coordinators and waiver service coordinators:

Risk Tier	Care Coordination Ratio
Tier 1 (low monitoring)	1:101–1:250
Tier 2 (medium)	1:76–1:100
Tier 3 (high)	1:51–1:75
Tier 4 (intensive)	1:25–1:50

iv. The MCOP's criteria and thresholds must identify the factors the MCOP considers when determining a member's risk stratification level.

1. At a minimum, the criteria and thresholds must include the following current and historical factors:

    a. Acuity and number of chronic conditions, substance use, and/or mental health disorders, inpatient and/or emergency department utilization, SDOH, and safety risk factors, receipt and duration of 1915(c) HCBS waiver enrollment or 1915(i) services, current waiver acuity level, change in existing waiver service coordinator or MCOP care coordinator relationship, change in caregiver status/support, nursing facility or assisted living placement, displayed risk factors for being institutionalized (e.g., previous history of institutionalization, enrollment in 1915(c) HCBS waiver).

    b. Information from the member's comprehensive risk assessment.

    c. Other available information.

2. Dual benefit members who are participating in care coordination must be assigned to at least Tier 2.

3. Members enrolled in the MyCare Ohio HCBS Waiver must be assigned to either Tier 3 or Tier 4.

v. The MCOP must assign an initial risk stratification tier within the first month of a member's enrollment for members newly enrolled with the MCOP. The MCOP must review and update the risk stratification tier following the completion of the member's comprehensive risk assessment.

vi. The MCOP must evaluate a member's risk stratification tier whenever there is a significant change in the member's needs or circumstances. If the MCOP changes the member's stratification tier as a result of this evaluation, the MCOP must document the change in member's need or circumstances that led to the change in stratification.

vii. The MCOP must communicate risk stratification to ODM, waiver service coordinators, and behavioral health care coordination entities.

viii. *General*

1. The MCOP must assign a care coordinator who will be the accountable point of contact for the member; ensure the integration of the member's medical, behavioral health, and LTSS needs; and will lead the Trans-Disciplinary Care team.

    a. Members who are not otherwise described below will receive care coordination from only the MCOP care coordinator (they will not have another care coordinator).

    b. Members who are enrolled in the MyCare Ohio HCBS Waiver may receive care coordination from the MCOP care coordinator and a waiver service coordinator (with the waiver service coordinator as primary).

    c. Members with behavioral health needs may receive care coordination from the MCOP care coordinator and a behavioral health care coordination entity or other behavioral health agency/ specialist (with behavioral health care coordination entity primary).

2. The care coordinator must have the appropriate experience and qualifications based upon the member's assigned risk level and needs.

3. The MCOP must have a process to ensure that the member is able to request a change in the member's care coordinator .

4. The MCOP must develop a Trans-Disciplinary Care team for each member. The MCOP must provide each member with access to, and input regarding the development of, a Trans-Disciplinary Care team.

    a. Composition of the Trans-Disciplinary Care team will vary based on the needs and preferences of the member but must, at a minimum, include the member, the member's managed care team, and other professionals and informal supports chosen by the member.

i. If the waiver service coordinator is not also the care coordinator , the waiver service coordinator must be a member of the Trans-Disciplinary Care team.

b. The Trans-Disciplinary Care team must participate in and support key care coordination activities such as completion of the comprehensive assessment and development, implementation, and updates to the person-centered care plan, at the direction of the MCOP care coordinator .

c. All members of the Trans-Disciplinary Care team are responsible for ensuring that care is person-centered, built on the member's specific preferences and needs, and delivered with transparency, individualization, respect, linguistic and cultural competency, and dignity.

d. Responsibilities of the MCOP care coordinator related to the Trans-Disciplinary Care team include but are not limited to the following:

i. Delineating roles and responsibilities for members of the Trans-Disciplinary Care team;

ii. Exchanging information between Trans-Disciplinary Care team members; and

iii. Facilitating Trans-Disciplinary Care team meetings.

e. The MCOP must ensure that members receive necessary care coordination, whether the care coordination is performed by the MCOP, the waiver service coordinator, a behavioral health care coordination entity or other behavioral health agency/specialist, or a combination thereof. The MCOP must ensure that waiver service coordinators and behavioral health care coordination entities are part of the members Trans-Disciplinary Care team.

ix. *Care Coordination Assignment*

1. MCOP assignment of care coordination staff must consider:

a. The assessment of the member's short- and long-term care coordination needs;

b. The member's level of needs based upon risk stratification;

c. Whether the member is receiving care coordination from a behavioral health care coordination entity or other behavioral health agency/specialist and the capability of the behavioral health care coordination entity to effectively manage the member's needs; and

d. Member choice.

x. *Care Coordination Status*

1. The MCOP must submit a file to ODM that contains a care coordination status for all members. The three care coordination status indicators are outreach and coordination, engaged, and monitoring, as defined in the table below.

Status Indicator	Description
Outreach and Coordination	This status indicator is used when the MCOP performs one or more of the following activities for a member: conducts outreach, educates the member, or makes referrals for physical, behavioral health, or social services.
Engaged	This status indicator is used when the member is active in care coordination and the contact frequency is in alignment with the member's risk tier and goals on the member's person-centered care plan are being addressed.
Monitoring	This status indicator is used after the MCOP identifies the population health stream and risk tier. The MCOP's role for this status is to respond to members who are not interested in active care coordination activities by maintaining knowledge of the individual's health and safety and providing suggested community resources or health education through activities such as monitoring claims, reviewing other member data, and tracking significant change events.

2. The MCOP must submit the MyCare Ohio Care Coordination Status Submission File in accordance with the *MyCare Ohio Care Coordination Status Submission* specifications and as specified in Appendix P, Chart of Deliverables.

e. Care Coordination Activities

i. *Activities for MCOP Care Coordinator When MCOP is Lead*

1. The MCOP care coordinator is responsible for performing the following care coordination activities for members:

a. Outreaching members to engage in care coordination;

b. Conducting or arranging for member assessments as described in more detail below;

c. Leading the development and ongoing updates to the person-centered care plan as described in more detail below;

d. Leading Trans-Disciplinary Care team meetings for members for whom the care coordinator is the leading care coordinator;

e. Offering and linking members, as appropriate, to health education, disease management, and wellness/prevention coaching;

f. Identifying and linking members to network providers as needed;

g. Connecting with the member's Medicare services providers, to ensure coordination of care;

h. Coordinating member access to covered services as needed (e.g., scheduling appointments, arranging transportation, making referrals, and linking the member to MCOP health and wellness programs);

i. Educating the member about available resources and services (e.g., value-added services) and assisting the member in accessing those resources and services;

j. Communicating and exchanging information with providers (e.g., PCP, specialists, labs, imaging facilities) and ODM to coordinate the care of the member;

k. Sharing care coordination data and information with ODM to prevent gaps in care and duplication of efforts;

l. Identifying gaps in care and taking action as necessary to close gaps in care;

m. Participating in discharge planning activities with the inpatient facility to support a safe discharge placement and to prevent unplanned or unnecessary readmissions, emergency department visits, and adverse outcomes;

n. Ensuring member access to post discharge as specified in the discharge and transition plan;

o. Facilitating clinical hand offs between the discharging facility and other network providers involved in the care and treatment of the member;

p. Actively securing the necessary authorizations for the services to ensure the member's timely access to the services identified in the person-centered care plan;

q. Monitoring to ensure that the services are delivered as recommended in the person-centered care plan;

r. Assessing and monitoring the member's progress in achieving goals and outcomes contained in the member's person-centered care plan; and

s. Coordinating with community organizations that provide care coordination to the member.

ii. *MCOP Activities when Member is Enrolled in the MyCare Ohio HCBS Waiver*

1. For members enrolled in the MyCare Ohio HCBS Waiver, the MCOP is responsible for assisting its delegated waiver service coordinators in a timely manner with the following care coordination activities:

a. Supporting member outreach efforts;

b. Participating in Trans-Disciplinary Care team meetings;

c. Participating in meetings to support the assessment and person-centered care planning process;

d. Developing and maintaining the person-centered care plan and assuring integration of the Waiver service plan into the person-centered care plan;

e. Assisting the waiver service coordinator with the identification and linkage of members to network providers as needed (e.g., specialists, dentists, behavioral health providers);

f. Coordinating with the member's Medicare services providers, to ensure coordination of care;

g. Assisting in the coordination of MCOP covered services as needed (e.g., scheduling appointments, arranging transportation, facilitating referrals, and linking members to MCOP health and wellness programs);

h. Educating waiver service coordinators about resources/services (e.g., value-added services) that are available to members;

i. Arranging for MCOP staff to provide clinical consultation upon request of a waiver service coordinator;

j. Assisting with bi-directional communication between the waiver service coordinator and specialists, pharmacies, labs, and imaging facilities as needed in order to facilitate timely exchange of information;

k. Sharing care coordination data and information to prevent gaps in care and duplication of efforts;

l. Identifying gaps in care and taking action as necessary to close gaps in care;

m. Participating in discharge planning activities with the inpatient facility to support a safe discharge placement and to prevent unplanned or unnecessary readmissions, emergency department visits, and adverse outcomes;

n. Ensuring member access to post discharge services covered by the MCOP as specified in the discharge and transition plan;

o. Facilitating clinical hand offs between the discharging facility and other MCOP network providers involved in the care and treatment of the member;

p. Actively securing the necessary authorizations for the services that are the responsibility of the MCOP, and coordinating with the waiver service coordinator and providers to ensure the member's timely access to the services identified in the person-centered care plan;

q. Monitoring to ensure that the services are delivered as specified in the person-centered care plan; and

r. Assessing and monitoring the member's progress in achieving goals and outcomes contained in the member's person-centered care plan.

iii. *MyCare Ohio HCBS Waiver Service Coordination*

1. The MCOP must contract with AAAs as the primary waiver service coordination entity for members age 60 and older who are enrolled in the MyCare Ohio HCBS Waiver, as specified in Section 333.320 of Am.Sub.H.B. No.33 (135th General Assembly).

    a. For members under the age of 60 enrolled in the MyCare Ohio HCBS Waiver, the MCOP may contract with AAAs for waiver service coordination or with other entities that have experience working with people with disabilities.

    b. The MCOP may choose to delegate all or some care coordination activities to the AAA (for all members) or other entity (for members under age 60).

2. If a member selects or requests a change in their waiver service coordination entity, or if the MCOP or ODM identify a performance issue that affects member's health, welfare, or safety, the MCOP must assist the member in linkage with another waiver service coordination entity or perform the function themselves if the member so chooses.

3. The waiver service coordinator must perform the following functions:

    a. Initial waiver assessment for individuals who present a need after a level of care determination has been made;

    b. Ongoing waiver re-assessments for individuals currently receiving waiver services;

c. Participating in Trans-Disciplinary Care team meetings.

d. Waiver service plan development, review, and updates including education to members on waiver service array and available providers;

   i. If a member chooses to utilize non-agency providers, assuring the member or their authorized representative trains or specifies required training for the provider(s) to meet the member's needs;

   ii. Development of a backup plan and integration into the Waiver Service Plan;

e. Coordination of approved waiver services including communication with waiver providers as needed;

f. Required member contacts based on member's risk tier assignment;

g. Crisis intervention;

h. Event-based visits;

i. Follow-up after critical and reportable incidents;

j. Verification and documentation on the use of seclusion, restraints, or restrictive interventions in the member's person-centered care plan, Waiver Service Plan, and communication record;

k. Development of a health and safety plan, as applicable;

l. Provider monitoring;

m. Linkage and referral to address behavioral health needs;

n. Education on and assistance with self-directed care; and

   i. Evaluation of the appropriateness of legal guardian/authorized representative to provide paid services to the member; or

   ii. In the event of involuntary termination of self-direction when there is no available qualified authorized representative, the waiver service coordinator will assist the waiver individual to choose a different provider type to meet the member's assessed needs.

o. Coordination with community organizations that provide care coordination.

4. The MCOP must provide oversight of waiver service coordination entities to ensure the waiver service coordination entity's compliance with all operational requirements specified in the MyCare Ohio HCBS Waiver.

5. The MCOP must complete the "Monthly Waiver Service Coordination Log" provided by ODM. The monthly log must reflect the number of waiver service coordination

assignments for individuals age 60 and older to the MCOP and to an AAA. The MCOP must make these logs available to ODM upon request.

6. The MCOP must share with any AAA that performs waiver service coordination for the MCOP's waiver members the following data elements: person-centered care plans; most recent comprehensive assessment and due dates for next assessment; previous incident data; risk stratification and approved contact schedule; claims, including inpatient hospitalizations, emergency department visits, and MyCare Ohio HCBS Waiver services; and health and safety action plans and risk agreements, as applicable.

7. The MCOP must comply with the following HCBS Waiver Operational Reporting Requirements, as specified in Appendix P, Chart of Deliverables.

    a. Total number of individuals who have a health and safety action plan by the following categories: drug/alcohol issues, unsafe smoking, noncompliance with health care, and other.

    b. Total number of individuals with behavior support plans by category: mechanical restraints, chemical restraints, physical, seclusion, and restrictive interventions.

    c. Total number of behavior support plans by category as indicated above by authorizing entity: physician, psychologist, county board of developmental disabilities, and other behavioral health professional.

    d. Total number of individuals with behavior support plans for which the MCOP activated the behavioral support plan with an indication of the used restraint or seclusion.

    e. Total number of individuals with behavior support plans for which the MCOP activated the behavioral support plan with an indication of the restrictive intervention used.

    f. In the event the MCOP activates the Emergency Response plan , the MCOP must document the outcomes of the Emergency Response plan and submit to ODM when requested.

iv. *Assessments — General*

1. The MCOP must conduct or arrange for assessments (e.g., comprehensive risk assessment, comprehensive assessment, and disease specific assessment). The MCOP must share results of any identification and assessment of the member's needs through the MCOP's Care Coordination Portal to prevent duplication of those activities.

2. The MCOP must have a process for conducting or arranging for assessments appropriate to each member's unique circumstances and needs (e.g., physical, behavioral, LTSS, social, and safety) that includes the following:

a. Methods and timelines used by the MCOP to complete assessments, including any variances by risk tier;

   i. Upon enrollment into the MCOP, initiation of the comprehensive risk assessment must be performed within the 1st 90 days and annually thereafter.

   ii. The comprehensive risk assessment must be re-administered at any time based on significant changes identified and or reported.

b. Identification of the triggers for completion of reassessments or certain types of assessments, including;

   i. ODM-approved comprehensive risk assessment;

   ii. Comprehensive assessment;

   iii. Disease-specific assessments; and

   iv. Re-assessments when there is a change in the member's health status or needs, a change in diagnosis, or as requested by the member, provider, waiver service coordinator, or behavioral health care coordination entity or other behavioral health agencies/specialists.

c. How data from the member's PCP or other providers will be identified and used to prevent duplication of assessment efforts and to assist with identification of priorities for the member;

d. How the assessment will be used to confirm the risk stratification level for each member, determine the appropriate care coordination assignment, and develop and update the person-centered care plan

e. How the MCOP will share assessment data with ODM waiver service coordinators and behavioral health care coordination entities, as applicable, to prevent duplication of efforts.

v. *ODM Approved Comprehensive Risk Assessment Tool*

1. The ODM-approved comprehensive risk assessment must address self-assessment of health status and physical functioning, psychosocial risks, and behavioral risks and must meet all Medicaid and Medicare requirements, so that only one comprehensive risk assessment tool is used for dual benefit members. Other age appropriate domains should also be included in the ODM-approved comprehensive risk assessment (e.g., activities of daily living and instrumental activities of daily living). The MCOP must use a standardized assessment tool approved by ODM.

2. The MCOP must complete or ensure completion of an ODM-approved comprehensive risk assessment for all members. The ODM-approved comprehensive risk assessment must be completed within 90 calendar days of a member's effective enrollment date into the MCOP. Thereafter, the MCOP must

complete or ensure an ODM-approved comprehensive risk assessment is completed, at a minimum, annually (every 365 days) thereafter.

a. At a minimum, the MCOP must make two attempts per month, utilizing various methods, at various times of day during the first 90 days or until all required assessments are complete. The MCOP must maintain documentation in the clinical record of all attempts to reach the member.

3. The MCOP must report ODM-approved comprehensive risk assessment results (Comprehensive Risk Assessment Submission File) as specified in Appendix P, Chart of Deliverables.

4. The MCOP must include the following components as part of its care coordination program for ODM approval:

a. The methods and timelines utilized to complete the ODM-approved comprehensive risk assessment, including any variances by risk tier;

b. How the MCOP will use the ODM-approved comprehensive risk assessment to develop and confirm the risk stratification level for each member, and determine the appropriate care coordination assignment;

c. The MCOP's outreach and engagement approaches for members who cannot be reached or who refuse to complete ODM-approved comprehensive risk assessments;

d. How the MCOP will store ODM-approved comprehensive risk assessment data and make it available to members of the Trans-Disciplinary Care team to coordinate care; and

e. How the MCOP will share ODM-approved comprehensive risk assessment data with ODM, waiver service coordinators, and behavioral health care coordination entities, as applicable, to prevent duplication of efforts.

vi. *Comprehensive Assessment*

1. Based on results of the comprehensive risk assessment, the MCOP must complete a comprehensive assessment.

2. Assessments must be completed by appropriately qualified health professionals who possess an appropriate professional scope of practice, licensure, and/or credentials, and are appropriate for responding to or managing the member's needs.

3. Initial comprehensive assessments and annual comprehensive reassessments must be completed face-to-face, either in-person or as visual, real-time, interactive digital encounter. They should be completed at the location of the member’s primary place of service (i.e., home or institutional facility).

4. The comprehensive assessment used by the MCOP must be approved by ODM and include the following evaluation domains:

a. Behavioral health needs;

b. Medical needs;

c. Cognitive needs;

d. LTSS needs;

e. Social needs;

f. Nutritional needs;

g. Medical and behavioral health history;

h. Activities of daily living and/or instrumental activities of daily living;

i. Transitional and/or discharge plans;

j. Member's strength and abilities;

k. Member's goals, preferences, and desired level of involvement in the care planning process;

l. Willingness/readiness to change behaviors;

m. Caregiver status and capabilities;

n. Informal and formal supports;

o. Health literacy;

p. Health, welfare, and safety;

q. History, suspicion, or detection of abuse, violence, or trauma;

r. Environmental/residential assessment;

s. Spiritual needs/considerations;

t. Cultural needs/considerations;

u. Financial needs/considerations;

v. Special communication needs;

w. Transportation capabilities;

x. Advance care planning; and

y. Wellness and prevention activities.

5. Assessments must be completed as expeditiously as the member's needs warrant, from the member's enrollment effective date.

6. A reassessment must be completed within 365 days of the last assessment completion date. For any member who declined an assessment, the MCOP must reengage with the member to attempt to complete an assessment within 365 days of the last refusal date.

7. Assessments must be updated when there is a change in the member's health status or needs, change in diagnosis, change in caregiver status, change in functional status, a significant health care event (e.g., hospital admission or transition between care settings), or as requested by the member, their caregiver, or their provider.

8. The MCOP is not required to conduct a new initial comprehensive assessment or annual reassessment if an assessment or reassessment was previously conducted by the current or prior MCOP and one of the following conditions apply:

    a. The member remains enrolled with the MCOP;

    b. The member was previously enrolled with the current MCOP in the prior 90 calendar days; or

    c. The member had an assessment completed with a prior MCOP and the assessment was transferred from the disenrolling MCOP to the enrolling MCOP.

vii. *MyCare Ohio HCBS Waiver Assessments*

1. For new enrollment on the MyCare Ohio HCBS Waiver, as well as annual or event-based assessments, the MCOP or its designee must submit an Aged Care Assessment (ACAT) request to the local Area Agency on Aging (AAA) via the ODM-designated system.

2. Once a member is enrolled in the MyCare Ohio HCBS Waiver, in accordance with OAC 5160-58-02.2, the MCOP or its designee must reassess the member's level of care using the ACAT at least annually. If the reassessment determines the member no longer meets MyCare Ohio HCBS Waiver eligibility requirements, the member must be disenrolled from the MyCare Ohio HCBS Waiver.

3. At a minimum for members receiving MyCare Ohio HCBS Waiver services, upon discovery of a potential significant change event, telephone contact between the care coordinator or the waiver service coordinator must occur by the end of the next full business day. If it is determined through this telephone contact that a significant change occurred, a face-to-face visit must take place by the end of the third full business day following discovery or at member preference as documented by the MCOP.

4. The MCOP must ensure each member enrolled in the MyCare Ohio HCBS Waiver receives the waiver member handbook at the time of each annual reassessment.

5. For a member who has chosen MyCare Ohio HCBS Waiver services, the MCOP must have an ODM-developed freedom of choice form signed by the member indicating they have chosen waiver services over institutional care. This form must be signed at the time the member enrolls in the waiver.

a. In addition, the form must be signed annually thereafter at the time of reassessment of waiver eligibility, closest to the member's level of care redetermination; and

b. The MCOP must maintain signed freedom of choice forms.

viii. *Person-Centered Care Plans*

1. The MCOP must lead the development of a single person-centered care plan for all member's participating in care coordination who are not assigned to the monitoring care coordination status, that is shared with waiver service coordination entities, the member, authorized member representative, providers, and other members of the Trans-Disciplinary Care team as applicable.

2. The MCOP must have a person-centered care planning process that includes the following:

a. Developing the person-centered care plan based on the member's most recent assessment; and

i. The MCOP must include a process for the development and maintenance of a person-centered care plan for a member receiving private duty nursing services or receiving services in a skilled nursing facility.

b. Updating the person-centered care plan at least every 12 months or when the member's needs change significantly;

c. Tracking and complying with the timeframes for developing the initial person-centered care plan and making subsequent updates to the care plan;

d. Developing measurable goals, interventions, and anticipated outcomes with completion timeframes with the member and obtaining the member's agreement;

e. Incorporating identified special transportation assistance needs in the person-centered care plan;

f. Addressing the integration of Medicare benefits;

g. Incorporating any Medicare care coordination providers for Medicaid only members, as appropriate;

h. Integrating the waiver service plan for members enrolled in the MyCare Ohio HCBS Waiver;

i. Identifying and prioritizing the member's concerns, strengths, and preferences for care (e.g., cultural considerations);

j. Developing initial person-centered care plans within 15 calendar days of the initial assessment completion date;

k. Developing, updating, and reviewing the person-centered care plan (i.e., initial and revised) with the member, family/caregivers, the PCP, specialists, and members of the Trans-Disciplinary Care team, as appropriate;

l. Aligning person-centered care plan goals with the priority issues identified by the member and provider (e.g., PCP) so the MCOP can support the provider-member relationship;

m. Validating that the member received the services in the person-centered care plan and has a backup plan developed in the event services cannot be received. If services were not received, taking necessary action to address and close gaps in care; including activating the backup plan and updating services, if needed;

n. Reviewing backup plans for all members. If a backup plan is not feasible, the MCOP must assist with the development and adjustment of the backup plan, as needed;

o. Retaining the person-centered care plan and sharing it with members of the Trans-Disciplinary Care team; and

p. Assuring compliance with all federal person-centered planning requirements including those set forth in the HCBS settings rule.

ix. *Waiver Service Plans for MyCare Ohio HCBS Waver Enrollees*

1. Members enrolled in the MyCare Ohio HCBS Waiver must have a waiver service plan which is integrated into the person-centered care plan.

2. The MCOP must comply with all waiver service plan requirements described in Appendix D of the MyCare Ohio HCBS Waiver.

3. The MCOP must allow a member to exercise choice and control over the provision of MyCare Ohio HCBS Waiver services they receive as determined during the waiver service planning process.

    a. The MCOP must also honor a member's choice and preference for which individuals participate in the waiver service planning process;

    b. The member must be allowed to exercise authority over the selection and direction of certain MyCare Ohio HCBS Waiver self-directed services, as described in Appendix B, Coverage and Services.

    c. Services and supports must be planned and implemented in accordance with each member's needs and expressed preferences.

4. The MCOP must monitor and review to ensure that members enrolled in the MyCare Ohio HCBS Waiver are receiving LTSS services authorized in their waiver service plan and take corrective action as needed to remedy any gaps in service, including gaps due to inability to find a direct care worker or direct worker no shows.

5. In accordance with federal regulations, the MCOP must obtain a signature from any MyCare Ohio HCBS Waiver service provider acknowledging and affirming agreement to provide the service as specified on the waiver service plan per ODM's specifications.

x. *Contacts*

1. The MCOP must establish an ODM-approved minimum contact schedule for members assigned a care coordinator, including an MCOP care coordinator or waiver service coordinator, to facilitate ongoing communication with the member. The ODM-approved contact schedule must reflect the following minimum contact expectations by risk stratification level:

Risk Tier	**Contact Schedule**
Tier 1 — Low-monitoring	In-person visits determined by MCOP or per member request. Telephonic contact as needed.
Tier 2 — Medium	One in-person visit every six months. Maximum of 180 days between visits. Telephonic contact as needed.
Tier 3 — High	One in-person visit every three months. Maximum of 90 days between visits. Telephonic contact every 30 days.
Tier 4 — Intensive	One in-person visit every two months. Maximum of 60 days between visits. Telephonic contact every 30 days.

2. The ODM-approved contact schedule must include number of subsequent attempts to reach the member if the member does not respond to the initial attempt. The ODM-approved contact schedule must reflect telephonic and in-person, face-to-face visits, depending on the member's needs and preferences.

    a. At a minimum, the MCOP must attempt to reach the member at least three times during the first ninety days of enrollment. If the member's situation requires a more immediate contact based upon health, safety, and welfare assurance or member preference the MCOP must fulfill that need.

    b. If a member is unable to be reached following the minimum contacts above, the MCOP should complete a pre-call review to determine if alternative forms of contact can be located (e.g., home health agency, MyCare Ohio HCBS Waiver provider, primary care provider).

c. If no contact is achieved following all attempts above, an unable to reach letter should be generated and mailed to the address of record.

d. The MCOP should reserve the right to attempt alternative methods of contact to assure health, safety, and welfare of the member (e.g., unannounced visit to the address of record, etc.) if a member is still unable to be reached.

3. The MCOP must submit Care Coordination Contact lists as specified in Appendix P, Chart of Deliverables.

xi. *Incident Reporting*

1. The MCOP must report critical incidents as described in OAC rule 5160-44-05 upon discovery/identification/notification for all members within one business day into Ohio's Incident Management System (IMS).

a. The MCOP must collaborate, communicate, and coordinate as needed with the waiver service coordinators to support a prevention plan and/or intervention (e.g., re-evaluating risk stratification, doing a home visit, offering services and resources, and creating a prevention plan).

b. For members assigned to behavioral health care coordination entities or other behavioral health agencies/specialists, incidents must be submitted by the behavioral health care coordination entities or other behavioral health agencies/specialists. The MCOP must work with the behavioral health care coordination entities or other behavioral health agencies/specialists to support the prevention plan and/or intervention. The MCOP must collaborate with the behavioral health care coordination entities or other behavioral health agencies/specialists to ensure the incident is submitted in the appropriate incident system.

c. Unless a longer timeframe has been prior approved by ODM, the MCOP must conclude the incident review and enter any relevant information, including the contributing factors, into the IMS no later than 45 calendar days after the initial receipt of the incident report.

d. Except in the case of death, the MCOP must enter a prevention plan into the IMS and close the case no later than seven business days after the conclusion of the review.

e. The MCOP must review critical incident reports for root causes and develop a prevention plan as appropriate. The MCOP must enter prevention plans in ODM's IMS for all members, regardless of tier assignment.

f. The MCOP must assure that critical incidents involving nursing facility residents are reported to Bureau of Survey and Certification, Ohio Department of Health Complaint Unit.

g. Upon a member's enrollment in the MyCare Ohio HCBS Waiver, and at the time of each reassessment, the MCOP or waiver service coordinator must

provide the member and their authorized representative with written information and education about how to report abuse, neglect, exploitation, and other incidents. The MCOP or waiver service coordinator must secure written confirmation of receipt of education and written materials from the member/authorized representative and must maintain the written confirmation in the member's person-centered care plan or other written record.

2. The MCOP must report reportable events as described in OAC rule 5160-44-05 for members enrolled in the MyCare Ohio HCBS Waiver within one business day into Ohio's IMS.

xii. *Cooperation and Exchange of Information with ODM Incident Management System and Provider Oversight Vendor for Members enrolled in the MyCare Ohio HCBS Waiver or Specialized Recovery Services Program*

1. ODM contracts with a vendor to serve as the investigative entity and provider oversight vendor for ODM with respect to the investigation of incidents and to conduct provider oversight activities for MyCare Ohio HCBS Waiver and SRS program enrollees.

2. The MCOP must report and address all incidents for its MyCare Ohio HCBS Waiver and SRS program members in accordance with OAC rule 5160-44- 05 via entry into the ODM IMS.

3. The MCOP must report, no later than three business days of discovering a provider occurrence, to the ODM provider oversight vendor via the ODM IMS and/or to the Ohio Dental Association (ODA) via the ODA-established mailbox (unless otherwise directed), any discovery of provider noncompliance with the provider conditions of participation outlined in OAC rule 5160-44-31 or 173-39-02, according to the entity that certified/approved the waiver provider.

4. With each critical incident reported, the MCOP must also provide waiver member case notes (at least one month prior to the incident; and at least three months prior to an unexplained death), the most recent assessment, and the person-centered care plan in effect at the time of the incident.

5. If the MCOP is unable to submit these documents at the time the incident report is made, the MCOP must upload them to the ODM IMS no later than three business days after submitting the incident report to the IMS.

6. For the purpose of investigating critical incidents set forth in OAC rule 5160-44-05, the incident management vendor, ODM, or the incident management vendor and ODM jointly, may ask the MCOP for additional information, records, data, documentation, prevention plans, etc. as deemed necessary by ODM or the incident management vendor to complete the investigation or prevention plan evaluation.

7. If necessary, to ensure the immediate health and welfare of the members, the request may be made before the three-business day standard.

8. The MCOP must respond promptly to the incident management vendor and/or ODM requests for documentation (to ensure incident investigations may be completed within the required timeframe established in OAC rule 5160-44-05 or as otherwise instructed by ODM). The MCOP and incident management vendor must exchange such information as necessary for the MCOP to meet both entities' contractual duties.

9. The MCOP must comply with the requirements set forth in the ODM MyCare Ohio Waiver Incident Escalation procedure.

10. For each provider occurrence reported into the IMS, the MCOP must submit the following documentation: waiver member case notes (at least one month prior to the occurrence); the Waiver service plan in effect at the time of the occurrence; any documents the MCOP has obtained related to the occurrence; and any historical incident information the MCOP has regarding issues involving the provider related to the occurrence. The provider oversight vendor may request more documentation, or other documentation pertinent to their review of the occurrence and if so, the MCOP must provide it.

11. Pursuant to this Agreement, and the business associate agreement between ODM and the provider oversight vendor, ODM, the MCOP, and the ODM provider oversight vendor may exchange member protected health information (PHI) as a part of the incident and provider occurrence management process.

xiii. *Member Safeguards*

1. The MCOP must comply with the member safeguard requirements below when the MCOP identifies or becomes aware of risks to a member's health, safety, or welfare.

2. The MCOP must develop and implement safeguards, systems, and processes that detect, prevent, and mitigate harm and/or risk factors that could impact a member's health, safety, or welfare.

3. When the MCOP identifies or becomes aware of risk factors, it must put in place services and supports to mitigate and address the identified issues as expeditiously as the situation warrants.

4. When a member poses or continues to pose a risk to the member's own health, safety, or welfare, the MCOP must develop and implement a health and safety action plan between the MCOP and the member, identifying the risks and setting forth action steps recommended by the MCOP to remedy risks to the member's health, safety, and/or welfare.

    a. The MCOP's process for development and implementation of a health and safety action plan must be in accordance with ODM's specifications.

        i. The MCOP must evaluate the possible need for a health and safety action plan as part of the MCOP's review of a reportable/critical incident.

ii. The MCOP should evaluate if a member's health and safety action plan requires modification if a reportable/critical incident is related to activities that the health and safety action plan is intended to address.

b. The MCOP must document in the clinical record the member's health and safety action plan, any refusal of the member to sign the health and safety action plan, and/or lack of adherence by the member to the agreed upon actions or interventions.

c. The MCOP may submit a request for disenrollment from the MyCare Ohio HCBS Waiver, for ODM consideration, when it is believed the health, welfare, or safety of the member cannot be ensured on the waiver program.

5. ODM or its designee will conduct administrative reviews, in-home checks, and/or other oversight activities to ensure a member's health, safety, and welfare.

6. The MCOP's failure to meet member safeguard requirements that places a member at risk for a negative health outcome or jeopardizes the member's health, safety, or welfare may result in the assessment of sanctions as specified in Appendix N, Compliance Actions.

f. Care Coordination Information Systems/Data

i. *Care Coordination Portal*

1. The MCOP must provide a Care Coordination Portal that collects, stores, integrates, shares, and pushes out pertinent member information with/to the entities involved in coordinating the member's care (e.g., ODM, waiver service coordinators, behavioral health care coordinators, and the member's PCP, as applicable). The MCOP's Care Coordination Portal must have the capability of sending electronic notifications of sentinel events to entities involved in the member's care coordination.

2. The MCOP must provide timely electronic notification of sentinel events to all entities involved in the member's care coordination to support appropriate care coordination. Sentinel events, with expectations of required reporting timeframes, must be entered as follows:

a. All cause (physical health and behavioral health) inpatient hospitalizations/re-hospitalizations must be entered on the same day as admission;

b. Emergency department visits must be entered upon notification to the MCOP;

c. Identified gaps in care must be entered within 72 hours of identification, unless immediate action is necessary to ensure health or safety of the member;

d. Residential treatment admissions must be entered within 72 hours of admission; and

e. Residential treatment discharges must be entered at least 72 hours prior to the planned discharge.

3. The MCOP's Care Coordination Portal must be available to ODM, subject to access controls and requirements necessary to comply with state and federal privacy requirements.

4. The MCOP must provide ODM full access to the Care Coordination Portal , subject to the privacy requirements as specified in Appendix A, General Requirements.

5. The MCOP must create a "single sign on" as specified in Appendix K, Information System, Claims, and Data, for the Care Coordination Portal for state staff, as well as waiver service coordinators and behavioral health care coordination entities providing care coordination services.

ii. *MCOP Responsibilities for Portal Data*

1. The MCOP must maintain the following data in the MCOP's Care Coordination Portal:

a. MCOP name;

b. Member name, all membership numbers assigned to the member (e.g., MCOP identifier, Medicaid number, and Medicare number) Medicare status, and eligibility span;

c. Member demographics and contact information;

d. Care coordination assignment (e.g., MCOP care coordinator , waiver service coordinator, and/or behavioral health care coordination entity or other behavioral health agency/specialist);

e. MCOP care coordinator name/contact information;

f. Any and all notes regarding the member maintained by the MCOP care coordination team;

g. Risk tier;

h. MCOP care coordination status (e.g., outreach and coordination, engaged, or monitoring);

i. MCOP conducted assessments, including the ODM-approved comprehensive risk assessment;

j. MCOP-developed person-centered care plan;

k. Utilization data (e.g., claims, prior authorizations, emergency department visits and hospitalizations, and value-added services) within 24 hours;

l. Grievances, appeals, and/or state hearings;

m. 24 hours a day, seven days a week medical advice line information and notes;

n. Member service information;

o. MCOP-identified sentinel events;

p. MCOP-identified critical and reportable incidents; and

q. Care team contacts, including all care coordinators and providers of services currently received by the member.

2. The MCOP's Care Coordination Portal must allow for ODM to run reports on the following:

a. Claims;

b. Assessment history; and

c. Visit and contact schedule.

g. Care Coordination Monitoring

i. The MCOP must monitor to ensure the care coordination needs of members are met.

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

iii. The MCOP must monitor the quality and effectiveness of care coordination provided by the MCOP, waiver service coordinators, or other delegated arrangements through the review of member and provider surveys and case reviews. Case reviews must include whether established quality, clinical best practice, and care coordination standards have been met.

iv. Following the identification of unmet member needs or care coordination delivery deficiencies, the MCOP, in coordination with ODM, the behavioral health care coordination entities or other behavioral health agencies/specialists, and/or waiver service coordinator, as applicable, must ensure that the member needs are expediently met and that care coordination deficiencies are systemically corrected.

3. Care Coordination Support for Specific Populations

a. The MCOP must adhere to care coordination requirements and protocols for specific populations as described in ODM's collaborative communication and coordination protocols.

4. Transitions of Care Requirements

a. Transitions of Care Between Health Care Settings

i. The MCOP, in coordination with the member's Trans-Disciplinary Care team, must effectively and comprehensively manage transitions of care settings to prevent unplanned or unnecessary readmissions, emergency department visits, crisis events, and/or adverse outcomes. The Care Coordination Portal must be used to facilitate the exchange of member-specific data. The MCOP must:

1. Identify members who require assistance transitioning between settings or between a dual benefit (e.g., nursing facility services), and notify the member's Trans-Disciplinary Care team, as applicable;

2. Develop a method for evaluating risk of readmission or deterioration (e.g., evaluating risk tier) in order to determine the intensity of follow-up required for the member after the date of discharge, and share this information with the member's Trans-Disciplinary Care team, as applicable;

3. Ensure the member's care coordinator communicates with the discharging facility and informs the facility of the designated contacts of the member's Trans-Disciplinary Care team and providers of services currently received by the member;

4. Ensure timely notification and receipt of admission dates, discharge dates, and clinical information is communicated between MCOP departments, with the Trans-Disciplinary Care team, care settings, and the member's PCP, as appropriate;

5. Participate in discharge planning activity with the facility, including making arrangements for safe discharge placement and facilitating clinical hand-offs between the discharging facility and the MCOP and/or other participants in a member's Trans-Disciplinary Care team, as assigned;

    a. This activity includes assuring medication reviews as appropriate, including assuring reconciliation of medications at the point of discharge or transfer between care settings;

6. Obtain a copy of the discharge/transition plan and share the plan with the member's care team;

7. Arrange and confirm services are authorized and delivered in accordance with the discharge/transition plan;

8. Ensure that providers can obtain copies of the member's medical records as appropriate and consistent with federal and state requirements; and

9. Conduct timely follow-up with the member and the member's primary provider to ensure post discharge services have been provided.

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

iii. When the MCOP, waiver service coordinator, and/or behavioral health care coordination entity or other behavioral health agency/specialist is contacted by an inpatient facility with a request to participate in discharge planning, the MCOP, waiver service coordinator, and/or behavioral health care coordination entity or other behavioral health agency/specialist must cooperate as outlined above to ensure a safe discharge placement and services are arranged for the member.

b. Transition of Care for Members New to MyCare Ohio

i. *General*

1. The MCOP must provide for the transition of Medicaid and Medicare services in accordance with the requirements specified within this section of the Agreement for new members transitioning to the MCOP from fee-for-service (FFS) or a managed care organization (MCO) who are new to MyCare Ohio. The Care Coordination Portal may be used, as appropriate, to facilitate the exchange of member-specific data.

2. The MCOP must pay out-of-network providers who provide services during the transition of Medicare and Medicaid services at least the Medicaid FFS rate. Prior to the end of any required transition period described in the table below, the MCOP must inform the member and out-of-network provider of the effective date of any transition to a network provider, during a meeting of the Trans-Disciplinary Care team, or by another method documented in the member's person-centered care plan.

3. For new members enrolled with the MCOP and transitioning from FFS or an MCO, the MCOP will receive member information as specified by ODM from FFS or the disenrolling MCO.

4. Upon receipt, the MCOP must be able to process and use the historic utilization, prior authorization, and care coordination data files to assess pending members' risk stratification levels, to coordinate care, and to adhere to transition requirements.

    a. When waiver service coordination data is omitted from the file transfer for a pending member enrolled in the FFS Pre-Admission Screening System Providing Options and Resources Today (PASSPORT) or Assisted Living waiver, the MCOP must reconcile the enrollment or data error with the PASSPORT Administrative Agency (PAA). When waiver service coordination data is omitted for pending members in the Ohio Home Care waiver, the MCOP must notify its contract administrator to request enrollment reconciliation and/or data completion.

5. The MCOP must make express arrangements to obtain current treatment plans from behavioral health care coordination entities or other behavioral health agencies/specialists as clinically appropriate to support the transition of behavioral health services.

6. The MCOP is responsible for implementing transition of care processes that prevent access problems for members who are transitioning to an MCOP. The transition of care processes for prescribed drugs must be consistent with Medicare Part D requirements.

7. The MCOP must coordinate with and utilize data provided by ODM, an MCO, and/or collected by the MCOP to identify existing sources of care and to ensure each new member is able to continue to receive existing services without disruption in accordance with this appendix.

8. Upon notification from ODM that a member will be transitioning from a MCO to an MCOP, the disenrolling MCO must provide specific information related to the disenrolling member to the enrolling MCOP as specified by ODM. The enrolling MCOP may prior authorize these services or assist the member to access services through a network provider when any of the following occur:

    a. The member's condition stabilizes and the MCOP can ensure no interruption to services;

    b. The member chooses to change to a network provider;

    c. The member's needs change to warrant a change in service; or

    d. Quality concerns are identified with the provider.

ii. *Continuation of Services for Members*

1. The MCOP must follow the transition requirements described in the table below, including the use of network and out-of-network providers, for members coming from Medicaid FFS and/or a Medicaid MCO at the time of a member's enrollment in the MCOP to assure continuity of care for members.

Table D.1 Transition of Care Requirements

Transition Requirements	HCBS Waiver Beneficiaries	Non-HCBS Waiver Beneficiaries with LTSS Needs (Home Health and Private Duty Nursing [PDN] use)	Nursing Facility Beneficiaries Assisted Living Beneficiaries	Beneficiaries not Identified for LTSS
Physician	180 days	180 days	180 days	180 days

Transition Requirements	HCBS Waiver Beneficiaries	Non-HCBS Waiver Beneficiaries with LTSS Needs (Home Health and Private Duty Nursing [PDN] use)	Nursing Facility Beneficiaries Assisted Living Beneficiaries	Beneficiaries not Identified for LTSS
Durable Medical Equipment	Must honor prior authorizations when item has not been delivered and must review ongoing prior authorizations for medical necessity.	Must honor prior authorizations when item has not been delivered and must review ongoing prior authorizations for medical necessity.	Must honor prior authorizations when item has not been delivered and must review ongoing prior authorizations for medical necessity.	Must honor prior authorizations when item has not been delivered and must review ongoing prior authorizations for medical necessity.
Scheduled Surgeries	Must honor specified provider.	Must honor specified provider.	Must honor specified provider.	Must honor specified provider.
Chemotherapy/ Radiation	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider.	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider.	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider.	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider.
Organ, Bone Marrow, Hematopoietic Stem Cell Transplant	Must honor specified provider.	Must honor specified provider.	Must honor specified provider.	Must honor specified provider.
Dialysis Treatment	180 days with same provider and level of service; and person-centered care plan documents successful transition planning for new provider.	180 days with same provider and level of service; and person-centered care plan documents successful transition planning for new provider.	180 days with same provider and level of service; and person-centered care plan documents successful transition planning for new provider.	180 days with same provider and level of service; and person-centered care plan documents successful transition planning for new provider.
Vision and Dental	Must honor prior authorization when item has not been delivered.	Must honor prior authorization when item has not been delivered.	Must honor prior authorization when item has not been delivered.	Must honor prior authorization when item has not been delivered.

Transition Requirements	HCBS Waiver Beneficiaries	Non-HCBS Waiver Beneficiaries with LTSS Needs (Home Health and Private Duty Nursing [PDN] use)	Nursing Facility Beneficiaries Assisted Living Beneficiaries	Beneficiaries not Identified for LTSS
Medicaid Home Health and PDN	Maintain service at current level and with current providers at current Medicaid reimbursement rates. Changes may not occur unless: A significant change occurs as defined in OAC rule 5160-45-01; or member expresses a desire to self-direct services; or after 180 days.	Sustain existing service for 90 days and then review for medical necessity after an in-person assessment that includes provider observation.	For AL: Sustain existing service for 90 days and then review for medical necessity after an in-person assessment that includes provider observation.	N/A
Assisted Living Waiver Service			Provider maintained at current Medicaid rate.	
Medicaid Nursing Facility Services			Provider maintained at current Medicaid rate.	

Transition Requirements	HCBS Waiver Beneficiaries	Non-HCBS Waiver Beneficiaries with LTSS Needs (Home Health and Private Duty Nursing [PDN] use)	Nursing Facility Beneficiaries Assisted Living Beneficiaries	Beneficiaries not Identified for LTSS
Waiver Services- Direct Care Personal Care Waiver Nursing Home Care Attendant Choice Home Care Attendant Out of Home Respite Enhanced Community Living Adult Day Health Services Social Work Counseling Independent Living Assistance	Maintain service at current level and with current providers at current Medicaid reimbursement rates. MCOP initiated changes may not occur unless: A significant change occurs as defined in OAC rule 5160-45-01; or member expresses a desire to self-direct services; or after 180 days.	N/A	N/A	N/A
Waiver Services- All other	Maintain service at current level for 180 days and existing service provider at existing rate for 90 days. MCOP initiated change in service provider can only occur after an in-home assessment and plan for the transition to a new provider.	N/A	N/A	N/A

Transition Requirements	HCBS Waiver Beneficiaries	Non-HCBS Waiver Beneficiaries with LTSS Needs (Home Health and Private Duty Nursing [PDN] use)	Nursing Facility Beneficiaries Assisted Living Beneficiaries	Beneficiaries not Identified for LTSS
Medicaid Community Behavioral Health Organizations (Provider types 84 & 95).	Maintain current provider, level of services documented in the behavioral health plan of care at the time of enrollment for 180 days. Medicaid rate applies during transition.	Maintain current provider, level of services documented in the behavioral health plan of care at the time of enrollment for 180 days. Medicaid rate applies during transition.	Maintain current provider, level of services documented in the behavioral health plan of care at the time of enrollment for 180 days. Medicaid rate applies during transition.	Maintain current provider, level of services documented in the behavioral health plan of care at the time of enrollment for 180 days. Medicaid rate applies during transition.
Pregancy-Related Services	Allow an out-of-network provider if the member is in her third trimester of pregnancy and/or has an established relationship with an obstetrician and/or delivery hospital.	Allow an out-of-network provider if the member is in her third trimester of pregnancy and/or has an established relationship with an obstetrician and/or delivery hospital.	Allow an out-of-network provider if the member is in her third trimester of pregnancy and/or has an established relationship with an obstetrician and/or delivery hospital.	Allow an out-of-network provider if the member is in her third trimester of pregnancy and/or has an established relationship with an obstetrician and/or delivery hospital.
SRS	N/A	Maintain service at current level and with current providers at current Medicaid reimbursement rates for 180 days after initial enrollment.	N/A	Maintain service at current level and with current providers at current Medicaid reimbursement rates for 180 days after initial enrollment.

Transition Requirements	HCBS Waiver Beneficiaries	Non-HCBS Waiver Beneficiaries with LTSS Needs (Home Health and Private Duty Nursing [PDN] use)	Nursing Facility Beneficiaries Assisted Living Beneficiaries	Beneficiaries not Identified for LTSS
OhioRISE	N/A	Maintain current provider and level of services currently received at the time of enrollment for at least 45 days regardless of whether the authorized or treating provider is a network or out-of-network provider. OhioRISE rates apply during transition.	N/A	Maintain current provider and level of services currently received at the time of enrollment for at least 45 days regardless of whether the authorized or treating provider is a network or out-of-network provider. OhioRISE rates apply during transition.

a. If the member has a FFS or MCO prior authorization approved prior to the member's transition.

i. The MCOP must honor the prior authorization through the expiration of the authorization, regardless of whether the authorized or treating provider is a network or out-of-network.

ii. The MCOP may conduct a medical necessity review for previously authorized services if the member's needs change to warrant a change in service. The MCOP must render an authorization decision pursuant to OAC rule 5160-26-03.1.

iii. The MCOP may assist the member to access services through a network provider when any of the following occur:

1. The member's condition stabilizes and the MCOP can ensure no interruption to services;

2. The member chooses to change the member's current provider to a network provider; or

3. If there are quality concerns identified with the previously authorized provider.

2. Upon notification from a member or provider of a need to continue services, the MCOP must allow a new member to continue to receive services from network and out-of-network providers when the member could suffer detriment to their health

or be at risk for hospitalization or institutionalization in the absence of continued services.

iii. *Documentation of Transition of Services*

1. The MCOP must document the provision of transition of services as follows:

    a. The MCOP must seek confirmation from an out-of-network provider that the provider agrees to provide the service and accepts the Medicaid FFS rate as payment or a negotiated rate.

        i. If the provider agrees, the MCOP must distribute materials to the out-of-network provider as specified in Appendix E, Marketing and Member Materials, of this Agreement.

        ii. If the provider does not agree, the MCOP must notify the member of the MCOP's availability to assist with locating another provider as expeditiously as the member's health condition warrants.

    b. If the service will be provided by a network provider, the MCOP must notify the network provider and the member to confirm the MCOP's responsibility to cover the service.

    c. The MCOP must use the ODM-specified model language for the provider and member notices and maintain documentation of all members and/or provider contacts relating to such services.

c. Transition of Care for Members Receiving Behavioral Health Services

i. For members with behavioral health needs transitioning to the MCOP from FFS, MCO, OhioRISE, or another MCOP, the MCOP must:

1. Employ specific strategies to identify behavioral health risk including risk for emergency department visits, behavioral health crisis, and inpatient admission. The MCOP must share/coordinate with the behavioral health care coordination entities or other behavioral health agencies/ specialists where/when appropriate.

2. Identify members with unmet behavioral health needs and risk of progressing behavioral health needs. (in transitions and as part of a larger population health strategy).

3. Provide evidence of effective strategies and outcomes related to behavioral health emergency department visits, inpatient admissions, and behavioral health crisis crucial or high-risk periods, particularly 24 hours post discharge.

ii. The MCOP must ensure that when a member is linked to a behavioral health care coordination entity or other behavioral health agency/specialist the MCOP or delegate includes the behavioral health care coordination entity or other behavioral health agency/specialist in transition of care planning.

d. Transition of Care for Individuals Enrolled in Specialized Recovery Services

i. The MCOP, in coordination with any entity contracted to provide authorized services related to the administration of SRS, must effectively and comprehensively manage transitions between FFS, MCOs, or other MCOPs to prevent unplanned or unnecessary disruption of SRS services. The MCOP must:

1. Identify members, through the monitoring of the 834 files, who have upcoming SRSP eligibility changes which may warrant future transitions for the SRSP.

2. Identify members who have requested a change in their Recovery Services agency.

3. Develop a method for collecting and sharing a minimum data set with the Recovery Services agency. This information should include, but not be limited to: the most recent ODM approved SRS assessment, member notes associated with the activities and member contacts, current authorizations under the SRS, copy of the SRS service plan, and access to incidents as applicable related to the SRS member.

4. Upon confirmation that MyCare Ohio eligibility will be lost and the member will transition to FFS, the MCOP must ensure that ODM receives the information in item 3 by submitting information to CareManagement@medicaid.ohio.gov in order to facilitate the transfer of SRS related information.

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

e. Transitions of Care for Member Transitioning from the OhioRISE Plan

i. *General*

1. The MCOP must follow the transition of care requirements as outlined below for a member who is transitioning from the OhioRISE plan to the MCOP. The Care Coordination Portal must be used to facilitate the exchange of member-specific data.

2. The MCOP must reach out to the OhioRISE plan and primary care coordination staff to engage the OhioRISE plan in MCOP pre-enrollment planning.

ii. *Care Coordination Assignment*

1. Upon notification from ODM that an individual enrolled in the OhioRISE plan will be transitioning to enrollment with the MCOP, the MCOP must assign an MCOP care coordination staff person to lead the MCOP's responsibilities for coordinating the transition of behavioral health care from the OhioRISE plan.

2. The MCOP must ensure that the members disenrolling from the OhioRISE plan have an assigned MCOP care coordination staff member for at least 90 calendar days

following disenrollment to assist members with accessing needed services and resources.

3. Upon notification from ODM that an individual enrolled in the OhioRISE plan will be transitioning to enrollment in the MCOP, the OhioRISE plan will provide member information to the MCOP as specified by ODM.

iii. *Continuation of Services for Members*

1. Upon notification from the OhioRISE plan, the MCOP must participate in developing a transition of care plan for services the member was receiving from the OhioRISE plan that will be transitioning to the MCOP.

2. The MCOP must honor any prior authorizations, as applicable based on MCOP covered services, 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 MCOP.

3. The MCOP may conduct a medical necessity review for previously authorized services if the member's needs change to warrant a change in service. The MCOP must render an authorization decision pursuant to OAC rule 5160-26-03.1.

4. The MCOP 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 MCOP can ensure no interruption to services.

    b. The member chooses to change to a network provider.

    c. If there are quality concerns identified with the previously authorized provider.

5. The MCOP must honor any inpatient hospital prior authorization approved by the OhioRISE plan, for dual benefit members, when the primary diagnosis on the prior authorization request initially indicated the OhioRISE plan would be responsible for the claim and changes in care delivery result in the All Patient Refined Diagnosis Related group becoming the responsibility of the MCO per the OhioRISE Mixed Services protocol and may not require an additional prior authorization request from the provider, regardless of whether the authorized or treating provider is in or out-of-network with the MCOP.

6. The MCOP must provide the following services to the member regardless of whether services were prior authorized/pre-certified or the treating provider is in or out-of-network with the MCOP:

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

b. The MCOP must allow a member who was receiving behavioral health services from the OhioRISE plan to continue to receive those behavioral health services with out-of-network providers, as applicable based on MCOP covered services, if the provider is an ODM-enrolled provider, even if the services were prior authorized by the OhioRISE plan. The MCOP must allow the member to receive behavioral health services from out-of-network providers for at least 45 calendar days from the date of the member's transition out of the OhioRISE plan or until the MCOP is able to transition services to a network provider. For continuity of care purposes, the MCOP must:

   i. Work with the provider to add the provider to its network;

   ii. Implement a single case agreement with the provider; or

   iii. Assist the member in finding and transitioning service delivery to another provider without a disruption in services.

f. Transition of Care Requirements for Members who are Changing MyCare Ohio Plans

   i. Upon initial implementation of the Next Generation MyCare Ohio program, when existing MyCare Ohio members are transitioned to the MCOP, the MCOP must:

      1. Maintain existing services and providers, including any services authorized and documented in the member's person-centered care plan (including the waiver service plan, as applicable), in the same scope and duration as authorized by the previous/legacy MyCare Ohio plan for at least 90 days from initial enrollment.

      2. Prior to modifying an existing authorization, complete a comprehensive assessment, and a medical necessity review.

   ii. When the MCOP is notified by ODM via the 834C or 834F or the consumer contact record of a member who is changing to a different MCOP, the disenrolling MCOP must share, at a minimum, the current assessment, ODM-approved comprehensive risk assessment, and care plan, including the person-centered care plan, with the enrolling MCOP within five business days of notification of the pending change.

   iii. Upon notification from a member and/or provider of a need to continue services, the MCOP must allow a member transitioning from another MCOP 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.

   iv. The enrolling MCOP must honor the disenrolling MCOP's prior authorization for all new members until the enrolling MCOP is able to conduct a comprehensive assessment and medical necessity review. The MCOP must honor prior authorizations and continue services with network and out-of-network providers as specified by ODM.

   v. Upon notification from ODM that a member will be switching to a different MCOP, the disenrolling MCOP must provide specific information related to the disenrolling member to the enrolling MCOP/MCO as specified by ODM. The enrolling MCOP may prior authorize

these services or assist the member to access services through a network provider when any of the following occur:

1. The member's condition stabilizes and the MCOP can ensure no interruption to services;
2. The member chooses to change to a network provider;
3. The member's needs change to warrant a change in service; or
4. Quality concerns are identified with the provider.

vi. Upon notification from ODM that an enrolled member will be disenrolling from one MCOP and transitioning to another MCOP the MCOP must provide member information to the enrolling MCOP.

g. Transition of Care Requirements for Members Disenrolling to Fee-for-Service Medicaid

i. When the MCOP is notified by ODM via the 834C or 834F, consumer contact record, and/or via another source of information (e.g., waiver service coordinator, member, provider) that a member is no longer eligible for MyCare Ohio and will return to FFS, the MCOP must:

1. Assist the member and coordinate with the member's Trans-Disciplinary Care team and providers to arrange for services.
2. Ensure the members PCP is aware that they will no longer have MCOP care coordination services and assist with any linkages needed for continuity of care.
3. Coordinate with ODM for continued authorization of home health and/or PDN services, as applicable.
4. Supply requested documentation for disenrolled members within five business days of the request to FFS providers.

h. Transition of Care Requirements for Members Receiving MyCare Ohio HCBS Waiver Services who Lose MyCare Ohio Eligibility

i. As soon as the MCOP is notified by ODM via the 834C or 834F, consumer contact record, and/or via another source of information (e.g., waiver service coordinator, member, provider), that a member who is receiving MyCare Ohio HCBS Waiver services may be terminated due to loss of MyCare Ohio eligibility, the MCOP must identify the reason for loss of eligibility and timely assist the member, as appropriate, with maintenance of MyCare Ohio eligibility.

ii. Upon confirmation that a member's MyCare Ohio eligibility will be terminated, during the last month of the individual's active membership, the MCOP must instruct the appropriate local AAA to end the MyCare Ohio HCBS Waiver span in alignment with enrollment termination, and facilitate, as appropriate, referrals to programs (e.g., other Medicaid HCBS waivers), and/or community resources that may assist the individual with continuation of LTSS.

iii. The MCOP must notify the member and all current MyCare Ohio HCBS Waiver providers of the member's termination from MyCare Ohio, and as applicable, of any referral made to other Medicaid HCBS waivers. These referrals and notifications must be completed prior to the end of the month of termination, and when this is not possible, as soon as possible thereafter.

iv. If the member is found eligible for a Medicaid HCBS waiver program, the MCOP must provide the MyCare Ohio HCBS Waiver service plan and any identified service issues or follow-up necessary to successfully transfer care to the Waiver Case Management agency.

APPENDIX E – MARKETING AND MEMBER MATERIALS

1. Marketing

a. General

i. The MCOP must comply with Medicare requirements regarding marketing, including but not limited to Section 1851(h) of the Social Security Act, 42 CFR 422.111, 42 CFR Part 422, Subpart V, 42 CFR 423.120(b) and (c), 42 CFR 423.128, and 42 CFR Part 423, Subpart V, and the Medicare Communications and Marketing Guidelines. In addition, the MCOP must comply with Medicaid requirements regarding marketing, including but not limited to 42 CFR 438.104, and the requirements specified herein.

b. Marketing Activities

i. The MCOP must include the MyCare Ohio logo on all member communications and marketing materials, excluding nominal gifts.

ii. When marketing, the MCOP:

1. Must ensure MCOP representatives, as well as materials and plans, represent the MCOP in an honest and forthright manner, and do not make statements that are inaccurate, misleading, confusing, or otherwise misrepresentative, or that defraud eligible individuals or ODM;

2. Must ensure no marketing activity directed specifically toward eligible individuals begins prior to ODM's approval;

3. Must not engage directly or indirectly with cold-call marketing activities, defined as any unsolicited personal contact by the MCOP with an eligible individual for the purpose of marketing, including door-to-door or telephone contact;

4. Must request and receive prior approval from ODM for any event or location where the MCOP plans to provide information to eligible individuals;

5. Must convene MCOP-initiated educational events at sites that are physically accessible to all eligible individuals, including persons with disabilities and persons using public transportation;

6. Must not offer material or financial gain, including but not limited to the offering of any other insurance, to an eligible individual as an inducement to select MCOP membership;

7. Must not offer inducements to any County Department of Job and Family Services or Ohio Medicaid Consumer Hotline staff or to others who may influence an eligible individual's decision to select MCOP membership;

8. Is permitted to offer gifts, promotional products, prizes, or similar-type items worth no more than $15 prior approved by ODM to an eligible individual as long as these items are offered whether or not the eligible individual selects membership in the MCOP;

9. Is permitted as prior approved by ODM to host a free raffle or giveaway as part of a marketing event, as long as the prize is worth no more than $15. Additionally, the entry for the raffle or giveaway shall not require an eligible individual to provide contact information or select membership in the MCOP.

10. Is permitted as prior approved by ODM to reference member incentive/appreciation items that are available solely to its MyCare Ohio members in marketing presentations and materials;

11. Must not make marketing presentations, defined as a direct interaction between an MCOP marketing representative and an eligible individual, in any setting unless initiated and requested by the eligible individual;

12. Must offer the ODM-approved solicitation brochure to the eligible individual at the time of the marketing presentation and must provide:

    a. An explanation of the importance of reviewing the information in the ODM-approved solicitation brochure that describes how the eligible individual can receive additional information about the MCOP prior to making an MCOP membership selection, and the process for contacting ODM or its designee to select an MCOP;

    b. Information that membership in the particular MCOP is voluntary and that a decision to select or not select the MCOP will not affect eligibility for Medicare, Medicaid, or other public assistance benefits;

    c. Information that each dual benefit member must choose a primary care provider (PCP) and all members must access providers and services as directed in the MCOP's member handbook and provider directory:

        i. The MCOP must also provide information that the member may access a comprehensive provider directory on ODM's website. Upon request, the MCOP must provide eligible individuals with a printed copy of the provider directory.

    d. Information that all medically necessary Medicaid covered services, as well as any additional services provided by the MCOP, will be available to all members and that all medically necessary Medicare covered services, as well as any additional services provided by the MCOP, will be available to dual benefit members.

13. Must, prior to initiating a member-requested marketing contact for any corporate-family Medicare Advantage or special needs plan product, identify and resolve any confusion or service issues that may have motivated the member's request for a change in enrollment. The MCOP's member services representative or member's care manager must also educate the member about the MCOP's integrated benefits and mandatory enrollment for Medicaid benefits. Once the issues are resolved and clarification about integrated enrollment is made, the member must be invited to rescind the marketing request.

14. Must not market other Medicare products such as a Medicare Advantage Plan to members of the MCOP.

15. Must refer eligible individuals who inquire about MyCare Ohio eligibility or enrollment to the Ohio Medicaid Consumer Hotline; however, the MCOP may provide eligible individuals with accurate information about the MCOP and its benefits prior to referring the eligible individual to the Ohio Medicaid Consumer Hotline.

16. Must never offer eligible individuals the use of a portable device (e.g., laptop computer, cellular phone, etc.) to assist with the completion of an online application to select and/or change MCOPs for Medicaid benefits. All Medicaid enrollment activities must exclusively be completed by the Ohio Medicaid Consumer Hotline.

c. Marketing Representatives and Training

i. If the MCOP utilizes marketing representatives for marketing presentations requested by eligible individuals, the MCOP must ensure compliance with all of the following:

1. All marketing representatives must be employees of the MCOP. The MCOP must submit a copy of the representative's job description to ODM prior to engaging in marketing activities.

2. The MCOP must not contract with or permit any third party agents or independent agents/brokers to market to or enroll members in the MCOP's MyCare Ohio plan unless it receives advance written permission from ODM and ODM approves the contract.

3. No more than 50% of each marketing representative's total annual compensation, including salary, benefits, and bonuses may be paid on a commission basis. For the purpose of this requirement, any performance-based compensation is considered a form of commission. Upon ODM's request, the MCOP must make available for inspection the compensation packages of its marketing representatives.

4. Marketing representatives subject to Ohio Revised Code (ORC) section 3905.02 must be trained and duly licensed by the Ohio Department of Insurance (ODI) to perform such activities.

5. The MCOP must develop and submit to ODM for prior approval (at initial development and at the time of revision) a marketing representative training program that must include:

a. A training curriculum that includes:

i. A full review of the MCOP's solicitation brochure, provider directory, and all other marketing materials, including all video, electronic, and print;

ii. An overview of the applicable public assistance benefits designed to familiarize and impart a working knowledge of these programs;

iii. The MCOP's process for meeting the member information requirements under Appendix A, General Requirements, for oral and written marketing materials for eligible individuals to whom marketing presentations are being given;

iv. Instruction on acceptable marketing tactics, including a requirement that the marketing representatives may not discriminate on the basis of age, gender, gender identity, sexual orientation, disability, race, color, religion, national origin, military status, genetic information, ancestry, health status, or the need for health services;

v. An overview of the ramifications to the MCOP and the marketing representatives if ODM rules are violated; and

vi. Review of the MCOP's code of conduct or ethics.

b. Methods that the MCOP will use to determine initial and ongoing marketing representative competencies that reflect the training curriculum.

6. Any MCOP staff person providing MCOP information or making marketing presentations to an eligible individual must:

a. Wear a visible identification tag, offer a business card when speaking to an eligible individual, and provide identifying information that ensures the MCOP staff person is not mistaken for an Ohio Medicaid Consumer Hotline, federal, state, or county employee;

b. Inform eligible individuals that the following MCOP information or services are available and how to access the information or services:

i. Sign language, oral interpretation, oral translation, and auxiliary aids and services for persons with disabilities at no cost to the member;

ii. Written information in the prevalent non-English languages of eligible individuals or members , as identified by ODM; and

iii. Written information in alternative formats.

c. Not discriminate on the basis of age, gender, gender identity, sexual orientation, race, color, religion, national origin, military status, veteran status, ancestry, disability, genetic information, health status, or the need for health services; and

d. Not ask eligible individuals questions related to their health status or need for health services.

7. Only ODM-approved MCOP marketing representatives may make a marketing presentation upon request by the eligible individual or in any way advise or recommend to an eligible individual that they select membership in a particular MCOP. Pursuant to ORC Chapter 1751 and ORC section 3905.01, all non-licensed agents, including providers, are prohibited from advising or recommending to an

eligible individual that they select MCOP membership in a particular MCOP, as this would constitute the unlicensed practice of marketing; and

8. MCOP informational displays do not require the presence of a marketing representative if no marketing presentation will be made.

d. Marketing Materials

i. The MCOP must ensure that marketing materials comply with the following requirements:

1. MCOP marketing materials must be available in a manner and format that is easily understood.

2. Written materials developed to promote membership selection in the MCOP must meet the member information requirements under Appendix A, General Requirements.

3. Sign language, oral interpretation, oral translation, and auxiliary aids and services must be available for the review of marketing materials at no cost to eligible individuals.

4. MCOP marketing materials are distributed to the MCOP's entire service area.

5. The mailing and distribution of all MCOP marketing materials must be prior approved by ODM and must not contain information or text on the outside of the mailing that identifies the addressee as a Medicaid recipient.

6. MCOP marketing materials must not contain any assertion or statement, whether written or oral, that the MCOP is endorsed by the Centers for Medicare & Medicaid Services (CMS), the federal or state government, or similar entity.

ii. The MCOP may request ODM or its designee to mail MCOP marketing materials to eligible individuals. The MCOP must pay ODM or its designee for the postage and handling for each mailing. The MCOP must not use the MCOP's address as the return address in mailings to eligible individuals processed by ODM or its designee.

e. Solicitation Brochure

i. The MCOP must have a solicitation brochure available to eligible individuals that contains, at a minimum:

1. The identification of the Medicaid recipients eligible for enrollment in the MCOP;

2. Information that an eligible individual who becomes a member will receive an MCOP identification (ID) card from the MCOP that will replace the member's monthly Medicaid card;

3. A statement that all medically necessary Medicaid-covered services will be available to all members and that all medically necessary Medicare covered services will be available to dual benefit members;

4. A description of any additional services available to members;

5. Information that membership selection in a particular MCOP is voluntary, that a decision to select MCOP membership or to not select MCOP membership in the MCOP will not affect eligibility for Medicaid or other public assistance benefits, and that eligible individuals may change MCOPs under certain circumstances;

6. Information on how the eligible individual can request or access additional MCOP information or services, including clarification on how this information can be requested or accessed through:

    a. Sign language, oral interpretation, oral translation, and auxiliary aids and services for persons with disabilities at no cost to the eligible individual;

    b. Written information in the prevalent non-English languages of eligible individuals or members, as identified by ODM; and

    c. Written information in alternative formats.

7. Clear identification of corporate identity when a trade name or Doing Business As (DBA) is used for the Medicaid line of business;

8. Clear identification of the MCOP as a MyCare Ohio plan and distinguishing a MyCare Ohio plan from other Medicare Advantage plans, including Dual Eligible Special Needs Plans (D-SNPs) that are not Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs).

9. 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 MCOP operates, will be provided upon request;

10. Information that dual benefit members must choose a PCP from the MCOP's network of providers and that the PCP will assist with the coordination of the member's health care;

11. Information that a dual benefit member may change PCPs at least monthly;

12. A statement that all medically necessary Medicaid covered health care services, and all medically necessary Medicare covered health care services for dual benefit members, must be obtained from or through the MCOP's providers except emergency care and any other services or provider types designated by ODM;

13. A description of how to access emergency services, including information that access to emergency services is available within and outside the service area;

14. A description of the MCOP's policies regarding access to providers outside the state;

15. Information on member-initiated termination options in accordance with Ohio Administrative Code (OAC) rule 5160-58-02.1; and

16. Information on the procedures an eligible individual must follow to select membership in an MCOP, including any ODM selection requirements.

f. Annual Marketing Plan

i. The MCOP must submit an MCOP Marketing Plan to ODM as specified in Appendix P, Chart of Deliverables. The MCOP Marketing Plan must include all planned activities for promoting membership in, or increasing awareness of, the MCOP.

ii. The MCOP must include an attestation with its marketing plan submission attesting that the plan is accurate and not intended to mislead, confuse, or defraud eligible individuals or ODM.

iii. If the MCOP Marketing Plan does not include specific dates, events, and/or locations, the MCOP must provide to ODM, upon request, current schedules of all events.

g. Marketing and Member Material Approval

i. The MCOP must submit all new and revised marketing communications (including materials used for marketing presentations) and member communications (including scripted verbal communications and mailing and distribution of written materials) to ODM for review and approval prior to distribution to eligible individuals or members.

ii. The MCOP must submit marketing and member materials for review and approval using the process specified by ODM. This includes submitting marketing and member materials, as specified by ODM or CMS, in the Health Plan Management System (HPMS). The HPMS multi-plan submission process is not applicable to this Agreement.

iii. The MCOP must comply with ODM's Marketing Guidance Document for determining what constitutes "new and revised" marketing materials that require ODM's review and prior approval. The MCOP must submit all direct member contact materials (e.g., phone scripts and text messages) to ODM for review and approval.

iv. The MCOP must include an attestation with each marketing submission that the material is accurate and not intended to mislead, confuse, or defraud eligible individuals or ODM.

v. In accordance with 42 CFR 438.104(c), ODM will consult with the Medical Care Advisory Committee or an advisory committee of similar membership on the review process for MCOP-submitted marketing materials.

vi. The MCOP must cease use of any marketing or member materials upon notification from ODM.

h. Alleged Marketing Violations

i. The MCOP must immediately notify ODM in writing of its discovery of an alleged or suspected marketing violation. ODM will forward information pertaining to alleged marketing violations to the ODI and the Medicaid Fraud Control Unit (MCFU) as appropriate.

2. ODM-Requested Member Notifications

a. The MCOP must provide written notice to members as specified by ODM, including notification of a change to member services or access to network providers.

3. Member Materials

a. General

i. The MCOP must ensure that all member materials meet the member information requirements as stated in Appendix A, General Requirements.

ii. Member materials are those items developed by or on behalf of the MCOP to fulfill MCOP 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 MCOP and that do not include any reference to the MCOP are not considered to be member materials.

iii. Pursuant to OAC rules 5160-58-01.1 and 5160-26-05.1, the MCOP must ensure that the MCOP adopts and provides a copy of the MCOP's practice guidelines to eligible individuals and members upon their request.

iv. The MCOP must ensure that member materials do not include statements that are inaccurate, misleading, confusing, or otherwise misrepresentative, or that defraud eligible individuals or ODM.

v. For dual benefit members, the MCOP must provide integrated Medicare-Medicaid materials that are developed by the MCOP based on the standardized or model materials provided by ODM and are prior approved by ODM and CMS. This includes, but is not limited to, an Annual Notice of Changes (ANOC), member handbook/evidence of coverage (EOC), summary of benefits (SB), provider and pharmacy directory (provider directory), list of covered drugs (formulary), member ID card, integrated denial notice, notice of appeal decisions, and enrollment and disenrollment notices.

b. New Member Materials

i. *General*

1. The MCOP must provide each member or assistance group that selects or is auto-assigned to the MCOP or changes Medicaid or dual benefit status, an MCOP ID card, new member letter, MyCare Ohio Home- and Community-Based Services (HCBS) Waiver handbook as applicable, notice of advance directives, provider directory postcard, a quick guide(s), postcard providing the link to the member handbook, if sent in lieu of the full member handbook, the MCOP's formulary to dual benefit members, and any additional materials required by ODM or CMS.

2. In accordance with 42 CFR 438.10(c)(6), the MCOP must meet all of the following if the MCOP provides required member information or the member handbook electronically:

a. The format is readily accessible.

b. The information is located in a prominent and readily accessible place on the member page of the MCOP's website.

c. The information is provided in an electronic form, which can be electronically retained and printed.

d. The information provided electronically meets the member information requirements as stated in Appendix A, General Requirements.

e. The information is consistent with the content requirements in this appendix.

f. The member is informed that the information is available in paper form without charge upon request and provides it upon request within five business days.

ii. *MCOP ID Card*

1. The MCOP must provide MCOP ID cards in accordance with ODM specifications to each member or assistance group that selects or is auto-assigned to the MCOP. The MCOP is responsible for the production, distribution, and costs of MCOP ID cards.

2. For dual benefit members, the MCOP must provide a single MCOP ID card for use in obtaining all covered Medicare and Medicaid benefits. The single MCOP ID card must include the elements specified by ODM in a model single ID card.

3. For Medicaid only members, the MCOP ID card must include:

    a. The MCOP's name as stated in its article of incorporation and any other trade or DBA name used;

    b. The name of the member enrolled in the MCOP and the member's medical management information system billing number;

    c. The name and telephone numbers of the PCP assigned to the member (if a network PCP is not identified on the Medicaid only member's consumer contact record and the member does not select a network PCP, the ID card PCP field shall read "Refer to Medicare PCP");

    d. Information on how to obtain the current eligibility status of the member;

    e. Pharmacy benefit and contact information;

    f. The MCOP's emergency procedures, including the toll-free call-in system phone numbers;

    g. The MCOP's care management supports services telephone number; and

    h. Any other information required by ODM.

iii. *New Member Letter*

1. The MCOP must use the model language specified by ODM for the new member letter for Medicaid only members and dual benefit members. The MCOP New Member Letter must inform each member of the following:

    a. The new member materials issued by the MCOP, what action to take if the member did not receive those materials, and how to access the MCOP's provider directory;

    b. How to access MCOP-provided transportation services;

    c. How to change PCPs (for dual benefit members);

    d. The population groups not required to select MCOP membership and the action to take if a member believes they meet this criteria and does not want to be an MCOP member;

    e. The need and timeframe for a member to contact the MCOP if the member has a health condition that the MCOP should be aware of to allow the MCOP to most appropriately manage or transition the member's care; and

    f. The need and how to access information on pharmacy services, including medications that require prior authorization.

iv. *Member Handbook*

1. The MCOP must develop and distribute four different member handbooks: a member handbook for dual benefit members, a member handbook for Medicaid only members, a MyCare Ohio HCBS Waiver (waiver) member handbook, when applicable, for both dual benefit and Medicaid only members, and self-direction member handbook, when applicable, for both dual benefit and Medicaid only members directing their own care. The MCOP must develop each handbook using the model language specified by ODM for the specific member handbook. Each member handbook must be clearly labeled as such and include "MyCare Ohio" to clearly distinguish the applicability of the member handbook to members covered under this Agreement from other MCOP lines of business. The MCOP must ensure the member handbook table of contents precedes all content, with the exception of the tagline to comply with Section 1557 of the Patient Protection and Affordable Care Act. The member handbook must include ODM definitions of managed care terminology in accordance with 42 CFR 438.10.

2. The MCOP must ensure the member handbook for Medicaid only members includes:

    a. The rights of members, including all rights found in OAC rules 5160-58-01.1 and 5160-26-08.3 and any member responsibilities specified by the MCOP:

        i. With the exception of any prior authorization requirements the MCOP describes in the member handbook, the MCOP cannot

establish any member responsibility that would preclude the MCOP's coverage of a Medicaid-covered service.

b. Information regarding services excluded from MCOP coverage and the services and benefits available through the MCOP and how to obtain them including, at a minimum:

   i. All services and benefits requiring prior authorization or referral by the MCOP or the member's PCP;

   ii. Self-referral services, including Title X services, and women's routine and preventative health care services provided by a women's health specialist as specified in OAC rule 5160-58-03; and

   iii. Federally qualified health center (FQHC), rural health clinic (RHC), and certified nurse practitioner services specified in OAC rule 5160-58-03.

   iv. Any applicable pharmacy utilization management strategies prior-approved by ODM.

c. Information regarding available emergency services, the procedures for accessing emergency services and directives as to the appropriate utilization, including:

   i. An explanation of the terms "emergency medical condition", "emergency services", and "post-stabilization services", as defined in OAC rules 5160-58-01 and 5160-26-01;

   ii. A statement that prior authorization is not required for emergency services;

   iii. An explanation of the availability of the 911 telephone system or its local equivalent;

   iv. A statement that members have the right to use any hospital or other appropriate setting for emergency services; and

   v. An explanation of the post-stabilization care services requirements specified in OAC rule 5160-58-03.

d. Information required by ODM to promote member awareness and understanding of their rights under the Mental Health Parity and Addiction Equity Act;

e. The procedure for members to express their recommendations for change to the MCOP;

f. Identification of the categories of Medicaid recipients eligible for MCOP membership;

g. Information stating that the MCOP's ID card replaces the member's monthly Medicaid card, how often the card is issued, and how to use it;

h. A statement that medically necessary health care services must be obtained through the providers in the MCOP's provider network with any exceptions that apply, such as emergency care;

i. Information related to the selection of a PCP from the MCOP provider directory, how to change PCPs at least monthly, the MCOP's procedures for processing PCP change requests after the initial month of MCOP membership, and how the MCOP will provide written confirmation to the member of any new PCP selection prior to or on the effective date of the change;

j. Information on services available to members, including care management and care coordination;

k. A description of the MCOP'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;

l. An explanation of how to access information on the MCOP's website describing programs that reward members for meeting certain health goals;

m. Information on member-initiated termination options in accordance with OAC rule 5160-58-02.1;

n. Information about MCOP-initiated termination;

o. An explanation of automatic MCOP membership renewal in accordance with OAC rule 5160-58-02;

p. The procedure for members to file a grievance, an appeal, or state hearing request pursuant to OAC rule 5160-58-08.4, the MCOP's mailing address, and copies of the optional forms that members may use to file an appeal or grievance with the MCOP:

    i. Copies of the forms to file an appeal or grievance must also be made available through the MCOP's member services program.

q. The standard and expedited state hearing resolution timeframes as outlined in 42 CFR 431.244;

r. The member handbook issuance date;

s. A statement that the MCOP is prohibited from discriminating on the basis of race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, veteran status, ancestry, genetic information, health status, or need for health services in the receipt of health services;

t. An explanation of subrogation and coordination of benefits (COBs);

u. A clear identification of corporate or parent identity when a trade name or DBA is used for the Medicaid product;

v. Information on the procedures for members to access behavioral health services;

w. Information on the MCOP's advance directives policies, including a member's right to formulate advance directives, a description of state law, and a statement of any limitation regarding the implementation of advance directives as a matter of conscience;

x. A statement that the MCOP provides covered services to members through a provider agreement with ODM, and how members can contact ODM;

y. The toll-free call-in system phone numbers;

z. A statement that additional information is available from the MCOP upon request including, at a minimum:

    i. The structure and operation of the MCOP and any physician incentive plans the MCOP operates.

aa. Process for requesting or accessing additional MCOP information or services including, at a minimum:

    i. Oral interpretation, oral translation, and auxiliary aids and services for persons with disabilities;

    ii. Written information in the non-English language identified as the member's primary language; and

bb. Written information in alternative formats.

cc. If applicable, detailed information on any member co-payments;

dd. How to access the MCOP's provider directory;

ee. Access to provider network information to members via the MCOP's website and printed provider directories; and

ff. An explanation of the care coordination portal; the process by which clinical information, including diagnostic and medication information, will be available to authorized caregivers; and how to obtain a copy of the member's care coordination information.

3. The MCOP must provide a waiver member handbook to members enrolled in the MyCare Ohio HCBS Waiver at the time of enrollment and also at the time of each annual reassessment. The MCOP is responsible for ensuring the MCOP care manager or waiver service coordinator has verbally reviewed the content of the

handbook, with the member, and the MCOP must maintain documentation signed by the member of receipt of this information.

4. The MCOP must provide an ODM-approved handbook on self-direction detailing processes to all members who express interest in directing their own care.

v. *MCOP Quick Guide*

1. The MCOP must create a quick guide version of its member handbook for dual benefit members and a quick guide version of its member handbook for Medicaid only members that includes but is not limited to the following information:

    a. Taglines compliant with 42 CFR 438.10;

    b. The process for requesting or accessing additional MCOP information or services including, at a minimum:

        i. Oral interpretation, oral translation, and auxiliary aids and services for persons with disabilities;

        ii. Written information in the prevalent non-English languages, as identified by ODM; and

        iii. Written information in alternative formats.

    c. A statement that the MCOP provides covered services to members through a provider agreement with ODM, and how members can contact ODM;

    d. Toll-free phone numbers critical to accessing care, including the following:

        i. General (24/7 Call Center);

            1. Medical Advice Line;

            2. Behavioral Health Crisis;

            3. Care Management Support Services; and

            4. Prior Authorization, Coverage Determinations, and Appeals Call Center;

        ii. Member Services; and

        iii. Pharmacy Technical Health Call Center.

    e. The benefits available through the MCOP, how to obtain them, and any limits or prior authorization applied;

    f. Information regarding emergency services, the procedures for accessing emergency services, and that emergency services do not require prior authorization;

g. Information that indicates medically necessary health care services must be obtained through the providers in the MCOP's provider network with any exceptions that apply, such as emergency care;

h. How to access the MCOP's provider directory; and

i. The quick guide issuance date.

vi. *Provider Network Information and Advance Directives*

1. In addition to the MCOP ID card, a new member letter, quick guide, and member handbook(s), the MCOP must provide to each member or assistance group, as applicable, provider network information and information on advance directives, as specified by ODM.

vii. *Information Required for Enrollment Changes*

1. If a member's demographic information or enrollment changes, including change in Medicaid only or dual benefit status, the MCOP must issue a new MCOP ID card and a new member handbook postcard to the member if the member handbook has been revised since the initial MCOP membership date or the member's change triggers the need for a different member handbook. In addition, if a member's status changes from Medicaid only to dual benefit status, the MCOP must provide the member with the MCOP's provider directory, the MCOP's formulary, and any other materials required by ODM or CMS for dual benefit members.

c. Issuance of Member Materials

i. For both Medicaid only and dual benefit members, the MCOP must comply with Medicare timelines for providing member materials.

ii. The MCOP must mail the applicable MCOP ID card, new member letter, quick guide, formulary (for dual benefit members), and request postcard within ten calendar days of confirmation of enrollment or by the last day of the month prior to the effective date, whichever is later.

iii. The MCOP may mail ODM prior-approved postcards in lieu of mailing printed advance directives, provider directories, formulary (for dual benefit members), and member handbooks. At a minimum, the postcards must advise members to call the MCOP or return the postcards to request a printed advance directive, provider directory, formulary, and/or member handbook.

iv. If the MCOP does not use an ODM prior-approved postcard, the MCOP must mail printed advance directives, provider directories, formularies (for dual benefit members), and member handbooks to all new members within the timeframes specified in 3.c.i above.

v. If requested by a member, the MCOP must send a printed advance directive, provider directory, formulary, and member handbook within three business days of the request.

vi. The MCO must review the consumer contact record (CCR) upon receipt to verify if any member has requested a member handbook or provider directory.

vii. The mailing and distribution of all MCOP member materials must not contain information or text on the outside of the mailing that identifies the addressee as a Medicaid recipient.

viii. The MCOP must designate two MCOP staff members to receive a copy of the new member materials on a monthly basis to monitor the timely receipt of these materials. At least one of the staff members must receive the materials at their home address. The MCOP must provide documentation to ODM upon request that demonstrates compliance with this requirement.

ix. On an annual basis the MCOP must send Medicaid only members a member handbook postcard if the member handbook has been revised since the member's initial enrollment date.

x. In accordance with Medicare requirements, the MCOP must provide member materials, including the member handbook, formulary, and provider directory, to dual benefit members by October 15 of each year.

xi. In accordance with Medicare requirements, the MCOP must provide an Annual Notice of Change (ANOC) to dual benefit members.

APPENDIX F – PROVIDER NETWORK

1. General

a. The MCOP must comply with all state and federal provider network requirements, including but not limited to OAC rules 5160-58-01.1 and 5160-26-05, 42 CFR 438.206, 42 CFR 438.207, 42 CFR 422.112, 42 CFR 423.120, and the requirements of this appendix.

b. The MCOP must maintain a provider network that is sufficient to provide timely access to all medically necessary covered services to all members, including those with limited English proficiency or physical or mental disabilities. The MCOP must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities.

c. The MCOP must ensure that all Medicaid network providers are available to both dual benefit and Medicaid only members. The MCOP must not have a separate Medicaid network for dual benefit and Medicaid only members.

d. The MCOP must monitor compliance with provider network requirements and take corrective action as needed.

e. The MCOP is prohibited from having unreasonably more favorable financial arrangements, including payments, for a provider who is a related party than for providers that are not related parties for similar services. “Related party” is a term defined in Appendix A, General Requirements.

f. The MCOP is prohibited from steering members or requiring members or other providers to use or promote the use of specific services or benefits provided by any MCOP provider that is a related party. This provision does not apply when the MCOP is encouraging members to utilize in-network providers over out-of-network providers.

g. The MCOP must monitor and review to ensure that members enrolled in the MyCare Ohio Home- and Community-Based Services (HCBS) Waiver are receiving long-term services and support (LTSS) services authorized in their person-centered care plan and take corrective action as needed to remedy any gaps in service, including gaps due to inability to find a direct care worker or direct worker no shows.

h. ODM will monitor access and availability using multiple data sources, including but not limited to member grievances and appeals, member satisfaction surveys, provider complaints, quality data, performance measures, utilization data, demographic data, MCOP reports, and results from other oversight and monitoring activities.

2. Documentation of Network Capacity

a. In accordance with 42 CFR 438.207, the MCOP must give assurance to ODM and provide supporting documentation that demonstrates it has the capacity to serve the expected membership in accordance with the requirements of this Agreement.

b. In accordance with 42 CFR 438.207, the MCOP must submit documentation to ODM, in a format specified by ODM, that demonstrates it:

   i. Offers an appropriate range of preventive, primary care, behavioral health, specialty, and LTSS services adequate for the anticipated number of members; and

   ii. Maintains a provider network sufficient in number, mix, and geographic distribution to meet the needs of the number of anticipated members.

c. In accordance with 42 CFR 438.207, the MCOP must submit such documentation at each of the following intervals:

   i. At the time the MCOP enters into a contract with ODM;

   ii. On an annual basis thereafter;

   iii. At any time there is a significant change (as defined by ODM) in the MCOP's operations that would affect adequate capacity and services, including but not limited to changes in services, benefits, provider network, or payments or new services or benefits;

   iv. Any time there is enrollment of a new population in the MCOP; or

   v. As otherwise directed by ODM.

d. The MCOP must develop and maintain a Network Development and Management Plan to demonstrate that it maintains a network of providers sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members and ensures the provision of covered services, including MyCare Ohio HCBS Waiver services.

   i. The Network Development and Management Plan must include the information specified by ODM, which may include but is not limited to:

      1. Monitoring activities to ensure that access standards are met and that members have timely access to services;

      2. Provider capacity issues by service and county, the MCOP's remediation and quality improvement (QI) activities, and the targeted and actual completion dates for those activities;

      3. For areas where the MCOP is deficient, including those with approved exceptions to network access standards, or with known gaps in coverage, provider recruitment strategies and implementation plans;

      4. Provider network deficiencies by service and by county and interventions to address the deficiencies; and

5. Ongoing activities for provider network development and expansion taking into consideration identified network provider capacity, network deficiencies, service delivery issues, and current and future member needs.

ii. The MCOP must evaluate and update its Network Development and Management Plan and submit it to ODM as specified in Appendix P, Chart of Deliverables.

iii. The MCOP's annual submission of the Network Development and Management Plan satisfies the annual documentation requirement for network capacity.

3. Provider Contracting

a. Provider Selection

i. In accordance with 42 CFR 438.214, 42 CFR 422.204, 42 CFR 422.205, and OAC rules 5160-58-01.1 and 5160-26-05, the MCOP must have policies and procedures for selection and retention of network providers.

b. Written Contracts and Medicaid Addendum

i. In accordance with 42 CFR 438.206 and OAC rules 5160-58-01.1 and 5160-26-05, the MCOP must enter into written contracts with network providers.

ii. Pursuant to OAC rules 5160-58-01.1 and 5160-26-05, network provider contracts must include the appropriate ODM-approved Model Medicaid Addendum, which incorporates all applicable OAC rule requirements. The MCOP must not modify the Model Medicaid Addendum except to add personalizing information such as the MCOP's name.

iii. The MCOP must submit network provider contract templates to ODM for review prior to executing contracts using the applicable template.

iv. The MCOP must completely and accurately respond to ODM's questions and requests for information about network provider contracts within the timeframes established by ODM.

v. Upon ODM's request, the MCOP must disclose to ODM all financial and other terms that apply between the MCOP and any network provider.

c. Contracting with ODM-Enrolled Providers

i. In accordance with 42 CFR 438.608 and this Agreement, except for pharmacy providers, the MCOP must contract only with providers that are enrolled with ODM and are active providers or are in the process of becoming active in ODM's provider network management (PNM) system. This includes the financial management services (FMS) provider but does not include self-directed caregivers.

ii. For providers other than pharmacy providers, prior to contracting with a provider or listing the provider as a network provider, the MCOP must validate that the provider is active in ODM's PNM system and enrolled for the applicable service and/or specialty. If a provider is not active in ODM's PNM system, the MCOP must direct the provider to ODM's portal to submit an application for screening, enrollment, and credentialing prior to contracting.

Providers operating under single case agreements with the MCOP are not considered network providers.

iii. Prior to contracting with a provider to render a MyCare Ohio HCBS Waiver service, the MCOP must check the Ohio Department of Aging (ODA) provider file to confirm that the provider is certified to provide the applicable waiver service. This requirement does not apply to self-directed caregivers.

iv. The MCOP must conduct a daily (seven days per week) reconciliation of the MCOP's provider network and ODM's PNM system. The MCOP must use PNM system data, the provider master file (PMF), supplemental files generated by ODM systems, and any data elements as directed by ODM. Network providers and staff affiliations must remain active and in alignment with ODM's PNM system.

v. As specified in Appendix P, Chart of Deliverables, the MCOP must submit a report (Medicaid Providers Enrolled in Medicare Report) to ODM that provides information on the number of Medicaid network providers that are also enrolled in Medicare, by provider type and by county.

d. Centralized Credentialing for Medicaid Providers

i. If credentialing is required for a specific Medicaid provider type, the MCOP must only use providers credentialed or approved through ODM's process.

ii. A provider's Medicaid credentialing status will be indicated in ODM's PNM system.

iii. The MCOP must accept ODM's credentialing status for credentialing as a Medicaid provider.

iv. The MCOP must not request any credentialing or recredentialing information from an ODM-enrolled provider for credentialing as a Medicaid provider. The MCOP may request information for initial and ongoing contracting and ongoing network management provided that the requested information is not available in ODM's PNM system.

v. To the extent possible, the MCOP must use information available in ODM’s PNM system to minimize the credentialing and recredentialing information requested from an ODM-enrolled provider for credentialing as a Medicare provider.

vi. The MCOP must not credential or recredential any ODM-enrolled providers for provision of Medicaid services under this Agreement, including provider types that are not credentialed by ODM.

vii. The MCOP must coordinate and cooperate with ODM in the credentialing and recredentialing of the MCOP's network providers.

viii. The MCOP's Medical Director/Chief Medical Officer (CMO) must participate in ODM's credentialing committee.

ix. As specified in Appendix P, Chart of Deliverables, the MCOP must submit a report (Centralized Credentialing Member Grievances) of member grievances regarding providers. The report must include the National Provider Identifier (NPI)/Medicaid ID of the provider, grievance receive date, grievance resolution date, and a narrative.

x. The MCOP must provide to ODM, in the format and at the frequency specified by ODM, the information specified by ODM to inform ODM's credentialing and recredentialing process. This information may include but is not limited to:

1. The MCOP's credentialing and recredentialing files, including provider demographic information, primary source verification, and results of any site surveys;
2. Changes in a provider's demographic information;
3. Changes in a provider's contracting status for any line of business;
4. Changes in a provider's credentialing status for other lines of business;
5. Findings from the MCOP's ongoing monitoring of network providers, including but not limited to complaints, adverse events, and quality of care issues; and
6. Information about the provider maintained by the MCO for credentialing or recredentialing the provider for other lines of business, including Medicare.

e. MCOP Provider Network Information

i. The MCOP must submit provider network information, including provider additions and deletions, to ODM in the format and at the frequency specified by ODM to ODM's PNM system.

ii. As directed by ODM, the MCOP must provide documentation verifying the accuracy of information submitted to ODM's PNM system.

iii. ODM will use the information provided by the MCOP and uploaded into ODM's PNM system to determine if the MCOP meets the provider network access standards specified in this Agreement.

iv. The MCOP must immediately notify ODM of any discrepancy between the MCOP's provider network information in ODM's PNM system and the MCOP's system and resubmit the correct information within one business day of becoming aware of the discrepancy.

f. Sole Source Contracting

i. The MCOP must receive ODM's approval prior to executing a sole source contract for any covered services or otherwise limiting the availability of any service to one provider.

ii. As part of its request for ODM's prior approval, the MCOP must include the information and documentation specified by ODM.

iii. If ODM approves a sole source contract, the MCOP must ensure that providers and members are notified of the sole source contract and ensure an effective transition for members receiving services from another provider.

4. Provider Network Access Requirements

a. General

i. The MCOP must comply, at a minimum, with the provider network access requirements specified in this appendix applicable to the MCOP's service area.

ii. If ODM determines that changes have occurred in the availability of specific provider types and/or the number and composition of the eligible population, ODM will, via amendment to this Agreement, revise the provider network access requirements.

iii. The MCOP must monitor compliance with provider network access requirements and take corrective action as needed to comply with this appendix.

iv. As specified in Appendix P, Chart of Deliverable, the MCOP must submit to ODM the Centers for Medicare & Medicaid Services (CMS) network reporting standards results (CMS Network Results) for the provider types and specialties, as defined in Table F.2. This must include both CMS county-based and CMS time and distance quarterly results.

v. The MCOP must ensure members have access to LTSS services listed in Table F.3 below. As specified in Appendix P, Chart of Deliverables, the MCOP must submit the following reports, as specified by ODM, for LTSS services access and provider network compliance requirements:

1. LTSS Time and Distance Report. The MCOP must ensure compliance with the time and distance standards defined in Table F.4 below. The MCOP must submit time and distance reports for assisted living, adult day health, and out-of-home respite. The MCOP must ensure 90% of all members residing in a county are within 30 miles or 45 minutes of at least one adult day health provider, one assisted living provider, and one out-of-home respite provider.

2. LTSS Service Delivery Wait Time Report. ODM will monitor access to LTSS services and/or providers using the service delivery wait time by comparing the date from the waiver service plan request/time-of-service order or authorization to the service date on the submitted claim. The MCOP must meet the LTSS service delivery wait times standards identified in Table F.5 below.

3. LTSS Service Delivery Validation Report. ODM will measure unmet need for LTSS services by monitoring LTSS services on the person-centered care plan to LTSS services submitted on a claim to validate the required service hours and/or units are being met. If there are services that have not been appropriately reduced due to member death, institutionalization, or by the member moving out of state, then those reductions can occur. The MCOP must achieve at least 95% on the LTSS service validation measures.

4. Member to LTSS Service Provider Ratio Report. The MCOP must ensure compliance with the member to LTSS service provider ratio. The MCOP must meet the LTSS service provider ratio standards identified in Table F.3 below.

vi. ODM will use a time and distance geo mapping and statistical software that uses the Euclidean metric to measure the maximum time and distance for the MCOP's membership and provider network.

vii. The MCOP must notify ODM within one business day of determining that the MCOP is not in compliance with the provider network access requirements specified in this appendix.

b. Primary Care Physicians

i. The MCOP must ensure members have adequate access to primary care physicians, including but not limited to those identified in Table F.2.

ii. The MCOP must comply with CMS' time and distance standards for primary care physicians listed in Table F.2.

c. Specialty Physicians

i. The MCOP must ensure members have adequate access to specialty physicians, including but not limited to the specialties listed in Table F.2.

ii. The MCOP must comply with CMS' time and distance standards for specialty physicians listed in Table F.2.

iii. If a provider must have hospital admitting privileges to meet credentialing standards, the provider must have hospital admitting privileges in order for the provider to be included in ODM's PNM system, listed in the MCOP's provider directory, or counted toward meeting the applicable CMS time and distance standard.

d. Certified Nurse Midwives and Certified Nurse Practitioners

i. The MCOP must ensure access to certified nurse midwife and certified nurse practitioner services in the service area if such provider types are present within the service area.

ii. The MCOP may contract directly with the certified nurse midwife or certified nurse practitioner providers or with a physician or other provider entity that is able to obligate the participation of a certified nurse midwife or certified nurse practitioner.

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

iv. In order to be included in ODM's PNM system, the MCO's provider directory, or counted toward meeting the time and distance standard for Gynecology and Obstetrics and Gynecology (OBGYN), a network certified nurse midwife must have current hospital privileges at a hospital under contract with the MCOP in the service area.

e. Hospitals

i. The MCOP must comply with the time and distance standards for hospitals as specified in the CMS Provider Panel Table F.2.

ii. The MCOP must comply with the CMS county-based standards for hospitals.

iii. In order to meet these access requirements, the MCOP might have to contract with an out-of-state hospital located in a state bordering Ohio.

iv. If a hospital in the MCOP's network elects not to provide specific covered services because of an objection on moral or religious grounds, the MCOP must ensure these hospital services are available to its members through another network hospital in the specified county.

f. Nursing Facilities

i. The MCOP must contract with at least the minimum number of nursing facilities per county as specified in Table F.6. In order to meet these requirements, the MCOP might have to contract with an out-of-state nursing facility located in a state bordering Ohio.

g. Behavioral Health Providers

i. *Behavioral Health Care Coordination Entities*

1. The MCOP must contract with all providers identified by ODM in ODM's PNM system as behavioral health care coordination entities, except where there are documented instances of quality concerns. The MCOP must notify ODM if it is not willing to contract with a particular provider and must collaborate with ODM on next steps.

2. For behavioral health care coordination entities identified by ODM after the effective date of this Agreement, the MCOP must contract with the identified provider no later than 90 calendar days from the provider being identified as a behavioral health care coordination entity in ODM's PNM system.

3. The MCOP must monitor behavioral health care coordination entities for compliance with ODM standards and guidance using a standardized protocol as specified by ODM.

ii. *Community Mental Health Services Providers*

1. The MCOP must contract with Ohio Department of Mental Health and Addiction Services- (OMHAS)-certified community mental health services providers (CMHSPs) and ensure adequate provider network capacity to provide its members with reasonable and timely access to all covered mental health services.

2. Community mental health services providers count toward the county-based standard in Table F.6 for Behavioral Health providers.

iii. *Substance Use Disorder Treatment Providers*

1. The MCOP must contract with OMHAS-certified substance use disorder treatment providers and ensure adequate provider network capacity to provide its members with reasonable and timely access to all covered substance use disorder treatment services.

2. MCOP network providers that are OMHAS-certified substance use disorder treatment providers count toward the county-based standard in Table F.6 for Behavioral Health, SUD-Outpatient, and SUD-Residential, as applicable.

iv. *Medication Assisted Treatment Prescribers*

1. The MCOP must contract with at least the minimum number of Medication Assisted Treatment (MAT) prescribers per county as specified in Table F.6, including all willing Opioid Treatment Programs (OTPs) licensed by OMHAS and certified by the United States Substance Abuse and Mental Health Services Administration (SAMHSA).

2. The MCOP must report any additional providers prescribing MAT not previously identified by ODM in the format and frequency specified by ODM.

v. *Other Behavioral Health Providers*

1. The MCOP must contract with at least the minimum number of other behavioral health providers per county as specified in Table F.6.

2. For purposes of this standard, other behavioral health providers includes independent marriage and family therapists, licensed independent chemical dependency counselors, licensed independent social workers, and psychologists who are contracted with the MCOP to provide behavioral health services privately and unrelated to the community mental health services providers or OMHAS-certified substance use disorder treatment providers.

h. Vision Care Providers

i. The MCOP must contract with at least the minimum number of vision care providers (ophthalmologists and optometrists) per county as specified in Table F.6.

ii. In order to be counted toward meeting this access standard, the ophthalmologist/optometrist must maintain a full-time practice at a site or sites located in the county and regularly perform routine eye exams.

iii. The MCOP must contract with an adequate number of ophthalmologists as part of its provider network, but only ophthalmologists who regularly perform routine eye exams can be used to meet the vision care access requirement.

iv. If optical dispensing is not sufficiently available in a county through the MCOP's contracting ophthalmologists/optometrists, the MCOP must separately contract with an adequate number of optical dispensers located in the county.

i. Dental Care Providers

i. The MCOP must contract with at least the minimum number of dental care providers per county as specified in Table F.6.

ii. In order to be counted toward meeting this access standard, the dental provider must maintain a full-time practice at a site or sites located in the county and serve all ages (adults and children).

j. Federally Qualified Health Centers/Rural Health Clinics

i. The MCOP must ensure member access to any federally qualified health center (FQHC) and/or rural health clinic (RHC), regardless of whether the FQHC/RHC is a network provider.

ii. Even if no FQHC/RHC is available within a county, the MCOP must cover services provided by an FQHC/RCH outside of the county.

k. Long-Term Services and Support Service Providers

i. In order to be counted toward meeting this county access standards, the LTSS service provider must provide services to the member in the county they reside.

ii. Private Duty Nursing (PDN) (agency or independent) and Home Health Services (agency only)

1. The MCOP must contract with at least the minimum number of PDN providers per county as specified in Table F.3.

2. The MCOP must contract with at least the minimum number of home health agency providers per county as specified in Table F.3 for home health nursing and home health aide services.

iii. *MyCare Ohio HCBS Waiver Providers*

1. The MCOP must contract with at least the minimum number of home-delivered meals providers as specified in Table F.3.

2. The MCOP must contract with at least the minimum number of homemaker providers per county as specified in Table F.3.

3. The MCOP must contract with at least the minimum number of home modification providers per county as specified in Table F.3.

4. The MCOP must contract with at least the minimum number of non-medical transportation providers per county as specified in Table F.3.

5. The MCOP must contract with at least the minimum number of personal care providers per county as specified in Table F.3.

6. The MCOP must contract with at least the minimum number of personal emergency response service providers per county as specified in Table F.3.

7. The MCOP must contract with at least the minimum number of specialized medical equipment and supplies providers per county as specified in Table F.3.

8. The MCOP must contract with at least the minimum number of waiver nursing providers per county as specified in Table F.3.

9. The MCOP must ensure all MyCare Ohio HCBS Waiver providers, including but not limited to those listed in Tables F.3, meet the requirements set forth in OAC Chapters 173-39, 5160-44, and 5160-45, and the MCOP must validate that MyCare Ohio HCBS Waiver providers hold applicable approval from ODM or certification from the Ohio Department of Aging for each waiver service to be rendered prior to rendering waiver services. These requirements do not apply to self-directed caregivers.

l. Qualified Family Planning Providers

i. The MCOP must permit members to self-refer for services and supplies allowed under Title X of the Public Health Services Act (Title X services) provided by a qualified family planning provider. A description of Title X services is available on the Ohio Department of Health website.

ii. A qualified family planning provider is defined as any public or not-for-profit health care provider that complies with Title X guidelines/standards and receives either Title X funding or family planning funding from the Ohio Department of Health.

iii. The MCOP must reimburse a qualified family planning provider for all Title X services provided to a member that are medically necessary covered services (including on-site diagnostic services), regardless of whether the qualified family planning provider is a network provider.

iv. The MCOP must work with qualified family planning providers in the service area to develop mutually-agreeable Health Insurance Portability and Accountability Act (HIPAA) compliant policies and procedures to preserve patient/provider confidentiality and convey pertinent information to the member's PCP and/or the MCOP.

m. Specialty Treatment Centers

i. The MCO must provide reasonable and timely access to specialty treatment centers, including Hemophilia Treatment Centers supported and funded by the United States Centers for Disease Control and Prevention (CDC), Cystic Fibrosis Care Centers accredited by the Cystic Fibrosis Foundation, and Ohio metabolic centers approved by the Ohio Department of Health.

n. Other

i. The MCOP must provide reasonable and timely access to all medically necessary covered services to its members, including Medicare services for dual benefit members; therefore, the MCOP's provider network must include additional specialists and provider types not listed in this appendix.

ii. The MCOP must provide reasonable and timely access to services provided by pharmacist providers in accordance with OAC rule 5160-8-52.

5. Exception Process for Provider Network Access Requirements

a. Upon written request of the MCOP, and in accordance with the exception request process outlined by ODM, ODM may grant an exception to a provider network access requirement if one or both of the following have occurred:

   i. Action taken by ODM adversely impacted the MCOP's ability to meet the requirement; or

   ii. There is no provider available to meet the requirement.

b. If ODM grants an exception to a provider network access requirement, the MCOP must recruit new or contract with existing Medicaid enrolled providers within the time/distance and/or county-based requirements during the approved exception request period. The provider recruitment strategy must be submitted as part of the exception request.

c. ODM will approve exception requests in either 90-day or 180-day increments, as determined by ODM.

6. Provider Network Changes

a. The MCOP must comply with the provider network notification requirements in OAC rules 5160-58-01.1 and 5160-26-05.

b. In addition to the notification requirements in OAC rules 5160-58-01.1 and 5160-26-05, the MCOP must notify ODM within one business day of becoming aware that a network provider that served 100 or more of the MCOP's members in the previous 12 months failed to notify the MCOP that they are no longer available to serve as an MCOP network provider.

c. In addition to the notification requirements in OAC rules 5160-58-01.1 and 5160-26-05, the MCOP must notify ODM no less than 90 calendar days before the end date of an MCOP-initiated termination of a network provider contract when the provider is a nursing facility or assisted living facility or has served 100 or more of the MCOP's members in the previous 12 months. This includes individual practitioners in group practices that cumulatively have served 100 or more members in the previous 12 months. Unless otherwise approved by ODM, MCOP-initiated terminations of network provider contracts for nursing facilities or assisted living facilities or for providers that have served 100 or more of the MCOP's members shall not take effect during the 90 calendar days after the open enrollment month ends.

d. In addition to the notification requirements in OAC rules 5160-58-01.1 and 5160-26-05, the MCOP must notify ODM at least 90 calendar days prior to implementing any MCOP-initiated changes that may foreseeably result in the provider network being reduced by 10% or more of available network providers for one or more services or provider types. MCOP-initiated changes include but are not limited to terminating or not renewing contracts, restricting or limiting contracts for a service or provider type, sole source contracting for a service or provider type, terminating or restricting a provider type or group of providers, or reducing payment rates for a service or provider type. Unless otherwise approved by ODM, MCOP-initiated changes that could reduce the MCOP's provider network by 10% or more may not take effect during the 90 calendar days after the open enrollment month ends. In addition to the provisions in OAC rules 5160-58-01.1 and 5160-26-05, the MCOP

must notify ODM within one business day of becoming aware of a provider-initiated hospital unit closure.

e. In addition to the provisions in OAC rules 5160-58-01.1 and 5160-26-05, the MCOP must notify ODM within one business day of becoming aware of a provider-initiated hospital unit closure.

f. When the MCOP has been notified of a hospital termination, the MCOP may request ODM authorize an alternative notification area (other than the service area), in accordance with OAC rules 5160-58-01.1 and 5160-26-05. Upon request, ODM will determine the authorized notification area no later than seven business days after receipt of the MCOP's submission. The MCOP must comply with the notification timelines outlined in OAC rules 5160-58-01.1 and 5160-26-05.

g. When submitting notification to ODM about provider network changes, the MCOP must include, at a minimum, the following:

    i. For all terminations:

        1. Provider information, including name, provider type, address, and county where services were rendered;

        2. Copy of the termination notice, including the termination reason and the termination date;

        3. Number of members who used services from, or were assigned to, the provider in the previous 12 months; and

        4. Results of an evaluation of the remaining provider network contracts to assure adequate access, including the average and longest distance a member will need to travel to another provider, and the name, provider type, address, and county of the remaining network providers that can meet the access requirements.

    ii. For hospital terminations or hospital unit closures:

        1. Zip codes or counties of residence for members who used services in the previous 12 months;

        2. Details for all PCPs and specialists affiliated with the hospital;

        3. Percent of the MCOP's membership that use the terminating hospital or hospital unit closure and the percent of the MCOP's membership that use the next closest network hospital; and

        4. Plan to ensure continuity of services for members in their third trimester, receiving chemotherapy, and/or receiving radiation treatment.

h. When the MCOP is notified by ODM or otherwise becomes aware of a current or planned loss of provider who delivers ongoing services to its members, the MCOP must immediately identify any members being served by that provider and ensure that all health, safety, and welfare needs are met (e.g., securing informal support). The MCOP must assist the member with selecting a new

provider as expeditiously as possible and ensure documentation in the clinical record reflects the member's choice of network providers.

i. The MCOP must provide ODM with the Provider Termination Report, as specified in Appendix P, Chart of Deliverables.

7. Timely Access

a. In accordance with 42 CFR 438.206:

i. The MCOP must ensure compliance with the appointment availability standards in this appendix.

ii. The MCOP must ensure that wait times for members to see a network provider are no longer than wait times for commercial patients.

iii. The MCOP must ensure that network providers offer hours of operation no less than the hours of operation offered to commercial members or comparable to ODM fee-for-service (FFS), if the provider serves only Medicaid members.

iv. The MCOP must ensure services are available 24 hours a day, seven days a week, when medically necessary.

v. The MCOP must establish mechanisms to ensure compliance with the requirements in this section, monitor network providers to determine compliance, and take corrective action as needed.

8. Appointment Availability

a. The MCOP must ensure the availability of medical, behavioral health, and dental care appointments.

b. At a minimum, the MCOP must ensure compliance with the appointment standards identified in the Table F.1 below.

Table F.2 Appointment Standards

Type of Visit	Description	Minimum Standard
Emergency Service	Services needed to evaluate, treat, or stabilize an emergency medical condition.	24 hours, 7 days/week
Urgent Care (includes medical, behavioral health, and dental services)	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include but are not limited to sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain, and severe, non-resolving headache. Acute illness or substance dependence that impacts the ability to function, but does not present imminent danger.	24 hours, 7 days/week

Type of Visit	Description	Minimum Standard
Behavioral Health Non-Life-Threatening Emergency	A non-life-threatening situation in which a member is exhibiting extreme emotional disturbance or behavioral distress, has a compromised ability to function, or is otherwise agitated and unable to be calmed.	Within 6 hours
Behavioral Health Routine Care	Requests for routine mental health or substance abuse treatment from behavioral health providers.	Within 10 business days or 14 calendar days, whichever is earlier
American Society of Addiction Medicine (ASAM) Residential/Inpatient Services — 3: 3.1, 3.5, 3.7	Initial screening, assessment, and referral to treatment.	Within 48 hours of request
ASAM Medically Managed Intensive Inpatient Services — 4	Services needed to treat and stabilize a member's behavioral health condition.	24 hours, 7 days/week
Primary Care Appointment	Care provided to prevent illness or injury; examples include but are not limited to routine physical examinations, immunizations, mammograms, and pap smears.	Within 30 business days
Non-Urgent Sick Primary Care	Care provided for a non-urgent illness or injury with current symptoms.	Within 3 calendar days
Prenatal Care — First or Second Trimester	Care provided to a member while the member is pregnant to help keep member and future baby healthy, such as checkups and prenatal testing.	First appointment within 7 calendar days; follow-up appointments no more than 14 calendar days after request
Prenatal Care — Third Trimester or High-Risk Pregnancy		Within 3 calendar days
Specialty Care Appointment	Care provided for a non-emergent/ non-urgent illness or injury requiring consultation, diagnosis, and/or treatment from a specialist.	Within 6 weeks
Dental Appointment	Non-emergent/non-urgent dental services, including routine and preventive care.	Within 6 weeks of request

c. The MCOP must disseminate the appointment standards to network providers and must educate network providers about the appointment standards.

d. The MCOP must have and implement policies and procedures for triage to assist MCOP staff and providers in determining whether a member's need is emergent, behavioral health non-life-threatening emergent, urgent, or routine, and to support member access to needed

services based on the urgency of the member's need. The MCOP's triage process must be transparent and compliant with Mental Health Parity and Addiction Equity Act (MHPAEA).

e. The MCOP must conduct regular reviews of appointment availability and report this information in appointment availability reports (Appointment Availability Report), as specified in Appendix P, Chart of Deliverables.

9. Telehealth

a. The MCOP must offer, promote, support, and expand the appropriate and effective use of telehealth.

b. At a minimum, the MCOP must follow OAC rule 5160-1-18 “Telehealth”, including any emergency rule versions of OAC rule 5160-1-18, and any future telehealth rules or services developed during the time that this Agreement is in effect, but the MCOP may be less restrictive if appropriate.

c. In addition to OAC rules mentioned above, the MCOP must cover telehealth services as specified in the ODM *Telehealth Services: Guidelines for Managed Care Entities* manual. The MCOP must implement any changes outlined in the *Telehealth Services: Guidelines for Managed Care Entities* manual within 30 calendar days of being notified by ODM of the change.

d. The MCOP must educate members and providers about the availability of telehealth, considerations for using telehealth versus in-person visits, applicable requirements, and how to access telehealth options.

e. The MCOP must ensure that telehealth does not replace provider choice and/or member preference for in-person service delivery.

f. ODM will not consider telehealth as an alternative to meeting provider network access requirements.

g. The MCOP must support providers in offering telehealth, including providing “how to” guides on the technical requirements, workflows, coding, and billing.

h. The MCOP must ensure that providers comply with state requirements regarding telehealth, including but not limited to in OAC rule 5160-1-18.

i. As specified in Appendix P, Chart of Deliverables, the MCOP must submit a telehealth report (Telehealth Report) to ODM that includes but is not limited to:

    i. The MCOP's goals for telehealth and progress on meeting those goals, including performance measures;

    ii. Barriers to increased use of telehealth and the MCOP's strategies to overcome those barriers;

    iii. Telehealth utilization, including any changes from the previous year;

    iv. The MCOP's activities to support increased use of telehealth, including any provider partnerships; and

v. Information regarding whether telehealth is improving access to needed services and/or helping make access more equitable.

10. Workforce Development

a. The MCOP must work with ODM, ODM-contracted managed care entities, and other stakeholders to develop and implement workforce development initiatives designed to support provider network adequacy and access. This includes but is not limited to providing qualified staff to actively participate in meetings; conducting and sharing a workforce analysis if requested by ODM; providing input to prioritize areas for workforce development; assisting with developing workforce development strategies; and implementing identified workforce strategies, including in partnership with other stakeholders.

11. Out-of-Network Requirements

a. In accordance with 42 CFR 438.206 and OAC rule 5160-58-03, if the MCOP is unable to provide medically necessary covered services to a member in a timely manner through its provider network, the MCOP must adequately and timely cover these services by an out-of-network provider for as long as the MCOP's provider network is unable to provide the services.

b. In accordance with 42 CFR 438.206 and OAC rules 5160-58-01.1 and 5160-26-05, the MCOP must coordinate with the out-of-network provider with respect to payment and must ensure the cost to the member is no greater than it would be if the services were furnished by a network provider.

c. If the out-of-network provider is not an active provider in ODM's PNM system, the MCOP must verify the provider's licensure and conduct federal database checks in accordance with 42 CFR 455.436, and must execute a single case agreement with the provider that includes the appropriate Model Medicaid Addendum.

d. The MCOP must ensure all providers, including providers with a single case agreement, are active provider in ODM's PNM system for the applicable service.

e. The MCOP must direct all out-of-network providers, whether out-of-state or unenrolled providers, who are not active providers in ODM's PNM system to the ODM portal to submit an application for screening, enrollment, and credentialing.

i. If the provider refuses to complete an online single case agreement provider enrollment application to ODM, the MCOP can have the provider complete the ODM 10282 and 10283 forms to submit to the MCOP. The MCOP must then submit the completed forms to ODM, as directed by ODM. This will allow the provider to have a five-year provider agreement.

ii. If the provider refuses to complete the enrollment process or refuses to complete the ODM 10282 and 10283 forms, the MCOP can have the provider complete the ODM 10295 form to submit to the MCOP. The MCOP must then submit the completed form to ODM, as directed by ODM. This will allow the provider to have 120-day provider agreement. Providers cannot have more than one 120-day provider agreement.

f. The MCOP must report all single case agreements with providers who are not active in ODM's PNM system to ODM within seven calendar days of becoming aware of the need to execute a single case agreement with such a provider. If a provider who is not active in ODM's PNM system is not willing or able to become an active provider, the MCOP must terminate the single case agreement as

directed by ODM and must not reimburse the provider for services provided after termination of the single case agreement.

12. Provider Payment

a. General

i. Unless otherwise specified in this Agreement, the MCOP is free to establish reimbursement methodologies with its network providers that result in payments that are sufficient to enlist enough providers so that medically necessary covered services are available to members as specified in this appendix. To the extent possible, payment arrangements should encourage and reward innovations and positive clinical outcomes (see Appendix H, Value-Based Payment).

ii. If ODM determines that the MCOP's reimbursement rate or rates for a program, service, or provider type is not sufficient, the MCOP, as directed by ODM, must pay, at a minimum, the rate specified by ODM, which will be no more than 100% of the current Medicaid FFS rate.

iii. If ODM adds a new program, service, or provider type to this Agreement, the MCOP must pay, if so directed by ODM, no less than the rate established by ODM, which will be no more than 100% of the current Medicaid FFS rate. If ODM establishes such a rate, it will evaluate the need to continue the rate no less often than every six months.

iv. The MCOP must require, as a condition of payment, that a provider (network or out-of-network) accepts the amount paid by the MCOP or appropriate denial made by the MCOP (or, if applicable, payment by the MCOP that is supplementary to the member's third-party payer), and, in addition, any applicable co-payment or patient liability amount due from the member as payment in full for the service.

v. The MCOP must ensure that members are held harmless by providers for the costs of medically necessary covered services and additional services offered by the MCOP, except for applicable co-payment or patient liability amounts.

vi. The MCOP must only pay providers for services performed when they are enrolled with ODM and are active in ODM's PNM system, including the single case agreement options listed in this appendix. Except for emergency services, the MCOP must not pay a provider for services provided when the provider has been terminated or suspended by ODM, or has been terminated by Medicare, Medicaid, or the Children's Health Insurance Program.

vii. The MCOP must make timely payments to providers in accordance with the timeliness standards in Appendix L, Payment and Financial Performance.

b. Rate Changes

i. The MCOP must inform ODM of any rate changes that may adversely impact 50 or more network providers or an entire provider type (even if fewer than 50 providers of the provider type), prior to implementation of the rate change.

c. Retroactive Coverage Requirements

i. The MCOP must pay for covered services provided to members during retroactive enrollment periods. For services provided during retroactive enrollment periods that require FFS prior authorization as provided in Appendix DD of OAC rule 5160-1-60 or any other rule regarding ODM FFS prior authorization policy, the MCOP may conduct a medical necessity review, in accordance with Appendix B, Coverage and Services, for payment. If the service was reviewed and approved by ODM's FFS program, the MCOP must approve and pay for the service. The MCOP may also review to determine that home- and community-based services were in accordance with the pre-existing or current person-centered care plan.

d. Medicare Payment Guidelines for Medicaid Only Members

i. The MCOP must comply with the requirements in Appendix D, Care Coordination regarding coordination with Medicare payers for Medicaid only members.

ii. Unless the provider has agreed in writing to an alternative payment methodology or different secondary claims payment rate, the MCOP must adjudicate Medicare secondary claims for Medicaid only members as set forth in OAC rule 5160-1-05.3 for both network and out-of-network providers. The MCOP must apply exemptions to the Part B Medicaid maximum policy in accordance with OAC rule 5160-1-05.3 and other guidance issued by ODM.

iii. During transition and/or when a member exhausts their Medicare lifetime benefit, unless the provider has expressly agreed to MyCare Ohio contract terms that include quality incentives and a different secondary claims payment rate, not including simple rate changes proposed by the MCOP, the MCOP must pay Medicare secondary claims at a rate no less than the Medicaid FFS Part B methodology, set forth in OAC rule 5160-1-05.3, for network and out-of-network providers. Exemptions to the Part B Medicaid maximum policy must be applied in accordance with the OAC and other guidance issued by ODM. The Part C Medicaid maximum policy, set forth in OAC rule 5160-1-05.1, may only be applied for secondary claims on behalf of Medicaid only members enrolled with a Part C (Medicare Advantage) plan that is not the MCOP. The MCOP must provide a method for enrollment of any out of network provider who is an enrolled provider with ODM for purposes of Medicaid payment of “crossover” claims pursuant to the CMCS-MMCO-CM Informational Bulletin of June 7, 2013.

iv. If Medicare does not cover a Medicaid covered service provided to a Medicaid only member, the MCOP must pay the provider the MCOP’s applicable Medicaid rate.

e. Nursing Facility and MyCare Ohio HCBS Waiver Provider Payment

i. At a minimum, the MCOP must pay nursing facility providers for Medicaid services in accordance with ORC section 5165.15.

ii. The MCOP must ensure accurate claims payment to nursing facility and MyCare Ohio HCBS Waiver providers by appropriately modifying payment pursuant to OAC rule 5160-3-39.1 and OAC rule 5160:1-6-07.1 when a member has patient liability obligations or lump sum amounts.

iii. The MCOP must apply patient liability as an offset against the amount the MCOP would otherwise reimburse for the claim. If the patient liability exceeds the amount the MCOP would reimburse, the MCOP must process the claim with a payment of $0.

iv. The MCOP must not pay for nursing facility MyCare Ohio HCBS Waiver services during a member's restricted Medicaid coverage period (RMCP).

v. The MCOP must utilize HIPAA compliant enrollment files from ODM to determine a member's patient liability obligations and restricted Medicaid coverage period.

f. Ventilator Program

i. The MCOP must comply with requirements outlined in OAC rule 5160-3-18 with regard to the alternative purchasing model for the provision of nursing facility services to members who are ventilator dependent.

g. Hospice Services

i. The MCOP must comply with the requirements in Appendix C (Coverage and Services) regarding payment of hospice services.

h. Federally Qualified Health Centers/Rural Health Clinics

i. To ensure a federally qualified health center (FQHC) or rural health clinic (RHC) can submit a claim to ODM for the state's wraparound payment per visit as defined in OAC rule 5160-28-01, the MCOP must comply with the following for both network and out-of-network FQHCs/RHCs:

1. The MCOP must provide payment on a service-specific basis, by procedure code, in an amount no less than the payment made to other providers for the same or a similar service. Bundled payments are not permissible.

2. If the MCOP has no comparable service-specific rate structure, the MCOP must pay the FQHC/RHC no less than 100% of the current Medicaid FFS payment schedule for the same or a similar service provided by a non-FQHC/RHC provider.

3. The MCOP must provide FQHCs/RHCs the MCOP's Medicaid provider number to enable FQHC/RHC providers to bill for the ODM wraparound payment as defined in OAC rule 5160-28-01.

i. Out-of-Network Emergency Services

i. In accordance with 42 CFR 438.114 and OAC rule 5160-58-03, the MCOP must reimburse out-of-network providers of emergency services the lesser of billed charges or 100% of the current Medicaid FFS rate.

j. Providers During Transition

i. In accordance with Appendix D, Care Coordination, as part of the MCOP’s transition of care process, the MCOP must reimburse nursing facilities and assisted living service providers for Medicaid services at their current rate.

ii. In accordance with Appendix D, Care Coordination, the MCOP must reimburse out-of-network providers who provide Medicaid services during the transition at 100% of the current Medicaid FFS rate.

k. Out-of-Network Qualified Family Planning Providers

i. Pursuant to OAC rule 5160-58-03, the MCOP must reimburse an out-of-network qualified family planning provider for all Title X services provided to a member that are medically necessary covered services (including on-site diagnostic services) at the lesser of billed charges or 100% of the current Medicaid FFS rate.

l. COVID-19 Testing and Treatment

i. The MCOP must pay at least 100% of the current Medicaid FFS rate for COVID-19 testing codes.

ii. The MCOP must pay at least 100% of the current Medicaid FFS rate for all Medicaid covered COVID-19 vaccination codes.

iii. The MCOP must reimburse out-of-network providers for COVID-19 vaccinations provided to its members as long as the provider is enrolled with ODM and an active provider in ODM's PNM system.

13. Provider Directory

a. General

i. The MCOP's provider directory must include all of the MCOP's network providers, and the Medicaid providers must be the same for both dual benefit and Medicaid only members.

ii. The MCOP must ensure that the information in the MCOP's provider directory exactly matches the data in ODM's PNM system for the MCOP's network providers. The MCOP may supplement ODM PNM system data with MCOP information to the extent needed to comply with the provider directory content requirements in this Agreement.

iii. The MCOP's provider directory must be in the format specified by or otherwise prior approved by ODM.

iv. The MCOP's provider and pharmacy directory for dual benefit members must be developed based on the model materials provided by ODM.

b. Content

i. In accordance with 42 CFR 438.10 and this Agreement, the MCOP's provider directory must include the following information about each provider:

1. Provider's name as well as any group affiliation;

2. Provider's street address or addresses;

3. Provider's telephone number or numbers;

4. Provider's website uniform resource locator (URL), as appropriate;
5. Provider's specialty, when applicable;
6. Indication of the provider's office/facility accessibility and accommodations (e.g., offices, exam room(s), and equipment), when applicable;
7. Indication of whether the provider offers telehealth, and if so, when telehealth is available;
8. Indication of whether the provider is accepting new members;
9. Indication of the provider's linguistic capabilities, including the specific language or languages offered, including American Sign Language (ASL), and whether they are offered by the provider or a skilled medical interpreter at the provider's office; and
10. Provider's cultural competence training status, when available.

ii. The MCOP's provider directory must also include:

1. Instructions on how members may obtain directory information in alternate formats that takes into consideration the special needs of eligible individuals, including but not limited to visually-limited, limited English proficiency (LEP), and limited reading proficiency (LRP) eligible individuals; and
2. Detail on any sole-sourced or selectively contracted network providers (e.g., durable medical equipment). The description must clearly identify:
    a. The services, including supplies or equipment, that must be obtained from the provider;
    b. How to obtain the services;
    c. How to contact the provider; and
    d. How to obtain services to meet an urgent need (e.g., additional supplies needed post-surgery or for vacation).

c. Printed Provider Directory

i. The MCOP's printed provider directory must be approved by ODM prior to distribution. Once approved, in accordance with 42 CFR 438.10, the provider directory content may be updated with provider additions or deletions by the MCOP without ODM prior-approval; however, the MCOP must submit a copy of the revised directory (or inserts) to ODM prior to distribution to members. Any revisions to the printed provider directory format must be approved by ODM before distribution.

d. Online Provider Directory

i. The MCOP's website must have a link to ODM's provider directory and PNM system.

ii. The MCOP must have an internet-based provider directory.

iii. The MCOP's internet-based provider directory must comply with 42 CFR 438.242 regarding a publicly-accessible standard-based Application Programming Interface (API).

iv. The MCOP's internet-based provider directory must be updated at the same frequency as ODM's online provider directory so that the two are synchronized.

v. The MCOP's internet-based provider directory must be in a format prior approved by ODM. Any revisions to the internet provider directory format must be approved by ODM before implementation.

vi. The MCOP's internet-based provider directory must be easy to understand and use and allow members to electronically search for MCOP network providers based on, at a minimum, name, provider type, provider specialty, geographic proximity, and whether the provider is accepting new Medicaid members.

vii. If the MCOP's internet-based provider directory includes information for both members enrolled pursuant to this Agreement and another agreement with ODM, the MCOP must ensure that the results of any search by a member enrolled pursuant to this Agreement only include providers available to such members.

e. Long-Term Services and Support Service Providers

i. *Independent Providers*

1. When a member expresses a preference for an independent (non-agency) provider for an eligible service identified on the member's person-centered care plan, the MCOP must make available a directory of all independent providers of the following services:

    a. Personal care;

    b. Waiver nursing;

    c. Home care attendant; and

    d. State plan PDN.

2. The directory must be organized by service and location and clearly identify which providers are accepting new members.

3. The MCOP must offer members assistance with the provider enrollment process, incorporating easily understood guidance to facilitate provider enrollment into ODM's PNM system.

4. The MCOP's provider recruitment plan must include the recruitment of independent providers.

ii. *Self-Directed Caregivers*

1. The MCOP must work with the FMS to provide information on self-directed caregivers.

14. Verification of Provider Network Information

a. General

i. ODM contracts with an external quality review organization (EQRO) to conduct telephone surveys of a statistically valid sample of providers' offices to verify information submitted to ODM's PNM system. ODM will use these results to evaluate MCOP performance, including but not limited to the following two measures.

b. PCP Locations Not Reached

i. The “PCP Locations Not Reached” measure identifies the proportion of PCP locations not reached during the survey. A PCP is considered “not reached” if the provider is no longer practicing at the sampled location or the provider did not return phone calls after the EQRO made two attempts at different times during the survey.

ii. In order to meet this performance standard, the MCOP's “PCP Locations Not Reached” percent must be 30% or less (at least 70% of PCP locations were reached).

c. Number of PCP Locations Not Contracted with the MCOP

i. The “Number of PCP Locations Not Contracted with the MCOP” measure reports the proportion of PCP locations no longer contracted with the MCOP at the time of the survey.

ii. In order to meet this performance standard, the MCOP's “Number of PCP Locations Not Contracted with the MCOP” percent must be 8% or less (92% or more of the PCP locations were contracted with the MCO).

Table F.3 CMS Provider Panel

Provider Type/Specialty	Time/Distance	County-Based
Primary Care (General Practice, Family Practice, Internal Medicine, Geriatrics, Primary Care Physician Assistants, Primary Care Nurse Practitioners)	x	x
Allergy and Immunology	x	x
Cardiology	x	x
Chiropractor	x	x
Dermatology	x	x
Endocrinology	x	x
ENT/Otolaryngology	x	x
Gastroenterology	x	x
General Surgery	x	x
Gynecology/OBGYN	x	x
Infectious Diseases	x	x
Nephrology	x	x
Neurology	x	x
Neurosurgery	x	x
Oncology — Medical, Surgical	x	x
Oncology — Radiation/Radiation Oncology	x	x
Ophthalmology	x	x
Orthopedic Surgery	x	x
Physiatry, Rehabilitative Medicine	x	x
Plastic Surgery	x	x
Podiatry	x	x
Psychiatry	x	x
Pulmonology	x	x
Rheumatology	x	x
Urology	x	x
Vascular Surgery	x	x
Cardiothoracic Surgery	x	x
Clinical Psychology	x	x

Provider Type/Specialty	Time/Distance	County-Based
Clinical Social Work	x	x
Acute Inpatient Hospital Beds (Facility)	x	x
Cardiac Surgery Program (Facility)	x	x
Cardiac Catheterization Services (Facility)	x	x
Critical Care Services/Intensive Care Units (Facility)	x	x
Surgical Services (Outpatient or Ambulatory Surgery Centers [ASC]) (Facility)	x	x
Skilled Nursing Facilities (Facility)	x	x
Diagnostic Radiology (Facility)	x	x
Mammography (Facility)	x	x
Physical Therapy (Facility)	x	x
Occupational Therapy (Facility)	x	x
Speech Therapy (Facility)	x	x
Inpatient Psychiatric Facility Services (Facility)	x	x
Outpatient Infusion/Chemotherapy (Facility)	x	x

Table F.4 Home-Based LTSS Services Standards — Member to Provider Ratio with County Requirements

County	Home Delivered Meals	Home Health Aide	Home Health Nursing	Homemaker*	Home Modification	Non-Medical Transportation	Personal Care*	Personal Emergency Response Services	Private Duty Nursing*	Specialized Medical Equipment and Supplies	Waiver Nursing*
*Indicates Agency Provider-Only Requirement											
Provider to Member Ratio Requirements – Statewide Ratio (Members : Provider)											
STATEWIDE	**1800:1**	**775:1**	**775:1**	**775:1**	**1200:1**	**775:1**	**775:1**	**1800:1**	**775:1**	**1200:1**	**775:1**
County-Based Requirements – per County Number of Providers											
Adams	1	1	1	1	1	1	1	1	1	1	1
Allen	1	3	3	3	2	3	3	1	3	2	3
Ashland	1	1	1	1	1	1	1	1	1	1	1
Ashtabula	2	4	4	4	3	4	4	2	4	3	4
Athens	1	2	2	2	1	2	2	1	2	1	2
Auglaize	1	1	1	1	1	1	1	1	1	1	1
Belmont	1	2	2	2	2	2	2	1	2	2	2
Brown	1	2	2	2	1	2	2	1	2	1	2
Butler	4	8	8	8	5	8	8	4	8	5	8
Carroll	1	1	1	1	1	1	1	1	1	1	1
Champaign	1	1	1	1	1	1	1	1	1	1	1
Clark	2	5	5	5	3	5	5	2	5	3	5
Clermont	2	4	4	4	3	4	4	2	4	3	4
Clinton	1	1	1	1	1	1	1	1	1	1	1
Columbiana	1	3	3	3	2	3	3	1	3	2	3
Coshocton	1	1	1	1	1	1	1	1	1	1	1

County	Home Delivered Meals	Home Health Aide	Home Health Nursing	Homemaker*	Home Modification	Non-Medical Transportation	Personal Care*	Personal Emergency Response Services	Private Duty Nursing*	Specialized Medical Equipment and Supplies	Waiver Nursing*
Crawford	1	1	1	1	1	1	1	1	1	1	1
Cuyahoga	21	48	48	48	31	48	48	21	48	31	48
Darke	1	1	1	1	1	1	1	1	1	1	1
Defiance	1	1	1	1	1	1	1	1	1	1	1
Delaware	1	2	2	2	1	2	2	1	2	1	2
Erie	1	2	2	2	1	2	2	1	2	1	2
Fairfield	1	3	3	3	2	3	3	1	3	2	3
Fayette	1	1	1	1	1	1	1	1	1	1	1
Franklin	13	31	31	31	21	31	31	13	31	21	31
Fulton	1	1	1	1	1	1	1	1	1	1	1
Gallia	1	1	1	1	1	1	1	1	1	1	1
Geauga	1	1	1	1	1	1	1	1	1	1	1
Greene	1	3	3	3	2	3	3	1	3	2	3
Guernsey	1	2	2	2	1	2	2	1	2	1	2
Hamilton	11	24	24	24	15	24	24	11	24	15	24
Hancock	1	2	2	2	1	2	2	1	2	1	2
Hardin	1	1	1	1	1	1	1	1	1	1	1
Harrison	1	1	1	1	1	1	1	1	1	1	1
Henry	1	1	1	1	1	1	1	1	1	1	1
Highland	1	2	2	2	1	2	2	1	2	1	2
Hocking	1	1	1	1	1	1	1	1	1	1	1
Holmes	1	1	1	1	1	1	1	1	1	1	1
Huron	1	1	1	1	1	1	1	1	1	1	1
Jackson	1	1	1	1	1	1	1	1	1	1	1

County	Home Delivered Meals	Home Health Aide	Home Health Nursing	Homemaker*	Home Modification	Non-Medical Transportation	Personal Care*	Personal Emergency Response Services	Private Duty Nursing*	Specialized Medical Equipment and Supplies	Waiver Nursing*
Jefferson	1	2	2	2	1	2	2	1	2	1	2
Knox	1	2	2	2	1	2	2	1	2	1	2
Lake	2	5	5	5	3	5	5	2	5	3	5
Lawrence	1	3	3	3	2	3	3	1	3	2	3
Licking	2	4	4	4	2	4	4	2	4	2	4
Logan	1	1	1	1	1	1	1	1	1	1	1
Lorain	3	8	8	8	5	8	8	3	8	5	8
Lucas	7	16	16	16	11	16	16	7	16	11	16
Madison	1	1	1	1	1	1	1	1	1	1	1
Mahoning	4	11	11	11	6	11	11	4	11	6	11
Marion	1	2	2	2	1	2	2	1	2	1	2
Medina	1	3	3	3	2	3	3	1	3	2	3
Meigs	1	1	1	1	1	1	1	1	1	1	1
Mercer	1	1	1	1	1	1	1	1	1	1	1
Miami	1	2	2	2	2	2	2	1	2	2	2
Monroe	1	1	1	1	1	1	1	1	1	1	1
Montgomery	7	17	17	17	11	17	17	7	17	11	17
Morgan	1	1	1	1	1	1	1	1	1	1	1
Morrow	1	1	1	1	1	1	1	1	1	1	1
Muskingum	1	3	3	3	2	3	3	1	3	2	3
Noble	1	1	1	1	1	1	1	1	1	1	1
Ottawa	1	1	1	1	1	1	1	1	1	1	1
Paulding	1	1	1	1	1	1	1	1	1	1	1
Perry	1	1	1	1	1	1	1	1	1	1	1

County	Home Delivered Meals	Home Health Aide	Home Health Nursing	Homemaker*	Home Modification	Non-Medical Transportation	Personal Care*	Personal Emergency Response Services	Private Duty Nursing*	Specialized Medical Equipment and Supplies	Waiver Nursing*
Pickaway	1	1	1	1	1	1	1	1	1	1	1
Pike	1	1	1	1	1	1	1	1	1	1	1
Portage	1	3	3	3	2	3	3	1	3	2	3
Preble	1	1	1	1	1	1	1	1	1	1	1
Putnam	1	1	1	1	1	1	1	1	1	1	1
Richland	2	4	4	4	3	4	4	2	4	3	4
Ross	1	3	3	3	2	3	3	1	3	2	3
Sandusky	1	2	2	2	1	2	2	1	2	1	2
Scioto	2	4	4	4	2	4	4	2	4	2	4
Seneca	1	1	1	1	1	1	1	1	1	1	1
Shelby	1	1	1	1	1	1	1	1	1	1	1
Stark	5	11	11	11	7	11	11	5	11	7	11
Summit	7	17	17	17	11	17	17	7	17	11	17
Trumbull	3	6	6	6	4	6	6	3	6	4	6
Tuscarawas	1	3	3	3	2	3	3	1	3	2	3
Union	1	1	1	1	1	1	1	1	1	1	1
Van Wert	1	1	1	1	1	1	1	1	1	1	1
Vinton	1	1	1	1	1	1	1	1	1	1	1
Warren	1	3	3	3	2	3	3	1	3	2	3
Washington	1	2	2	2	1	2	2	1	2	1	2
Wayne	1	3	3	3	2	3	3	1	3	2	3
Williams	1	1	1	1	1	1	1	1	1	1	1
Wood	1	2	2	2	2	2	2	1	2	2	2
Wyandot	1	1	1	1	1	1	1	1	1	1	1

Table F.5 LTSS Time and Distance Standards*

Specialty	Maximum Time (minutes)	Maximum Distance (miles)
Assisted Living	45	30
Adult Day Health	45	30
Out-of-Home Respite	45	30

***May be adjusted for rural areas**

Table F.6 LTSS Service Delivery Wait Times

Service Type	Wait Time to Receive Service
Home Delivered Meals	No more than 20 business days from the waiver service plan request or authorization.
Home Modification	No more than 60 business days from the waiver service plan request or authorization.
Personal Emergency Response Services	No more than 30 business days from the waiver service plan request or authorization.
Private Duty Nursing	No more than 20 business days from the time-of-service order or authorization.
Home Health Nursing	No more than 20 business days from the time-of-service order or authorization.
Waiver Nursing	No more than 20 business days from the waiver service plan request or authorization.
Specialized Medical Equipment and Supplies	For common items no more than 30 business days and for highly specialized items no more than 120 business days from the waiver service plan request or authorization
Non-Medical Transportation	No more than 20 business days from the waiver service plan request or authorization.
Home Health Aide	No more than 20 business days from the time-of-service order or authorization.
Personal Care	No more than 20 business days from the waiver service plan request or authorization
Homemaker	No more than 20 business days from the time-of-service order or authorization.

Table F.6 Non-LTSS Medicaid Provider County Based Standards

County	Other Community Behavioral Health Providers	Dental	MAT	Nursing Facility	OMHAS Certified/Licensed SUD Treatment Program	OMHAS Community Mental Health Agency	Vision
Adams	0	1	0	1	0	0	0
Allen	4	3	2	2	0	2	1
Ashland	1	1	0	1	0	0	0
Ashtabula	5	3	2	3	0	2	2

County	Other Community Behavioral Health Providers	Dental	MAT	Nursing Facility	OMHAS Certified/Licensed SUD Treatment Program	OMHAS Community Mental Health Agency	Vision
Athens	2	2	1	1	0	1	1
Auglaize	0	0	0	0	0	0	0
Belmont	2	2	1	2	0	1	1
Brown	0	1	0	1	0	1	0
Butler	11	13	8	7	2	6	4
Carroll	0	0	0	0	0	0	0
Champaign	0	0	0	0	0	0	0
Clark	7	6	2	4	1	4	3
Clermont	6	5	4	4	1	3	1
Clinton	1	1	0	1	0	1	1
Columbiana	6	2	3	5	1	2	0
Coshocton	2	1	0	1	0	0	0
Crawford	0	1	0	1	0	0	0
Cuyahoga	74	85	34	31	6	37	32
Darke	1	1	0	1	0	0	0
Defiance	0	0	0	0	0	0	0
Delaware	2	3	1	3	0	1	3
Erie	2	2	1	2	0	1	1
Fairfield	3	3	2	2	0	1	1
Fayette	0	1	0	1	0	0	0
Franklin	26	60	43	16	7	15	20
Fulton	2	0	0	2	0	0	0
Gallia	1	1	0	1	0	0	0
Geauga	2	1	1	2	0	1	0
Greene	5	3	5	3	1	2	3
Guernsey	1	1	1	1	0	0	0
Hamilton	31	34	30	23	5	16	14

County	Other Community Behavioral Health Providers	Dental	MAT	Nursing Facility	OMHAS Certified/Licensed SUD Treatment Program	OMHAS Community Mental Health Agency	Vision
Hancock	2	1	1	1	0	1	0
Hardin	1	0	0	0	0	0	0
Harrison	0	0	0	0	0	0	0
Henry	0	0	0	0	0	0	0
Highland	0	1	1	1	0	1	0
Hocking	0	0	0	0	0	0	0
Holmes	0	0	0	0	0	0	0
Huron	1	1	0	1	0	0	0
Jackson	1	1	0	1	0	0	0
Jefferson	0	2	0	2	0	1	1
Knox	2	1	1	1	0	0	0
Lake	7	7	4	4	1	4	2
Lawrence	2	3	1	1	0	1	1
Licking	4	4	2	2	0	2	2
Logan	1	1	0	1	0	0	0
Lorain	12	11	2	4	1	6	3
Lucas	34	26	14	12	5	8	9
Madison	1	1	1	1	0	0	0
Mahoning	16	11	12	7	3	5	5
Marion	3	2	1	1	0	1	1
Medina	4	4	1	4	0	2	1
Meigs	0	0	0	0	0	0	0
Mercer	1	0	0	0	0	0	0
Miami	3	2	1	1	0	1	0
Monroe	0	0	0	0	0	0	0
Montgomery	27	23	18	12	4	13	13
Morgan	0	0	0	0	0	0	0

County	Other Community Behavioral Health Providers	Dental	MAT	Nursing Facility	OMHAS Certified/Licensed SUD Treatment Program	OMHAS Community Mental Health Agency	Vision
Morrow	0	0	0	0	0	0	0
Muskingum	4	3	2	1	0	1	1
Noble	0	0	0	0	0	0	0
Ottawa	2	1	0	2	0	0	0
Paulding	0	0	0	0	0	0	0
Perry	0	1	0	1	0	0	0
Pickaway	1	1	2	2	0	1	1
Pike	0	1	0	1	0	0	0
Portage	6	3	2	2	1	2	0
Preble	0	0	0	0	0	0	0
Putnam	0	0	0	0	0	0	0
Richland	5	4	2	2	0	2	2
Ross	4	3	2	1	0	1	1
Sandusky	2	1	1	1	0	1	0
Scioto	1	2	2	2	0	2	2
Seneca	0	1	0	1	0	0	0
Shelby	0	1	0	0	0	0	0
Stark	18	17	6	11	3	6	7
Summit	27	23	14	14	4	9	11
Trumbull	11	8	4	7	2	3	4
Tuscarawas	4	3	1	2	0	1	0
Union	1	1	0	1	0	0	1
Van Wert	0	0	0	0	0	0	0
Vinton	0	0	0	0	0	0	0
Warren	4	3	4	6	1	2	2
Washington	0	2	0	1	0	1	1
Wayne	4	3	1	5	1	1	0

County	Other Community Behavioral Health Providers	Dental	MAT	Nursing Facility	OMHAS Certified/Licensed SUD Treatment Program	OMHAS Community Mental Health Agency	Vision
Williams	1	1	0	0	0	0	0
Wood	5	2	2	4	1	1	2
Wyandot	0	0	0	0	0	0	0

APPENDIX G – PROGRAM INTEGRITY

1. General

a. The MCOP must comply with all applicable state and federal program integrity requirements, including but not limited to those specified in OAC rule 5160-26-06, 42 CFR Part 455, 42 CFR Part 1002, 42 CFR Part 438 Subpart H, 42 CFR Part 420, 42 CFR 422.503, 42 CFR 422.504, the MyCare Ohio Home- and Community-Based Services (HCBS) Waiver, and the MyCare Ohio 1915(b) Waiver.

b. The MCOP must comply with and participate in ODM's program integrity initiatives.

2. Compliance Program

a. In accordance with 42 CFR 438.608(a)(1), the MCOP must implement and maintain a compliance program.

b. The compliance program must include, at a minimum, all the following elements:

i. Written policies, procedures, and standards of conduct that demonstrate compliance with requirements and standards under this Agreement, and all applicable federal and state requirements;

ii. A designated Chief Compliance Officer who is responsible for developing and implementing policies and procedures designed to ensure compliance with this Agreement. The Chief Compliance Officer must report to the Chief Executive Officer and the Board of Directors;

iii. A Regulatory Compliance Committee, consisting of members of the Board of Directors and senior management, that is responsible for oversight of the MCOP's compliance program and its compliance with this Agreement;

iv. A system for training and education for the Chief Compliance Officer, the MCOP's senior management, and the MCOP's employees regarding the MCOP's compliance program and the requirements of this Agreement;

v. Effective lines of communication between the Chief Compliance Officer and the MCOP's employees;

vi. Enforcement of standards through well-publicized disciplinary guidelines;

vii. A system of dedicated staff with established and implemented procedures for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues, investigations of potential compliance problems identified in the course of self-evaluation and audits, prompt and thorough correction of identified compliance problems, and ongoing compliance with the requirements of this Agreement;

viii. Designated staff responsible for administering the plan and clear goals, milestones or objectives, measurements, key dates for achieving identified outcomes, and an explanation of how the MCOP will determine the effectiveness of the compliance plan;

ix. Education of staff, subcontractors, and providers about fraud, waste, and abuse and how to report suspected fraud, waste, and abuse to the MCOP and ODM;

x. Education of members about fraud, waste, and abuse, and how to report fraud, waste, and abuse to the MCOP;

xi. Establishment and/or modification of internal MCOP controls to ensure the proper submission and payment of claims; and

xii. Prompt reporting of all instances of suspected fraud, waste, and abuse to ODM.

c. The MCOP must develop an Ohio-specific compliance plan that describes the MCOP's compliance program for this Agreement and includes the MCOP's monitoring and auditing work plan for the upcoming year. As specified in Appendix P, Chart of Deliverables, the MCOP must submit its compliance plan (Compliance Plan), including updates, to ODM for approval.

3. Employee Education about False Claims Recovery

a. In accordance with 42 CFR 438.608(a)(6), the MCOP must provide written policies for all MCOP employees, and the employees of any MCOP subcontractor or agent that provide detailed information about the Federal False Claims Act and other federal and state laws described in Section 1902(a)(68) of the Social Security Act, including the rights of employees to be protected as whistleblowers.

b. The MCOP's policies must include the following whistleblower fraud and/or abuse reporting contacts:

i. Ohio Attorney General's Office Medicaid Fraud Control Unit (MFCU) by phone at 1-800-282-0515 or online at http://www.ohioattorneygeneral.gov/Individuals-and-Families/Victims/Submit-a-Tip/Report-Medicaid-Fraud; and

ii. The Ohio Auditor of State (AOS) by phone at 1-866-FRAUD-OH or by email at fraudohio@ohioauditor.gov.

c. The MCOP's policies must include detailed provisions regarding the MCOP's policies and procedures for preventing and detecting fraud, waste, and abuse.

d. The MCOP's policies must be included in the MCOP's employee handbook.

e. The MCOP must disseminate its policies to its subcontractors and agents and ensure that its subcontractors and agents abide by these policies.

4. MCOP Disclosures

a. In accordance with 42 CFR 438.608, the MCOP must disclose to ODM any prohibited affiliations under 42 CFR 438.610.

b. Pursuant to 42 CFR 455.104 and OAC rule 5160-1-17.3, the MCOP must disclose ownership and control information, including any change in this information.

c. In accordance with 42 CFR 438.602, the MCOP must post on its website the name and title of individuals included in 42 CFR 438.604(a)(6).

d. In accordance with 42 CFR 455.105, the MCOP must submit within 35 calendar days of the date requested by ODM or the US Department of Health and Human Services full and complete information about:

   i. The ownership of any subcontractor with whom the MCOP has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

   ii. Any significant business transactions between the MCOP and any wholly owned supplier, or between the provider and any subcontractor, during the five-year period ending on the date of the request.

e. In accordance with 42 CFR 455.106, the MCOP must disclose the identity of any person who:

   i. Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and

   ii. Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

f. In accordance with Section 1903(m)(4)(A) of the Social Security Act, if the MCOP is not a federally qualified health maintenance organization (HMO), it must report to ODM a description of certain transactions with parties of interest.

5. ODM-Enrolled Providers

c. As specified in Appendix F, Provider Network, the MCOP must only contract with and issue payment to non-pharmacy providers for service provided when they are enrolled with ODM and are active providers in ODM's provider network management (PNM) system.

d. Except as otherwise allowed by federal law or regulations for single case agreements and emergency services, in accordance with 42 CFR 455.410 and this Agreement, the MCOP must ensure that any ordering, referring, or prescribing non-pharmacy provider is enrolled with ODM and is an active provider in ODM's PNM system.

e. Except for MyCare Ohio HCBS Waiver providers, in accordance with 42 CFR 438.602, an MCOP may execute a temporary 120 calendar day network provider agreement pending the outcome of the ODM screening, enrollment, and revalidation process. The MCOP 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 MCOP must submit the form to ODM for

screening and enrollment. The application can be found at: http://www.medicaid.ohio.gov/Provider/EnrollmentandSupport/ProviderEnrollment.

f. In accordance with 42 CFR 438.608, the MCOP must notify ODM when it receives information about a change in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including when a network provider contract is terminated.

g. The MCOP must notify ODM when the MCOP denies a request for a network provider contract from a provider that is active in ODM's PNM system, including the reason for the denial. The MCOP must indicate the reason or reasons for the denial using ODM-specified reasons.

h. Except as otherwise provided in Appendix F, Provider Network, the MCOP must notify ODM at least 45 calendar days prior to the termination/non-renewal of a network provider contract, whether by the MCOP or the provider. If the MCOP receives less than 45 calendar days' notice of a provider's termination/non-renewal or terminates a network provider contract with less than 45 calendar days' notice, the MCOP must notify ODM within one business day of becoming aware of the termination/non-renewal.

    i. The MCOP must provide the reason for the termination/non-renewal using ODM-specified reasons.

    ii. The MCOP must only terminate/not renew provider contracts for cause, as defined by ODM.

    iii. The MCOP must not suspend, terminate, or not renew a provider contract when the MCOP suspects fraud, waste, or abuse until it receives permission from ODM to proceed.

i. Except as provided in Appendix F, Provider Network, regarding single case agreements and emergency services, the MCOP must not pay a provider for services provided when the non-pharmacy provider is not active in ODM's PNM system. Except for emergency services, the MCOP must not pay a provider for services provided when the provider has been terminated or suspended by ODM or has been terminated by Medicare, Medicaid, or the Children's Health Insurance Program.

j. When ODM notifies the MCOP that a provider has been suspended, the MCOP must immediately suspend the provider, including any payments to the provider. The MCOP must continue to suspend the provider until it receives notice from the ODM to lift the suspension. When ODM notifies the MCOP that a provider is no longer suspended, the MCOP must lift the suspension and process any suspended claims.

k. The MCOP’s network provider contracts must include a provision for the return of episode, quality, or other value-based payments to the MCOP when the provider is convicted of fraud and the time

period of the fraudulent activity overlaps with the time period that the episode, quality, or other value-based payment is based.

l. The MCOP must attempt to recover any payment made to a provider for services provided after the provider is terminated pursuant to the requirements in this appendix.

m. In accordance with 42 CFR 455.436, the MCOP must routinely monitor the federal exclusion list for providers that have been excluded from Medicaid.

n. The MCOP must routinely monitor the Ohio Suspension and Exclusion List maintained on the ODM website for providers that have been excluded from Medicaid.

6. Data Certification

a. General

i. In accordance with 42 CFR 438.604 and 42 CFR 438.606, the MCOP must certify data, documentation, and information submitted to ODM.

b. Submissions

i. The MCOP must submit the appropriate ODM-developed certification concurrently with the submission of the following data, documentation, or information:

1. Primary care provider (PCP) data as specified in Appendix A, General Requirements;
2. Care coordination data, as specified in Appendix D, Care Coordination;
3. Health Care Effectiveness Data and Information Set (HEDIS) data and Consumer Assessment of Healthcare Providers and Systems (CAHPS) data as specified in Appendix I, Quality and Waiver Performance Measures;
4. Encounter data as specified in Appendix K, Information Systems, Claims, and Data;
5. Prompt pay reports, cost reports, and medical loss ratio (MLR) data, as specified in Appendix L, Payment and Financial Performance;
6. Data submitted to the Ohio Department of Insurance (ODI) to determine that the MCOP has made adequate provisions against the risk of insolvency;
7. Documentation used by ODM to certify that the MCOP has complied with ODM's requirements for availability and accessibility of services, including the adequacy of the provider network, as specified in Appendix F, Provider Network;
8. Information on ownership and control as specified in this appendix;
9. Information submitted in the program integrity quarterly inventory report as specified in this appendix; and
10. Any other data, documentation, or information related to the MCOP's obligations under this Agreement as specified by ODM.

c. Source, Content, and Timing of Certification

i. The above MCOP data submissions must be certified by one of the following:

1. The MCOP's Chief Executive Officer (CEO);

2. The MCOP's Chief Financial Officer (CFO); or

3. An individual who reports directly to the MCO's CEO or CFO with delegated authority to sign for the CEO or CFO so that the CEO or CFO is ultimately responsible for the certification.

ii. The certification must attest that, based on best information, knowledge, and belief, the data, documentation, and information is accurate, complete, and truthful.

iii. The MCOP must submit the certification concurrently with the submission of the applicable data, documentation, or information.

7. Explanation of Benefits Mailings

o. In accordance with 42 CFR 455.20, the MCOP must have a method for verifying with members whether Medicaid services billed by providers were received. For dual benefit members, the MCOP must have a method for verifying with members whether both Medicaid and Medicare services billed by providers were received.

p. The MCOP must conduct a mailing of explanation of benefits (EOBs) to a 95% confidence level (plus or minus 5% margin of error) to a random sample of the MCOP's members once a year and upon request as directed by ODM.

q. As an option, the MCOP may meet this requirement by using a strategy targeting services or areas of concern as long as the number of mailed explanation of benefits is not less than the number generated by the random sample described above. If the MCOP opts to use a targeted mailing, it must submit the proposed strategy in writing to ODM, and receive written prior approval from ODM.

r. The MCOP's explanation of benefits mailing must only include those members that have received health care services within the last six months, comply with all state and federal regulations regarding release of personal health information, outline the recent services identified as having been provided to the member, and request that the member report any discrepancies to the MCOP.

s. The MCOP's explanation of benefits mailing to dual benefit members must integrate information on Medicaid and Medicare services and coverage.

t. As specified in Appendix P, Chart of Deliverables, the MCOP must inform ODM of the date of the explanation of benefits mailing (EOB mailing date) and provide results of the EOB mailing (EOB results) as specified by ODM, including but not limited to the number mailed and the number of members reporting discrepancies.

8. Special Investigative Unit

a. The MCOP must establish a special investigative unit (SIU). The SIU's responsibilities must include preventing and detecting fraud, waste, and abuse; referring potential fraud, waste, and abuse to

ODM; conducting fraud, waste, and abuse investigations; coordinating with law enforcement; cooperating with ODM and other state and federal authorities; and implementing the MCOP's fraud, waste, and abuse plan.

b. The MCOP's proposed SIU staffing must comply with the requirements in Appendix A, General Requirements, and must be included in the MCOP's Ohio-specific fraud, waste, and abuse plan described in this appendix.

9. Fraud, Waste, and Abuse Plan

a. The MCOP must have a program that includes administrative and management arrangements or procedures to prevent, detect, and report both internal (e.g., MCOP staff) and external (e.g., provider, member, subcontractor) fraud, waste, and abuse.

b. The MCOP must develop and implement an Ohio-specific fraud, waste, and abuse plan for Ohio's Medicaid program that includes a risk-based assessment, designated staff responsible for administering the plan, clear goals, milestones or objectives, key dates for achieving identified outcomes, and an explanation of how the MCOP will determine effectiveness of the plan.

c. The fraud, waste, and abuse plan must include but is not limited to the following:

i. A risk-based assessment that includes the MCOP's evaluation of its fraud, waste, and abuse processes and the risk for fraud, waste, and abuse in the provision of services to members;

ii. An outline of activities proposed by the MCOP for the next reporting year based on the results of the risk-based assessment, including the MCOP's top five risk areas;

iii. A description of the MCOP's proposed activities related to provider education of federal and state laws and regulations related to Medicaid fraud, waste, and abuse and identifying and educating targeted providers with patterns of incorrect billing practices and/or overpayments;

iv. A description of the specific controls in place for prevention and detection of potential or suspected fraud, waste, and abuse, such as:

1. A description of all pre-payment review activities, including but not limited to pre-payment claims edits and claim reviews;

2. A list of automated post-payment claims edits;

3. A list of claims review algorithms;

4. Frequency and type of desk audits on post-payment review of claims;

5. A list of reports of provider profiling used to aid program and payment reviews; and

6. A list of surveillance and/or utilization management (UM) protocols used to safeguard against unnecessary or inappropriate use of Medicaid services.

v. A description of the MCOP's activities to prevent and detect fraud, waste, and abuse by providers who are reimbursed using value-based payment models such as incentive payments, shared savings, episode-based payments, and subcapitation;

vi. A description of how the MCOP will manually review all claims for providers placed on pre-payment review status as requested by ODM and how the MCOP will identify providers that should be placed on pre-payment review and place them on pre-payment review if deconfliction approved by ODM;

vii. A description of how the MCOP will monitor activities on an ongoing basis to prevent and detect activities involving suspected fraud, embezzlement, and theft (e.g., by staff, providers, contractors);

viii. A description of how the MCOP will vet every allegation of fraud, waste, or abuse and will investigate every allegation that passes vetting;

ix. A description of how the MCOP will track and ensure that at least 3% of total medical expenditures are subject to a post-payment investigation, including investigations based on an internal (e.g., data mining) or an external referral, over the contract year;

x. A description of how the MCOP will identify and correct claims submission and billing activities that are potentially fraudulent, including but not limited to double-billing and improper coding, such as upcoding and unbundling;

xi. A description of how the MCOP will use utilization, service denial, appeals, incident reporting, provider complaint, and provider dispute resolution data to detect potential fraud, waste, or abuse;

xii. A description of how the MCOP will identify and address over-, under-, or inappropriate utilization of covered services, including but not limited to review of the MCOP's utilization management criteria and processes, service denials, appeals, and utilization data; and

xiii. Work plans for conducting both announced and unannounced provider site audits for providers identified as high-risk by the MCOP to ensure services are rendered and billed correctly.

d. As specified in Appendix P, Chart of Deliverables, the MCOP must submit its fraud, waste, and abuse plan (Fraud, Waste, and Abuse Plan) to ODM for approval.

10. Reporting and Investigating Fraud, Waste, and Abuse

b. General

i. The MCOP must promptly report all instances of suspected provider and member fraud, waste, and abuse to ODM.

c. Reporting and Retention of Recovery

i. If the MCOP identifies and properly reports a case of suspected fraud, waste, or abuse before the suspected fraud, waste, or abuse is identified by state or federal authorities, the MCOP may share in any recovery from the reported fraud, waste, or abuse. If the MCOP fails to properly report a case of suspected fraud, waste, or abuse before the suspected fraud, waste, or abuse is identified by the state or federal authorities, it may not share in any portion of the recovery from the fraud, waste, or abuse.

d. Reporting Provider Fraud, Waste, or Abuse

i. The MCOP must, within one business day of identifying suspected provider fraud, waste, or abuse, submit a referral to ODM using ODM's Fraud Referral and Coordination system.

ii. ODM will review all fraud, waste, and abuse referrals to determine whether there is a credible allegation of fraud or if the allegation evidences abuse or waste.

iii. ODM will submit all fraud referrals to the MFCU and return the abuse and waste referrals to the MCOP for additional investigation and recovery, if appropriate. The MCOP must request deconfliction before beginning this investigation and/or recovery.

iv. ODM will distribute each fraud referral to all MCOPs.

v. The MCOP must respond to all fraud referrals distributed by ODM pursuant to Section 10.c.iv above by submitting the ODM Attestation form to ODM through ODM's Fraud Referral and Coordination system within 60 calendar days. The MCOP's failure to file an attestation timely, completely, and accurately waives the MCOP's right to participate in any MFCU recoveries.

e. Reporting Member Fraud or Abuse

i. The MCOP must, within one business day of learning of suspected member fraud or abuse, report suspected member fraud and abuse to ODM's Bureau of Program Integrity (BPI) at Program_Integrity_County_Referral@medicaid.ohio.gov and copy the appropriate County Department of Job and Family Services (CDJFS).

f. Coordination with Law Enforcement

i. *Stand Down*

1. The MCOP must stand down upon submission of either a fraud, waste, or abuse referral or a submission of a request for deconfliction. During stand down, the MCOP must not take any action related to the referral/request for deconfliction, including but not limited to contacting the subject of the referral or deconfliction request about any matter related to the suspected fraud, waste, or abuse.

ii. *Referrals*

1. Upon MCOP submission of a fraud, waste, or abuse referral to ODM, the MCOP must stand down until notified by ODM that the stand down period has ended.

2. The stand down time period will last for the shortest of the following events:

a. ODM determines there is no credible allegation of fraud contained in the referral;

b. MFCU closes their investigation for lack of prosecutorial merit; or

c. An initial period of one year, starting when the referral is received by ODM; however, this period may be extended once for an additional six months at ODM's discretion.

iii. *Deconflictions*

1. Prior to taking any action that would alert the provider that they are the subject of an audit, investigation, or review for program integrity reasons, prior to recovery (recoupment or withhold) for a program integrity reason, and prior to involuntarily terminating a provider for a program integrity reason, the MCOP must request deconfliction from ODM through ODM's Fraud Referral and Coordination system and stand down until it receives permission from ODM to proceed.

2. ODM will either grant the deconfliction request or notify the MCOP to stand down.

3. The stand down time period or the time period to conduct approved program activities will be valid for six months.

4. After the six month period expires, the MCOP must submit another deconfliction request.

5. ODM may extend the stand down for an additional six months upon the request of the MFCU and a showing that the extension is warranted. If requested by ODM, the MCOP must stand down for an additional six months.

    a. This provision does not apply to federal cases, joint task force cases, or other cases that are not under the MFCU's control. In those cases, the MCOP must stand down until the case is closed or completed.

iv. *Coordinating Provider On-Site Audits*

1. The MCOP must coordinate on-site provider reviews/audits (announced or unannounced) with ODM and must participate in joint reviews/audits as requested by ODM.

v. *ODM Investigation and Recovery*

1. ODM has the right to audit, review, investigate, and/or recover payment from the MCOP's network providers at any time and without notice to the MCOP.

11. Recovery of Provider Overpayments

a. Definition of Overpayment

i. In accordance with 42 CFR 438.2, provider overpayment means any payment made to the provider by the MCOP to which the provider is not entitled to under Title XIX of the Social Security Act.

b. General

i. In accordance with 42 CFR 438.608, the MCOP must require network providers to report to the MCOP when it has received an overpayment, to return the overpayment to the MCOP within 60 calendar days after the date on which the overpayment was identified, and to notify the MCOP in writing of the reason for the overpayment.

ii. The MCOP retains the right to recover any overpayments it identified arising out of provider fraud, waste, or abuse, as defined by OAC rules 5160-59-01 and 5160-26-01, in the following circumstance:

1. The MFCU has an open case, and the MCOP requested deconfliction and received leave to proceed since there was not a conflict with an active law enforcement investigation; or

2. The date of the deconfliction request occurred prior to the date that the MFCU opened their case on the same provider; and

3. The MCOP submitted a referral regarding the same provider after completion of its previously approved audit, investigation, or review.

iii. The MCOP must not act to recover overpayments if:

1. The overpayments were recovered from the provider by ODM, the state of Ohio, the federal government, or their designees as part of a criminal prosecution where the MCOP had no right of participation;

2. The improperly paid funds are currently being investigated by the state of Ohio, are the subject of pending federal or state litigation or investigation, or are being audited by ODM, the Ohio Auditor of State (AOS), the Centers for Medicare & Medicaid Services (CMS), the Office of Inspector General (OIG), or their agents; or

3. The overpayments relate to fraud, waste, or abuse, and the MCOP has not requested a deconfliction and received leave to proceed.

iv. If the MCOP obtains funds in cases where recoupment is prohibited by Section 11.b.iii of this appendix, the MCOP must notify ODM and take action in accordance with ODM's instructions, which may include forfeiture of the funds.

v. Absent any restrictions on recovery, the MCOP may otherwise recover from a provider any amount collected from the MCOP 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 MCOP that resulted from an audit, review, or investigation of the provider. The MCOP retains recovery rights to any amount paid to ODM when a provider self-reports an overpayment arising from a payment made by the MCOP to the provider or other reason.

vi. The MCOP may recover overpayments made to providers if the overpayment is identified and the provider is notified within two years of the date the MCOP improperly paid the provider, within 6 months of the MFCU returning a fraud referral to the MCOP, within any applicable statute limitations for fraud, or if ODM recovers an overpayment made by the MCOP to a provider directly from the MCOP, whichever is later.

vii. ODM may recover overpayments made by the MCOP to a provider under the time limits in ORC section 5164.57.

c. Notice

i. Prior to recovering an overpayment from a provider, the MCOP must provide the provider a notice of intent to recover due to an overpayment.

ii. The MCOP must submit the template for its notice of intent to recover an overpayment to ODM for review and approval prior to use.

iii. Consistent with ORC section 5167.22, the notice must include but is not limited to the following:

1. The patient's name, date of birth, and Medicaid identification number;

2. The date or dates of services rendered;

3. The specific claims that are subject to recovery and the amount subject to recovery, including any interest charges, which may not exceed the amount specified in Ohio law or rule;

4. The specific reasons for making the recovery for each of the claims subject to recovery, including a citation to the applicable statute, rule, or manual section;

5. If the recovery is a result of member disenrollment from the MCOP, the MCOP must provide the effective date of disenrollment;

6. An explanation that if the provider does not submit a written response to the notice within 30 calendar days from receipt of the notice, the overpayments will be recovered from future claims;

7. How the provider may submit a written response disputing the overpayment; and

8. How the provider may submit a written request for an extended payment arrangement or settlement.

d. Overpayment Dispute Process

i. The MCOP must allow the provider 30 calendar days from receipt of the notice to submit a written response disputing the overpayment or requesting an extended payment arrangement or settlement. If the provider fails to submit a written response within the time period provided, the MCOP may execute the recovery as specified in the notice.

ii. Upon receipt of a written response disputing the overpayment, the MCOP must, within 30 calendar days from the date the written response is received, consider the response, including any pertinent additional information submitted by the provider, together with any other material bearing upon the matter, and determine whether the facts justify recovery.

iii. The MCOP must provide a written notice of determination that includes the rationale for the determination. If the MCOP determines the facts justify the recovery, the MCOP may execute the recovery within three business days of sending the notice of determination.

iv. The MCOP must submit the template for its notice of determination to ODM for review and approval prior to use.

e. Extended Payment or Settlement

i. Upon receipt of a written response requesting an extended payment arrangement or settlement, the MCOP must, within 30 calendar days from the date the written response is received, consider the response, including any pertinent additional information submitted by the provider, and determine whether to allow an extended payment arrangement or enter into settlement discussions. The MCOP must provide a written notice of determination and, as applicable, the proposed extended payment arrangement or settlement terms.

1. The MCOP must not settle for less than amount specified in the notice of intent to recover unless there is the inability to collect.

2. The MCOP must submit any extended payment arrangement or settlement terms to ODM for prior approval per the separate guideline provided by ODM.

3. The MCOP must finalize any extended payment arrangement or settlement terms approved by ODM within 120 calendar days of sending the initial notice of intent to recover.

4. If the MCOP settles for less than the amount specified in the notice of intent to recover, the MCOP must report to ODM the amount specified in the notice and the settlement amount in the quarterly inventory report.

f. Accounting

i. The MCOP must maintain a detailed accounting of identified overpayments by provider and track recoveries, with the ability to report to ODM at any time the status of recovery for individual or cumulative recoveries.

g. Claims Adjustment

i. The MCOP must void or adjust (as applicable) all claims to reflect any identified provider overpayments, regardless of whether they have been recovered. This provision does not apply to recoveries due to settlement or statistical sampling of claims and extrapolation, where identification of individual claims is impossible.

h. ODM Recovery of Provider Overpayments from the MCOP

i. If ODM identifies a provider overpayment, ODM will notify the MCOP of its intent to recover the overpayment from the MCOP or the provider.

1. If ODM recovers directly from the provider, the recovery will get effectuated as a remittance by the provider or as a claim payment offset. ODM will retain the overpayment collected. The MCOP will be precluded from adjudicating an audit or taking any other collection action related to the overpayment discovered and recovered by ODM directly from the provider.

2. If ODM directly recovers from the MCOP, the recovery will be effectuated as a remittance by the MCOP, or a capitation payment offset. The MCOP may recover the payment from the provider.

i. In accordance with 42 CFR 438.608, provisions regarding treatment of recoveries of provider overpayments made by the MCOP do not apply to any amount of a recovery to be retained under the federal False Claims Act cases or through other investigations.

12. Recovery of MCOP Overpayments

a. In accordance with 42 CFR 438.2, MCOP overpayment means any payment made to the MCOP by the state of Ohio to which the MCOP is not entitled to under Title XIX of the Social Security Act. The MCOP overpayments include but are not limited to capitation payments made for members who are retroactively disenrolled.

ii. In accordance with 42 CFR 438.608, the MCOP must report any MCOP overpayments to ODM within 60 calendar days of identifying the overpayment.

b. ODM may recover overpayments made to the MCOP under the time limits in ORC Section 5164.57.

c. ODM will recover MCOP overpayments. Recovery will, at ODM's discretion, be effectuated as a remittance by the MCOP or a reduction to future capitation payments.

d. The MCOP may recover payments made to a provider for services rendered to a member who was retroactively disenrolled from the MCOP in accordance with the following:

i. The MCOP must initiate such recovery within 30 calendar days of notice of the capitation recovery.

iii. If the recovery is for payments made more than two years from the date of payment of the provider, the MCOP must notify ODM and receive permission to proceed with the recovery.

iv. The MCOP's recovery process must comply with the requirements for recovery of overpayments as described in this appendix. In addition, the MCOP must notify the provider of the option to submit a claim to ODM for services rendered to a member who was retroactively disenrolled from the MCOP.

v. The MCOP must not recover payments from a provider beyond two years from the date of payment of the claim due to a member's retroactive disenrollment from the MCOP, unless the MCOP is directed to do so by CMS or ODM.

13. Cooperation with State and Federal Authorities

a. The MCOP must cooperate fully and promptly with state and federal authorities, including but not limited to ODM, the Ohio Attorney General, the Ohio Auditor of State, law enforcement, and the US Department of Health and Human Services.

b. The MCOP must respond to requests from state or federal authorities within one business day of such request.

c. At the request of a state or federal authority, the MCOP must produce copies of all MCOP fraud, waste, and abuse investigatory files and data (including, but not limited to records of member and provider interviews) in the manner and format requested at no charge to the requestor. Unless

otherwise specified in the request, the MCOP must provide this information within 30 calendar days of the request.

d. The MCOP must provide all other data, documentation, and other information requested by state or federal authorities, in the manner and format requested at no charge to the requestor. Unless otherwise specified in the request, the MCOP must provide the requested data, documentation, or other information within 30 calendar days of the request.

e. The MCOP must cooperate fully in any investigation or prosecution by any state or federal authority, whether administrative, civil, or criminal at no charge to the requestor. This includes but is not limited to:

   i. Actively participating in meetings;

   ii. Providing requested information and access to requested records;

   iii. Providing access to interview MCOP employees, subcontractors, and consultants;

   iv. Providing qualified individuals to testify at or be a witness at any hearings, trials, or other judicial or administrative proceedings and

   v. Assuring confidentiality with regard to law enforcement records and discussions held at MCOP/ODM/law enforcement meetings.

f. Upon request, the MCOP must make available to state and federal authorities all administrative, financial, and medical data, documentation, and other information relating to the delivery of items or services under this Agreement. The MCOP must provide such data, documentation, and other information at no cost to the requesting entity. The MCOP must inform ODM before providing Ohio Medicaid related information to state and federal authorities.

14. Additional Reporting Requirements

a. Pursuant to OAC rules 5160-58-01.1 and 5160-26-06 and as specified in Appendix P, Chart of Deliverables, the MCOP must submit a fraud, waste, and abuse report (Fraud, Waste, and Abuse Report) to ODM that summarizes the MCOP's fraud, waste, and abuse activities for the year and identifies any proposed changes for the coming year. This report must include the information specified by ODM, including but not limited to the MCOP's prevention actions; referrals, reviews, and recoveries; provider terminations; and meeting attendance.

b. As specified in Appendix P, Chart of Deliverables, the MCOP must provide to ODM an "inventory" report on fraud, waste, and abuse activities (the Fraud, Waste, and Abuse Inventory Report). The report must include the information specified by ODM, including but not limited to tips received; investigations and audits started; provider referrals; overpayments identified; overpayments recovered; program integrity actions taken against providers; denied network applications; member fraud referrals; cost avoidance as a result of pre-payment review activities; and planned fraud, waste, and abuse activities for the upcoming quarter.

c. The MCOP must perform unit of service/claims validation for waiver services claims in accordance with Ohio’s approved 1915(c) Waiver and must respond promptly to requests for claims verification in support of provider certification and structural compliance processes administered by ODM, the Ohio Dental Association, or their designee. In accordance with ODM’s 1915(c) CMS-approved

Waiver, the MCOP must report, as specified in Appendix P, Chart of Deliverables (Waiver Service Claims Audit Report), the following information to ODM:

i. In accordance with ODM's 1915(c) CMS-approved Waiver, the MCOP must report as requested by ODM, the number and percent of waiver services claims that have been verified through a review of provider documentation to have been paid in accordance with members' person-centered care plans. The MCOP must review a representative sample stratified by waiver service type, with a confidence interval of 95% with a margin of error of +/- 5%.

ii. The MCOP must report as requested by ODM the number and percent of claims identified in i., above, for which the MCOP recovered payment. The report must include verifications that cover the entire period back to the MCOP's MyCare Ohio start-up date.

iii. The MCOP must report the number of providers and members affected in regard to sub-paragraphs i. and ii. above. This information is also due as requested by ODM.

d. The MCOP must regularly communicate with ODM about the MCOP's program integrity work through the MCOP's annual and quarterly reports, regular meetings, and, as needed, additional communications. Specifically, the MCOP's SIU lead must attend, or send a representative to attend, the Managed Care Program Integrity Group meetings and must hold at least one monthly Special Investigative Lead meeting with ODM and law enforcement. The MCOP must adjust its program integrity work based on ODM's directions and feedback following ODM's review of the annual and quarterly reports, meetings, or otherwise.

APPENDIX H – VALUE-BASED PAYMENT

1. Value-Based Payment

a. The MCOP must design and implement value-based care and payment reform initiatives to drive the transformation of the health care delivery system to improve individual and population health outcomes, improve member experience, and contain the cost of health care through the reward of innovation and results over volume of services provided.

b. The MCOP's value-based payment efforts must include the following:

i. *Value-Oriented Payment*

1. The MCOP must design and implement payment methodologies with its network providers to enhance population health and wellness outcomes for its members in alignment with ODM's population health strategy by improving all of the following:

a. Delivery of effective and efficient health care;

b. Opportunities for practice transformation and new flexibilities for network providers; and

c. Value for the Medicaid program.

2. For the purposes of this Agreement, payments that cut waste are those that by their design reduce unnecessary payment and unnecessary care; shift utilization to more home- and community-based services (HCBS) and delay or divert nursing facility admissions; and reduce inpatient hospital days.

3. For the purposes of this Agreement, "opportunities for practice transformation and new flexibilities for network providers" involve the use of financial incentives, including risk arrangements that can help providers improve outcomes and reduce costs in sustainable ways.

4. For purposes of this Agreement, "value" means the level of the quality of care in return for the amount of payment to the provider. Payments designed to reflect value are those tied to provider performance or efficiency payments may rise or fall in a pre-determined fashion commensurate with the level of performance assessed against standard quality measures.

ii. *Market Competition and Consumerism*

1. The MCOP must design contracting and payment methodologies that enhance competition among providers and reduce unwarranted price and quality variation.

2. The MCOP must stimulate additional provider competition by establishing mechanisms to engage members to make informed provider and care choices, and to select evidence-based, cost-effective care.

iii. *Transparency*

1. The MCOP must participate in ODM initiatives to design and implement member-accessible comparisons of provider information, including quality, cost, and member experience.

2. The MCOP must contribute to the design of initiatives, provide data as specified by ODM, and publish results in accordance with standards established by ODM.

iv. *Provider Partnerships*

1. The MCOP must encourage provider participation in, and partner with providers to support the success of, value-based payment initiatives. Provider partnership includes but is not limited to:

    a. Supporting provider-led innovation by:

        i. Working directly with providers to develop and implement value-based purchasing pilots; and

        ii. Soliciting new value-based payment initiative and implementation ideas from the provider advisory council.

        iii. Sponsoring provider cultural transformation and workforce development;

        iv. Developing alternative payment method (APM) funding arrangements to retain and train providers, especially related to certification to advance their technical skills; and

        v. Building capacity for value-based arrangements in underserved and at-risk geographic areas.

    b. Supporting provider readiness (e.g., data and analytic capabilities, financial stability);

    c. Recognizing that the MCOP's payment reform strategies must be different for different types (e.g., behavioral health providers, hospital providers, nursing facilities) and sizes of providers (e.g., small providers, rural providers, hospital systems, federally qualified health centers [FQHCs]);

    d. Assisting providers to identify and address barriers; and

    e. Encouraging member utilization of providers demonstrating value and quality.

v. *Payer Partnerships*

1. The MCOP may initiate value-based payment initiatives across its Medicaid and Medicare lines of business for MCOP enrollees so long as the payment initiative treats Medicare and Medicaid equally in payments and any savings.

2. Value-Based Payment Requirements

a. ODM will establish APMs measures based on the Health Care Payment Learning and Action Network (HCP-LAN) Framework and set MCOP performance standards for each measure. The APM measures will calculate the percent of the MCOP's payments to providers that qualify as HCP-LAN categories 3A, 3B, 4A, 4B, and 4C (3A+) and, separately, payments to providers that qualify as HCP-LAN categories 3B, 4A, 4B, and 4C (3B+). The measures are defined as total costs paid by the MCOP to providers for members in the specific HCP-LAN category or categories, each divided by total costs paid to providers for members in the specific HCP-LAN category or categories. ODM anticipates that measures will focus on nursing facilities separate from all other providers.

b. When entering into an APM arrangement, the MCOP must follow the HCP-LAN APM framework, and consider provider capacity, willingness, and readiness to participate in such value-based payment arrangements. ODM does not expect all providers to enter into value-based payment arrangements with the MCOP, specifically independent in-home providers and self-directed caregivers.

c. ODM will outline a multi-year glide path for APM measures' performance standards that reflects reporting only for the first two years of this Agreement, followed by gradual annual increases through 2033 that ultimately align with HCP-LAN goals for the percentage of health care payments tied to quality and value. The MCOP will be held accountable to the performance standards beginning in year three of this Agreement. Compliance will be assessed on an annual basis and the penalty for failure to meet the standards is described in Section 2.e of this appendix.

d. The MCOP must submit each of its proposed APM arrangements to ODM at least 90 calendar days prior to implementation of the arrangement using the ODM-provided template. ODM reserves the right to request additional information about a proposed APM arrangement, request changes to a proposed or implemented APM arrangement, and/or disapprove a proposed or implemented APM arrangement.

e. The MCOP's failure to meet any of the APM performance standards will result in a penalty based on the MCOP's after-tax underwriting margin for the measurement year as delineated below. ODM will calculate the MCOP's annual underwriting margin based on the MCOP's annual cost report.

    i. If the MCOP's annual underwriting margin is equal to or less than 1.5% of net revenue, the MCOP's member assignments will be reduced through ODM's auto-assignment algorithm.

    ii. If the MCOP's annual underwriting margin is greater than 1.5% of net revenue, the MCOP must invest the amount in excess of 1.5%, up to a maximum total investment of 1.5% of net revenue, in provider transformation activities that assists providers with advancement on the HCP-LAN APM glide path from category 1 to category 4. The MCOP must submit a written plan to ODM for ODM's approval that describes the MCOP's proposed allocation of expenditures and the associated rationale. The MCOP must submit associated financial reporting as directed by ODM.

3. Reporting

a. The MCOP must develop written APM strategies to meet APM performance standards and submit the strategies to ODM as specified in Appendix P, Chart of Deliverables.

b. The MCOP must submit a Value-Based Payment Progress Report that addresses the MCOP's progress towards meeting the requirements for value-based payment and APM performance standards outlined above and/or consideration of new or alternative value-based care and payment reform initiatives. The MCOP must use the report template provided by ODM, and submit the report as specified in Appendix P, Chart of Deliverables. Reporting elements for each value-based payment strategy include the:

   i. Description of the MCOP's value-based payment strategy;

   ii. Summary of the MCOP's performance regarding reaching objectives of the MCOP's value-based payment strategy;

   iii. Insights learned to inform future value-based activities; and

   iv. Changes to the MCOP's value-based payment strategy based on insights learned.

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

d. In order to determine compliance with the APM performance standards, the MCOP must submit the APM Data Set to ODM as specified in Appendix P, Chart of Deliverables, in accordance with *The Ohio Department of Medicaid's Alternative Payment Model (APM) Measure Methodology.*

4. Value-Based Initiatives

a. <u>General</u>

   i. The MCOP must implement the value-based initiatives as required in this section of this appendix and other APMs as directed by ODM.

b. <u>Behavioral Health Care Coordination Requirements</u>

   i. The MCOP must comply with behavioral health care coordination entity related MCOP requirements once the service and program details are finalized.

APPENDIX I – QUALITY AND WAIVER PERFORMANCE MEASURES

1. General

a. ODM uses the quality measures and standards within this appendix to evaluate MCOP performance in key program areas (e.g., access, clinical quality, member satisfaction). The selected measures align with specific priorities, goals, and/or focus areas of ODM's Quality Strategy. Most measures have one or more minimum performance standards (MPS).

b. ODM uses specific measures and standards to determine MCOP performance incentives. Table I.1 in this appendix identifies the measures and standards used by ODM to determine MCOP performance incentives.

c. ODM uses measures with an MPS to determine MCOP sanctions for noncompliance.

d. ODM requires MCOP reporting on a limited number of measures that are informational/reporting only and have no associated standards, incentives, or sanctions. Many measures utilized for performance evaluation derive from national measurement sets (e.g., Health Care Effectiveness Data and Information Set [HEDIS], Minimum Data Set [MDS), widely used for evaluation of Medicaid and/or managed care industry data.

e. ODM requires a subset of measures developed by ODM to measure the MCOP's performance specific to the Ohio Medicaid managed care program's service delivery system. For those measures, the MCOP must collect and report valid and reliable data in accordance with associated measure specifications, as well as technical guidance and instructions provided by ODM or ODM's External Quality Review Organization (EQRO) conducting validation activities.

f. MCOP performance measures and standards are subject to ODM change based on the revision or update of applicable national measures, including but not limited to the Ensuring Access to Medicaid Services final rule and the Home- and Community-Based Services (HCBS) Quality Measure Set, methods, benchmarks, or other factors as determined by ODM.

g. The establishment of quality measures and standards in this appendix does not limit ODM's evaluation and compliance assessments of other indicators of MCOP performance under this Agreement (e.g., appropriate use of telehealth).

h. ODM will assess MCOP's performance on multiple measures and report performance to the MCOP and others, including Medicaid only members.

2. Quality Measures

a. <u>Quality Measures with Minimum Performance Standards</u>

   i. The MCOP must meet MPS for measures that include an MPS.

b. <u>Reporting Only</u>

   i. The MCOP must report, as applicable, on measures that are informational/reporting only. Informational/reporting only measures do not have associated standards, incentives, or sanctions.

c. Results Methodology

i. ODM will evaluate the MCOP's statewide performance on each measure.

ii. ODM will use performance measure results to assess the quality of care provided by the MCOP to the managed care population and ODM may use MCOP results for federal reporting and ODM public reporting purposes (e.g., MCOP report card).

iii. The MCOP must submit aggregated and member-level self-reported and audited HEDIS data to ODM as described in this appendix and/or specified in the ODM Specifications for the Submission of MCOP Self-Reported, Audited HEDIS Results.

iv. The MCOP must stratify certain measures by race, in accordance with HEDIS specifications or as specified by ODM, for applicable measures.

v. ODM will use the measures in **Error! Reference source not found.**–Table I.13 below to assess MCOP performance.

vi. ODM posts the methodology for the non-HEDIS measures on ODM's website.

vii. The HEDIS measures and HEDIS/ Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey measures in Table I.1 are in accordance with National Committee for Quality Assurance's (NCQA's) Volume 2: Technical Specifications and NCQA's Volume 3: Specifications for Survey Measures, respectively.

d. Measures, Measurement Sets, Standards

i. ODM will evaluate the MCOP's performances on the measures separately for dual benefit members and Medicaid only members using statewide population-specific results. Results for each measure are calculated per MCOP and will either include all the MCOP's Ohio dual benefit members and/or Medicaid-only members per the criteria specified by the methodology for the given measure. ODM may establish separate MPS for the dual benefit population and the Medicaid-only population.

ii. ODM will assess the MCOP's performance using ODM calculated performance measurement data and results submitted to ODM by the MCOP. The measures in this appendix are calculated in accordance with CMS' Reporting Requirements for HEDIS, CAHPS Measures, non-HEDIS Measures Methods, and MyCare Ohio HCBS Waiver Performance Measures.

iii. ODM will evaluate the MCOP's performance on the measures, accompanying MPS, and measurement sets listed in Table I.1 below.

iv. No MPS standard appears for measures designated "reporting only" for the corresponding year.

v. Member level data, by measure and measurement year, for HEDIS measures must be provided to ODM on request.

vi. ODM will implement a retrospective adjustment of any MPS referenced in this appendix as needed, except for the CAHPS measure standards. This retrospective adjustment will be implemented at ODM's discretion.

Table I.178 Women's Health State Fiscal Year 2026 Performance Measures, Measurements Sets, Standards, and Measurement Year

State Fiscal Year 2026 Performance Measures, Measurements Sets, Standards, and Measurement Year (MY)		Minimum Performance Standards
Women's Health	**Measurement Set**	**SFY 2026/ MY**
Breast Cancer Screening (BCS-E)	NCQA/HEDIS	TBD

Table I.2910 Behavioral Health for Adults State Fiscal Year 2026 Performance Measures, Measurements Sets, Standards, and Measurement Year

State Fiscal Year 2026 Performance Measures, Measurements Sets, Standards, and MY		Minimum Performance Standards
Behavioral Health for Adults	**Measurement Set**	**SFY 2026/ MY**
Initiation and Engagement of Substance Use Disorder Treatment, Ages 18-64 and > Ages 65	NCQA/HEDIS	18–64 TBD
		65 < TBD
Follow-Up After Hospitalization for Mental Illness, Ages 18–64	NCQA/HEDIS	7-day TBD
		30-day TBD
Follow-Up After Emergency Department for Mental Illness, Ages 18–64	NCQA/HEDIS	7-day TBD
		30-day TBD
Follow-Up After Emergency Department Visit for Substance Use, Ages 18 and Older	NCQA/HEDIS	7-day TBD
		30-day TBD
Use of Opioids from Multiple Providers — Ages18 and Older	NCQA/HEDIS	Multiple Pharmacies TBD
		Multiple Prescribers TBD
		Multiple Pharmacies and Prescribers TBD
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	NCQA/HEDIS	TBD

Table I.311 Chronic Conditions State Fiscal Year 2026, Performance Measures, Measurements Sets, Standards, and Measurement Year

State Fiscal Year 2026 Performance Measures, Measurements Sets, Standards, and MY		Minimum Performance Standards
Chronic Conditions	**Measure Set**	**SFY 2026/ MY**
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	NCQA/HEDIS	TBD
Glycemic Status Assessment for Patients with Diabetes — Glycemic status > 9.0%	NCQA/HEDIS	TBD
Glycemic Status Assessment for Patients with Diabetes — Glycemic status < 8.0%	NCQA/HEDIS	TBD
Eye Exam for Patients with Diabetes	NCQA/HEDIS	TBD
Blood Pressure Control for Patients with Diabetes	NCQA/HEDIS	TBD
Kidney Health Evaluation for Patients with Diabetes, Total	NCQA/HEDIS	TBD
Statin Therapy for Patients with Diabetes, Received Statin Therapy	NCQA/HEDIS	TBD
Controlling High Blood Pressure	NCQA/HEDIS	TBD
Statin Therapy for Patients with Cardiovascular Disease, Received Statin Therapy	NCQA/HEDIS	TBD
Diabetes Monitoring for People with Diabetes and Schizophrenia	NCQA/HEDIS	TBD
Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	NCQA/HEDIS	TBD
Asthma Medication Ratio — Ages 19–50 and 51–64	NCQA/HEDIS	19 to 50 TBD
		51-64 TBD

Table I.412 Healthy Adults State Fiscal Year 2026 Performance Measures, Measurements Sets, Standards, and Measurement Year

State Fiscal Year 2026 Performance Measures, Measurements Sets, Standards, and MY		Minimum Performance Standards
Healthy Adults	Measure Set	**SFY 2026/ MY**
Adults' Access to Preventive/Ambulatory Health Services — Total	NCQA/HEDIS	TBD
Osteoporosis Screening in Older Women	NCQA/HEDIS	TBD

Table I.513 Care Coordination State Fiscal Year 2026 Performance Measures, Measurements Sets, Standards, and Measurement Year

State Fiscal Year 2026, Performance Measures, Measurements Sets, Standards, and MY		Minimum Performance Standards
Care Coordination	**Measure Set**	**SFY 2026/ MY**
Advance Care Planning Ages 66–80 and 81 and Older	NCQA/HEDIS	66-80 TBD
		81 and older TBD
Hospitalization Following Discharge from a Skilled Nursing Facility 30- and 60-days post discharge	NCQA/HEDIS	30 days TBD
		60 days TBD

Table I.614 Long-Term Care State Fiscal Year 2026 Performance Measures, Measurements Sets, Standards, and Measurement Year

State Fiscal Year 2026 Performance Measures, Measurements Sets, Standards, and MY		Minimum Performance Standards
Long-Term Care	**Measure Set**	**SFY 2026/ MY**
Percent of residents whose need for help with daily activities has increased	MDS	TBD
Percent of residents who were physically restrained	MDS	TBD
Percent of residents experiencing one or more falls with a major injury	MDS	TBD
Percent of residents with urinary tract infection	MDS	TBD
Percent of high-risk residents with pressure ulcers	MDS	TBD
Percent of residents who have/had a catheter inserted and left in their bladder	MDS	TBD

Table I.715 All Members State Fiscal Year 2026 Performance Measures, Measurements Sets, Standards, and Measurement Year

State Fiscal Year 2026 Performance Measures, Measurements Sets, Standards, and MY		Minimum Performance Standards
All Members	**Measure Set**	**SFY 2026/ MY**
Adult Rating of Health Plan	CAHPS	TBD
Adult Customer Service Composite	CAHPS	TBD

3. MyCare Ohio HCBS Waiver Performance Measures

a. ODM must submit evidence to CMS regarding the state's ability to adhere to the six federal assurances for operating the MyCare Ohio HCBS (c) Waiver annually. The six assurances include level of care, service planning, qualified providers, health and welfare, financial accountability, and administrative authority. ODM develops and reports to CMS performance measures which demonstrate compliance with the six waiver assurances. The MCOP must achieve a MPS of 90% for each measure listed in Table I.8 of this appendix.

i. Measure: Percentage calculated for each HCBS waiver performance measure.

ii. Measurement Periods: Beginning in calendar year (CY) 2026 and then each CY thereafter, the measurement period for each measure specified in Table I.8 below will be data from the previous CY.

iii. MPS: 90 %.

iv. The MCOP must comply with all applicable CMS required HCBS Quality Measures as described in the final Ensuring Access to Medicaid Services final rule.

Table I.816 MyCare Ohio HCBS Waiver Performance Measures

Performance Measure	Source
Number and percent of required reports submitted by the MCOP in a complete and timely manner.	MCOP
Number and percent of findings of MCOP's' noncompliance that were remediated through an approved corrective action plan or other method as required by the MCOP provider agreement.	MCOP/ODM Contract Administrator
Number and percent of MCOP waiver participants reviewed whose waiver service plans adequately address their assessed needs.	EQRO
Number and percent of MCOP waiver participants reviewed whose waiver service plan have strategies to address and mitigate their health and welfare risks factors.	EQRO
Number and percent of waiver service plans reviewed that address individuals' personal goals	EQRO
Number and percent of MCOP waiver participants reviewed whose waiver service plans were updated at least once in the past 12 months.	EQRO
Number and percent of sampled MCOP waiver participants whose waiver service plans were revised, as needed, to address changing needs.	EQRO
Number and percent of MCOP waiver participants reviewed who received services in the type, scope, amount, and frequency specified in their waiver service plan.	EQRO
Number and percent of the MCOP waiver participants reviewed whose records contained a document signed by the participant to indicate their choice to receive waiver services instead of institutional care.	EQRO
Number and percent of Abuse, Neglect, Exploitation, and Misappropriation Incidents (over $500) for MCOP waiver participants reported into the ODM approved incident management system within the required timeframe.	ODM incident management system
Number and percent of unauthorized (or unapproved) restraint, seclusion, or other restrictive interventions with a prevention plan developed as a result of the incident for MCOP waiver participants.	ODM incident management system
Number and percent of substantiated provider medication error incidents with a prevention plan developed as a result of the incident for MCOP waiver participants.	ODM incident management system

Performance Measure	Source
Number and percent of MCOP's claims verified through a review of provider documentation to have been paid in accordance with individuals' waiver service plans.	MCOP (Waiver service claims audit report)
Number and percent of MCOP's claims sampled in (the previous) performance measure that were found to be unsupported claims for waiver services for which payment was recouped.	MCOP (Waiver service claims audit report)

4. Data and Reporting

a. HEDIS Data

i. *Annual Submission of HEDIS Interactive Data Storage System Data*

1. The MCOP must collect, report, and submit self-reported, audited HEDIS data to ODM (see *ODM Specifications for the Submission of MCOP Self-Reported, Audited HEDIS. Results* on ODM's website) for the full set of HEDIS measures reported by the MCOP to NCQA for all members. This includes all HEDIS measures listed in this appendix. The MCOP must submit its self-reported, audited HEDIS data to ODM as specified in Appendix P, Chart of Deliverables.

2. If the MCOP fails to submit its self-reported, audited HEDIS data as specified by ODM, the MCOP will be considered non-compliant with the standards for all the self-reported, audited HEDIS performance measures in *MyCare Ohio Quality Performance Measures, Standards and Measurement Periods* referenced in Tables I.1–I.5 of this appendix for the corresponding contract period.

ii. *Annual Submission of HEDIS Final Audit Report*

1. The MCOP must submit its HEDIS Final Audit Report that contains the audited results for the full set of HEDIS measures reported by the MCOP to NCQA for Ohio Medicaid only members to ODM (see ODM Specifications for the Submission of MCOP Self-Reported, Audited HEDIS Results on ODM's website). This includes all HEDIS measures listed in this appendix. The MCOP must submit its HEDIS Final Audit Report to ODM as specified in Appendix P, Chart of Deliverables.

2. If the MCOP fails to submit its Final Audit Report as specified by ODM, the MCOP will be considered non-compliant with the standards for all the self-reported, audited HEDIS performance measures in MyCare Ohio Quality Performance Measures, Standards, and Measurement Periods referenced in Tables I.1–I.5 of this appendix for the corresponding contract period.

3. ODM will review the MCOP's Final Audit Report 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 MCOP may be required to submit to ODM requested documentation to account for an NR audit designation. Based on its review of the MCOP's Final Audit Report and any NR audit designations assigned, ODM may impose corrective action (e.g., requiring the MCOP to implement a corrective action plan (CAP) to resolve data collection and/or reporting issues).

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

1. In accordance with 42 CFR 438.604 and 42 CFR 438.606 and ODM requirements, the MCOP must submit a signed data certification letter to ODM attesting to the accuracy and completeness of its audited HEDIS Interactive Data Storage System (IDSS) data and of its HEDIS Final Audit Report submitted to ODM.

2. As specified in Appendix P, Chart of Deliverables, the MCOP must submit these HEDIS IDSS data certification letters per the instructions and by the due dates provided in the *ODM Specifications for the Submission of MCOP Self-Reported, Audited HEDIS Results.*

3. In accordance with 42 CFR 438.606 and Appendix G, Program Integrity, each data certification letter must be signed by the MCOP's Chief Executive Officer (CEO), Chief Finance Officer (CFO), or an individual who reports directly to the MCOP's CEO or CFO with delegated authority to sign for the CEO or CFO so that the CEO or CFO is ultimately responsible for the certification.

b. CAHPS Data

i. *Annual CAHPS Survey Administration and Data Submission*

1. The MCOP must contract with an NCQA certified HEDIS survey vendor to administer an annual CAHPS survey to the MCOP's members, per the survey administration requirements outlined in the *ODM CAHPS Survey Administration and Data Submission Specifications* available on ODM's website. The CAHPS survey data must be submitted to NCQA, the AHRQ CAHPS database, and ODM's designee consistent with the data submission requirements in the *ODM CAHPS Survey Administration and Data Submission Specifications* and as specified in Appendix P, Chart of Deliverables.

2. If the MCOP fails to submit its CAHPS data, the MCOP will be considered non-compliant with the standards for all the CAHPS performance measures referenced in Table I. 1 of this appendix for the corresponding contract period.

ii. *CAHPS Data Submission*

1. In accordance with 42 CFR 438.604 and 42 CFR 438.606 and ODM requirements, the MCOP must submit to ODM three CAHPS data certification letters consistent with the instructions and by the due dates provided in the *ODM CAHPS Survey Administration and Data Submission Specifications.*

2. In accordance with 42 CFR 438.606 and Appendix G, Program Integrity, each data certification letter must be signed by the MCO's CEO, CFO, or an individual who reports directly to the MCO's CEO or CFO with delegated authority to sign for the CEO or CFO so that the CEO or CFO is ultimately responsible for the certification.

3. If the MCOP fails to submit its CAHPS certification letter to ODM as specified in CMS' Reporting Requirements for HEDIS, Health Outcomes Survey, and CAHPS measures,

the MCOP will be considered non-compliant with the standards for all of the CAHPS performance measures referenced in Table I.1 of this appendix.

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

i. *Timely Submission of Nursing Facility 100-Day Threshold and Discharge Data*

1. The MCOP must collect, report, and submit nursing facility 100-day threshold and discharge data as specified in the *MyCare Ohio Rules for Reporting the Institutional 100-Day Requirement* and in Appendix P. Individual member records must be submitted within 30 business days of the nursing facility level of care (100-day threshold) date and date of discharge, and in every case, nursing facility level of care (100-day threshold) dates must be submitted in accordance with timeframes specified by ODM.

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

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

5. Additional Operational Considerations

a. Measures and Measurement Years

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

b. Performance Standards – Compliance Determination

i. In the event the MCOP's performance cannot be evaluated for a performance measure and measurement year established in Tables I.1–I.8 of this appendix, ODM in its sole discretion will determine if the MCOP has met or not met the standard or standards for that particular measure and measurement year depending on the circumstances involved. For example, if ODM assigned a "Not Report" audit result on a HEDIS measure on the MCOP's Final Audit Report and the "Not Report" designation was determined to be the result of a material bias caused by the MCOP, ODM would deem the MCOP to have not met the standard or standards for that measure and measurement year.

c. Termination or Non-Renewal – Compliance Determination

i. If this Agreement is terminated or not renewed, ODM will determine MCOP compliance for the most recent measurement year prior to termination or non-renewal.

APPENDIX J – QUALITY WITHHOLD

1. Quality Withhold Program

a. ODM's Quality Withhold program will be conducted in accordance with 42 CFR 438.6(b)(3).

b. ODM will withhold a specified percentage for each applicable state fiscal year (SFY) for use in ODM's Quality Withhold program. The amount to be withheld for each measurement year will be 3%[6] of the capitation payments.

c. ODM will use the health improvement activities identified within each applicable SFY QW payout determination to calculate the amount of the Withhold payout.

   i. Health improvement activities will be comprised of multiple quality improvement (QI) projects related to ODM's Population Health Strategy.

   ii. Health improvement activities will measure the effectiveness of the MCOP's Population Health Management Strategy and QI program to impact population health outcomes.

d. ODM will assess the MCOP's performance annually for purposes of determining quality withhold payouts (e.g., ODM will issue one assessment and payment, if applicable, for each measurement period).

e. ODM will use the MCOP's Quality Withhold QI Template and other related documentation to evaluate MCOP performance related to the Quality Withhold program.

f. ODM will determine the quality withhold payout as specified in this appendix.

2. Quality Withhold Payout Determination

a. Quality Withhold Payout Determination

   i. For the purpose of determining the return of the quality withhold, ODM will use the performance of the MCOP's collective efforts to advance ODM's Population Health Strategy using the Model for Improvement.[7] This includes investing in assessing, designing, and building the necessary internal and external infrastructures for efficient collaborative QI work and developing collaborative partnerships with health systems and providers. The MCOP must assess the effectiveness of QI collaborations, determine changes needed to enhance care efficiency and accelerate improving health outcomes, and implement these changes (e.g., enhance funding for interventions, increase staffing with appropriate knowledge and skills, improve communications, streamline documentation of work completed, develop a collaboration-wide QI capacity development plan, etc.).

   ii. Quality Withhold determinations will be made for the dual benefit population based on the MCOP's performance on applicable QI projects. The dual benefit quality withhold

[6] Subject to ODM actuarial approval.
[7] Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers;2009.

determination (e.g., percentage of withhold to be returned) will be applied to the dual benefit quality withhold withheld amount.

b. Quality Improvement Projects

i. Through improved health care quality activities or other improvement activities, the MCOP must work collaboratively with other managed care entities and apply ODM-established QI processes to:

1. Improve outcomes for members with diabetes;

2. Improve member experience with and access to transportation services through the MCOP or MCOP-contracted transportation broker; and

3. Other topics for QI activities identified by ODM.

c. Performance Evaluation

i. ODM's performance evaluation of the MCOP will include the following:

1. The MCOP's Population Health Management and QI activities, which include:

a. An organizational structure and sufficient staffing that supports common data and QI processes to advance each collective team's interventions at an accelerated pace. For each QI activity, this includes having:

i. An engaged executive sponsor (i.e., the MCOP's Administrator/Chief Executive Officer);

ii. Active involvement of the MCOP's Medical Director/Chief Medical Officer;

iii. Participating staff with knowledge and experience using the Model for Improvement methods to ensure fidelity to the Model;

iv. Dedicated data collection and analytical staff who are experienced with interpreting data for learning; and

v. Sufficient staff necessary to meet intervention implementation needs (i.e., staff with the subject matter expertise necessary to quickly bring up new structures and processes as required for intervention testing, implementation, sustainability, and spread).

b. An updated Population Health Management Strategy as described in Appendix C, Population Health and Quality, which addresses the needs of the MCOP's members and the communities the members live in that is aligned with ODM priorities.

c. Adherence to the Model for Improvement, including:

i. Actively and continually assessing member and provider perspectives to inform intervention selection, design, and

modifications, paying particular attention to disparities and high-risk populations;

ii. Conducting active primary and secondary research to develop changes to the MCOP's normal processes (e.g., care coordination, vendor agreements, data tracking and analysis, coverage of services, and addressing health-related social needs) to better serve members experiencing disparities;

iii. Using QI tools (e.g., key driver diagrams, process mapping, failure mode and effects analysis, Plan-Do-Study-Act [PDSA] testing, and run charts) to depict the theory of change, rationale for chosen interventions, intervention testing, and intervention impact;

iv. Monitoring of interventions implementation, sustainability, and spread (e.g., measuring the effectiveness and degree of intervention impact, and adjusting or refining to increase effectiveness); and

v. Documenting intervention impact on the Specific, Measurable, Achievable, Relevant, and Time-Bound (SMART) Aim, using annotated run charts.

vi. Maintaining or surpassing performance for each Quality Withhold 2026 SMART Aim at the level achieved at the end of the quality withhold 2026 measurement period for 24 months after the measurement year.

2. *Collaboration*

   a. Evidence of the MCOP's collaboration with community entities, providers, and other stakeholders as appropriate for the SMART Aim topic; and

   b. Evidence of the MCOP's collaboration with other health plans as appropriate for collective impact.

3. *Results*

   a. Achieving a decrease in the gap between the baseline and the goal by shifting the median (i.e., eight consecutive points between the median and goal) in the desired direction for each SMART Aim or another method specified by ODM;

   b. Demonstrating that the interventions have broad impact on the targeted populations by providing data showing the number and percent of members affected as applicable; and

   c. Demonstrating a significant impact on disparate populations (e.g., members with geographic or racial disparities and members with a gap in access to and usage of information and communication technology [the digital divide population]), as applicable.

d. Measurement Period

i. The quality withhold measurement year shall align with the rate setting period, which is the calendar year.

e. Potential Payout

i. Methods to determine the quality withhold payout are described in ODM's Methodology to Determine the Quality Withhold Payout.

3. Additional Operational Considerations

a. Timing of Quality Withhold Program Determinations

i. ODM will issue results for each Quality Withhold program determination to the MCOP within 12 months of the end of each established report period.

ii. ODM reserves the right to revise the timeframe in which the Quality Withhold program determination is issued (i.e., the determination may be made more than 12 months after the end of the contract period).

b. Agreement Termination or Non-Renewal

i. Upon termination or non-renewal of this Agreement, the incentive or withhold amount will be retained or awarded by ODM in accordance with Appendix O, MCOP Termination and Non-Renewal.

c. Quality Withhold Measures, Requirements, and Measurement Years

i. ODM reserves the right to revise quality withhold measures, standards, benchmarks, requirements, and measurement years, as needed.

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

APPENDIX K – INFORMATION SYSTEMS, CLAIMS, AND DATA

1. Health Information System Requirements

a. Federal Requirements

i. As required by 42 CFR 438.242:

1. The MCOP must maintain a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas, including but not limited to utilization, grievances and appeals, and MCOP membership terminations for reasons other than loss of Medicaid eligibility.

2. The MCOP must comply with Section 6504(a) of the Affordable Care Act, which requires that state claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the state to meet the requirements of Section 1903(r)(1)(F) of the Social Security Act.

3. The MCOP must collect data on member and provider characteristics and on all services furnished to its members.

4. The MCOP must ensure data received from providers is accurate and complete by verifying the accuracy and timeliness of reported data, screening the data for completeness, logic, and consistency, and collecting service information in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies used for ODM's quality improvement (QI) and care coordination efforts.

5. The MCOP must make all collected data available upon request by ODM or the Centers for Medicare & Medicaid Services (CMS).

b. ODM Access to MCOP's Systems and Data

i. The MCOP must provide ODM with table level access (remote connectivity) to all data relevant to care provided to members, including but not limited to encounter, care management, and utilization management (UM) information. The MCOP must provide ODM the schematic, data dictionary, and other systems documentation necessary for ODM to interpret and use the data.

ii. The MCOP (including subcontractors) must provide ODM staff query access to real-time operational data and information relevant to members.

iii. The MCOP's system must have the ability to exchange files through secure file transfer protocol (SFTP) with other systems through the state's file transfer protocol (FTP)/SFTP service.

c. MCOP Access to ODM Systems and Data

i. The MCOP may be provided access to ODM systems and data only after following the processes established pursuant to Appendix A, General Requirements, Paragraph 3, Subparagraph f.

ii. ODM may establish a centralized point of access for all member and provider data. Both aggregate and member-level data may be accessible to all ODM-contracted managed care entities. This data may only be accessed, used, or disclosed to support collaborative work across ODM-contracted managed care entities for population health management and QI efforts.

iii. The MCOP's use or disclosure of data obtained from ODM is subject to compliance with state and federal law, and all required administrative, technical, and physical safeguards. See Appendix A, General Requirements, Paragraph 3.

d. Data and Systems Integration

i. The MCOP must have an integrated system that allows the different MCOP functions to work seamlessly within the MCOP.

ii. If the MCOP has separate claims processing systems for physical and behavioral health, the MCOP must have appropriate front-end routing logic to ensure the provider's claim is seamlessly routed to the correct claims system based upon the provider type, services, and diagnoses. If the MCOP receives claims containing both physical and behavioral health services, the MCOP must adjudicate both service types without requiring resubmission.

iii. The MCOP must collect data from all subcontractors relevant to care of its members and integrate that data into the MCOP's systems.

iv. The MCOP's system must capture and maintain all ODM-identified data necessary to support business functions.

v. The MCOP's system must integrate data with all Ohio Medicaid Enterprise System (OMES) modules (e.g., member module, provider module, and fiscal intermediary module), through the systems integrator in real-time and batch (based on data currency needs), to support Ohio Medicaid managed care program.

vi. The MCOP's system must integrate with Ohio's Identity and Access Management System, the Innovate Ohio Platform, to provide single sign on services for all authorized users identified by the MCOP or ODM.

vii. The MCOP's system must use role-based authorization and access to ensure minimal necessary access to data and screens.

viii. The MCOP must have the ability to submit, accept, and integrate all data transmission protocols necessary to support the MyCare Ohio program, including internal and external entities.

ix. The MCOP must comply with the population health information system and data requirements in Appendix C, Population Health and Quality.

x. The MCOP must comply with the care coordination information system and data requirements in Appendix D, Care Coordination.

e. General

i. If the MCOP has systems and information technology staff and operations supported at the enterprise-level, the MCOP must ensure that required information technology changes, fixes, and enhancements are prioritized and resolved in a manner that meets ODM's contractual and performance expectations.

ii. The MCOP must conduct thorough end-to-end testing for all new program implementations, system upgrades, software updates, and new or revised data requirements. The MCOP must provide a description of system changes and a summary of testing results, including any corresponding mitigation plans to ODM for review and approval prior to implementation.

iii. The MCOP's technical security standards must include permission and role-based access mechanisms to monitor for unauthorized access, two-factor authentication, virus protection software, up-to-date security patch installation, encryption protection at the operating system level, and virtual private networks (VPNs) for remote users.

iv. The MCOP's systems and user environment must comply with National Institute of Standards and Technology (NIST) 800-53 Rev. 5 (or current release) moderate baseline and Minimum Acceptable Risk Standards for Exchanges (MARS-e) 2.2 (or current release) or a similar standard that demonstrates comparable controls by mapping a crosswalk to NIST 800-53 and MARS-e.

v. The MCOP's application systems foundation must employ a relational data model in its architecture (RDBMS). The MCOP's application systems must support query access using Structure Query Language. The MCOP's application systems must support open database connectivity (ODBC) and/or object linking and embedding (OLE).

vi. The MCOP must implement updates to national standard code sets as of their effective date. The MCOP must implement any other ODM specified updates within 30 calendar days unless otherwise specified by ODM.

vii. The MCOP must comply with all relevant federal and state information technology standards, information security standards, and privacy standards.

2. Information Systems Review

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

b. The MCOP must support the needs of reviewers.

c. The review will assess the extent to which the MCOP is capable of maintaining a health information system, including producing valid encounter data, performance measures, and other data necessary

to support quality assessment and improvement, as well as managing the care delivered to its members.

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

   i. Review the Information Systems Capabilities Assessment (ISCA) forms, as developed by CMS, which the MCOP must complete;

   ii. Review the completed ISCA and accompanying documents;

   iii. Conduct interviews with MCOP staff responsible for completing the ISCA, as well as staff responsible for the MCOP's information systems;

   iv. Analyze the information obtained through the ISCA, conduct follow-up interviews with MCOP staff, and write a statement of findings about the MCOP's information system;

   v. Assess the ability of the MCOP to link data from multiple sources;

   vi. Examine MCOP processes for data transfers;

   vii. If the MCOP has a data warehouse, evaluate its structure and reporting capabilities;

   viii. Review MCOP processes, documentation, and data files to ensure they comply with state and federal specifications for encounter data submissions; and

   ix. Assess the claims adjudication process and capabilities of the MCOP.

3. Business Continuity and Disaster Recovery

a. The MCOP must develop and be continually ready to invoke a comprehensive business continuity and disaster recovery (BC-DR) plan that addresses operations, staff, and systems that support this Agreement.

b. The BC-DR plan must comply with NIST 800-34. https://nvlpubs.nist.gov/nistpubs/Legacy/SP/nistspecialpublication800-34r1.pdf

c. The MCOP's BC-DR plan, and any significant updates to the plan, must be submitted to ODM for review 60 calendar days prior to its effective date.

d. The MCOP must periodically, but not less than annually, test its BC-DR plan through simulated disasters and lower-level failures.

   i. As specified in Appendix P, Chart of Deliverables, the MCOP must provide a summary of its BC-DR test results (Summary of BC-DR Plan Test Results), including any corrective actions, to ODM.

4. Acceptance Testing

a. General

i. Before the MCOP may submit production files to ODM, the MCOP must conduct acceptance testing of any data electronically submitted to ODM as follows:

1. Whenever the MCOP changes the method, preparer, or file layout of the electronic data; and/or

2. When ODM determines that the MCOP's data submissions have an error or failure rate of 2% or higher.

b. New or Modified Information System

ii. The MCOP must include ODM in user acceptance testing and end-to-end integration testing when significant system changes are made that impact the user experience and/or end-to-end data flow. System changes include any of the following:

1. Existing system updates;

2. New system implementations (replacing system or component with another);

3. New infrastructure support systems (replacing an infrastructure component [e.g., SFTP or electronic data interchange (EDI) system]);

4. File format changes; and

5. File transmission protocol changes.

iii. User acceptance testing must include training if there is a perceivable change to workflows or user screens.

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

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

5. Claims Adjudication and Payment Processing Requirements

a. Timely Filing

i. The MCOP must accept claims for 365 calendar days from the date of service, as described in OAC rule 5160-1-19. In addition, the MCOP must follow the overpaid claims and timely filing exceptions described in the rule.

b. Claims Adjudication

i. The MCOP must integrate with the OMES for claims, third party liability (TPL), authorizations, and any other types of data or processes as directed by ODM.

ii. The MCOP must electronically accept claims from the OMES and adjudicate all claims to final status (payment or denial) within the timeframes specified in Appendix L, Payment and Financial Performance. The diagram in Exhibit K.1 (below)provides a high-level overview of the claims flow.

iii. All claims forwarded from the OMES to the MCOP for processing are to be considered clean as these claims meet the threshold edits applied at the submission of the claim through the EDI and meet the X12/TR3 standard. If the claim forwarded from the OMES to the MCOP does not have the necessary documentation to adjudicate the claim, the MCOP may suspend the claim until documentation is provided. If system changes are required to properly adjudicate claims, the MCOP must notify ODM of the intent to suspend claims for programmatic and/or systems concerns via their compliance mailbox and follow the Claims Payment Systemic Errors requirements to report any potential impact to providers as outlined in this appendix.

iv. If there is information on the provider network management (PNM) system generated provider master file (PMF) or any other supplemental file generated by an ODM system to support claims payment, the MCOP must use the PMF or other ODM system generated supplemental file information to adjudicate the claim(s).

v. The MCOP must utilize the ODM PNM as the system of record and reconcile claims against the ODM PNM PMF data points as directed by ODM.

vi. The MCOP must provide updated claim status demonstrating all claims activity daily to ODM.

vii. The MCOP must provide its network providers detailed instructions on claims submission procedures, including information provided by ODM about the role of ODM's OMES.

viii. The MCOP must provide out-of-network providers detailed instructions on claims submission procedures, including information provided by ODM about the role of ODM's OMES, within one business day of the earlier of receiving a request from an out-of-network provider or becoming aware that an out-of-network provider has rendered services to a member.

ix. The MCOP must notify providers via ODM's OMES, who have submitted claims of claim status (paid, denied, and all claims not in a final paid or denied adjudicated status [hereinafter referred to as "suspended"]) within 30 calendar days of receipt by the MCOP or its designee. Such notification may be in the form of a claim payment/remittance advice produced on a routine monthly or more frequent basis.

x. If a provider and/or a provider's clearinghouse submits a Health Insurance Portability and Accountability Act (HIPAA) compliant 276 EDI transaction to the MCOP and/or the MCOP's clearinghouse via ODM's OMES, the MCOP/clearinghouse must respond with a complete HIPAA compliant 277 EDI transaction within the required Council for Affordable Quality Healthcare, Inc. (CAQH) Committee on Operating Rules for Information Exchange (CORE) timeframes with the HIPAA compliant claim status category code(s) and claim status code(s) that will provide information on all denied, paid, or suspended claims to the submitter.

xi. The MCOP must accept and use, and must require its providers to use, TPL data maintained by ODM's OMES for the MCOP's and provider's TPL activities.

c. Coordination of Benefits Agreement

i. In compliance with 42 CFR 438.3(t), the MCOP must maintain and update their Coordination of Benefits Agreement (COBA) Attachment to the ODM COBA Agreement with CMS' Benefits Coordination and Recovery Center (BCRC). The MCOP must provide ODM with a COBA communication contact to coordinate communication and attend meetings with the BCRC and ODM. The MCOP must also provide ODM with a technical contact to answer questions about the file transfer process and attend technical meetings as required to successfully test and administer the COBA process. Technical and communication contacts must attend a monthly conference call hosted by the BCRC.

ii. The MCOP must initiate file testing with the BCRC upon request from ODM and/or the BCRC. The MCOP must inform ODM in writing upon successful conclusion of testing and readiness for production.

iii. The MCOP must submit production files on the same schedule as ODM, in accordance with the file specifications issued by the BCRC, and must include all enrollment spans added or deleted on the MCOP's 834 C and F files.

iv. The MCOP must submit a status report (COBA Production Status Report) to ODM documenting production file status and any issues affecting testing and/or production. Production status reports must contain an attestation that the file submissions to the BCRC were accurate, complete, and timely; the information submission and receipt of data were made in accordance with 45 CFR 164.502 and 45 CFR 164.504(e); and all protected health information (PHI) was safeguarded appropriately. If there was a problem with any production file, the status report must document the reason for the error

d. Edits

i. The MCOP must implement claims edits (e.g., Strategic National Implementation Process [SNIP] and National Correct Coding Initiative [NCCI]) at the direction of ODM.

e. Grouping Methodology

i. When the MCOP uses a grouping methodology to pay Medicaid inpatient and/or outpatient hospital claims, or Medicaid ambulatory surgery center claims, the MCOP is expected to use the same grouper software and inpatient only procedure listing (determined by Medicare, 3M, or other grouping product) that ODM uses to process fee-for-service (FFS) claims.

f. Electronic Visit Verification

i. The MCOP must use, and must require its network providers to use, ODM's electronic visit verification (EVV) system, or an alternative EVV system that has been certified by ODM's EVV vendor, for the following services, or as otherwise specified by ODM: State Plan Home Health Aide — G0156, State Plan Home Health Nursing Registered Nurse (RN) — G0299, State Plan Home Health Nursing Licensed Practical Nurse (LPN) G0300, Private Duty Nurse (PDN)/Independent Nursing — T1000, RN Assessment — T1001, Home Health (HH) Physical

Therapy — G0151, HH Occupational Therapy — G0152, HH Speech Language Pathology — G0153, Waiver Nursing RN — T1002, Waiver Nursing LPN — T1003, Waiver Personal Care Aide — T1019, and Waiver Home Care Attendant — S5125.

ii. The MCOP must use data collected from the EVV data collection system to validate all claims against EVV data (100% review) during the claim adjudication process. The MCOP must inform providers of the outcome of the claim validation review for each claim line.

iii. The MCOP must have the ability to post alerts for edits and update to deny at the direction of ODM. In the instance of EVV edits, the MCOP must be able to post Remittance Advice Remark Code (RARC) N363 defined as "Alert: in the near future we are implementing new policies/procedures that would affect this determination" on a claim that does not have an EVV visit match and update to deny these claims at the direction of ODM. The N363 will be reported on the 835 transaction and on the encounter.

iv. The MCOP claim adjudication system must be flexible to allow the ability of modifying or denying payment, as directed by ODM, for EVV claim lines during validation.

v. The MCOP must inform providers of the use of the EVV data collection system and how the data will be utilized by the MCOP.

vi. The MCOP must also provide education about EVV, using ODM-provided resources to members receiving services, direct care workers, and providers.

vii. Upon request, the MCOP must submit a monthly report of all EVV-related claim lines to ODM in a format specified by ODM. The MCOP must review the monthly visit report provided by ODM to identify trends, provide outreach and education to providers, and identify potential fraud, waste, or abuse. The MCOP must report fraud, waste, and abuse to ODM in accordance with Appendix G, Program Integrity.

viii. The MCOP must work collaboratively with the EVV vendor to establish connectivity, to conduct system testing, and to adhere to technical specifications until all scenarios are passed and the system is production ready. The MCOP must also collaborate with the EVV vendor to implement any system updates or changes, as necessary.

g. Systems Audit

i. The MCOP and any subcontractor systems must undergo an annual third party audit that confirms that the MCOP's systems and environment comply with the NIST 800-53 Rev. 5 (or current release) moderate baseline.

ii. The MCOP and any subcontractor systems must also utilize a third party to determine compliance with MARS-e 2.2 (or current release) standards.

iii. If the MCOP or any subcontractor systems utilizes a cloud hosting provider, the cloud provider must be Federal Risk and Authorization Management Program (FedRAMP) certified or undergo an annual third party audit that certifies compliance with NIST 800-53 Rev. 5 (or current version) moderate baseline.

iv. The MCOP, and any subcontractors that adjudicate claims, must undergo a System and Organizational Control (SOC) 2 Type II or an alternative privacy and security systems audit

that is prior approved by ODM. This audit must be completed prior to implementation and at least annually thereafter.

v. As specified in Appendix P, Chart of Deliverables, the MCOP must submit the results of the systems audit (*Systems Audit Results*), including any corrective action, to ODM.

h. Claims Payment Systemic Errors

i. For the purpose of this appendix, a claims payment systemic error (CPSE) is defined as the MCOP's claims adjudication incorrectly underpaying, overpaying, denying, or suspending claims that impact five or more providers.

ii. The MCOP must submit the MCOP's CPSE report (CPSE Report) to ODM as specified in Appendix P, Chart of Deliverables.

iii. The MCOP must submit all communications regarding CPSEs to MedicaidCPSE@medicaid.ohio.gov, unless otherwise directed by ODM.

iv. The MCOP must follow all CPSE instructions as directed by ODM, including the CPSE reporting template instructions and guidelines.

v. The MCOP must report systemic errors to ODM within two business days of adjudication or identification, whichever is earlier. The MCOP must update the status of all active CPSEs on a monthly basis. The MCOP must report the identified errors at the provider type level, such that each element below is detailed for the impact on each provider type. The MCOP must ensure each identified error has a unique error identification (ID) to tie each reported line to a specific error the MCOP is addressing. For each error, the MCOP must provide a specified begin date, and when resolved, a definitive end date. For each provider type impacted, the following information is required on a monthly basis:

1. A detailed description and scope of all active CPSEs;
2. The date the CPSE was first identified;
3. The type or types of all providers impacted;
4. The number of providers impacted;
5. The date(s) and method(s) of all provider notification;
6. Estimated resolution date;
7. The timeline for fixing the CPSE;
8. The number of claims impacted; and
9. The date(s) or date span(s) for all claim adjustment projects or notifications of claim overpayments, if applicable.

vi. The MCOP must report all CPSEs on a monthly CPSE report posted on the MCOP's Ohio Medicaid website.

1. The CPSE report must be public facing for anyone to view and/or on the MCOP's provider portal. If the provider portal is used, timely communication of the CPSE must also be made to those impacted providers that are unable to access the CPSE report.

2. The MCOP must update the CPSE report at a minimum once a month and must label the report to reflect the updated date.

3. The MCOP's CPSE public report must include, at a minimum, the following information:

    a. A detailed description and scope of all CPSEs;

    b. The date of first identification;

    c. The type(s) of provider(s) impacted;

    d. The timeline for fixing the CPSE; and

    e. The date of claims adjustments or required provider action.

vii. The MCOP must have policies and procedures to identify, communicate, and correct CPSEs. The MCOP must keep its CPSE policies and procedures current to reflect the CPSE requirements. Upon request, the MCOP must submit its CPSE policies and procedures to ODM for review.

viii. The MCOP's CPSE policies and procedures must include, at a minimum:

1. The use of input from internal and/or external sources to identify a CPSE, including but not limited to:

    a. User acceptance testing activities;

    b. Claims processing activities;

    c. Provider complaints/inquiries; and

    d. ODM inquiries.

2. The identification of issues impacting smaller provider types (e.g., independent providers);

3. A description of the process, including timelines, to escalate from initial identification to definition of the error;

4. A full description of the root cause analysis conducted when issues or defects are found, and the software development life cycle (SDLC) processes followed, including timelines;

5. The timeframe to re-adjudicate claims, if applicable, or notify providers of an overpayment and the process for providers to dispute those actions in accordance with the requirements of this Agreement;

6. A description of the process to complete and submit a completed CPSE report monthly to ODM; and

7. A communication process, including timelines, to timely notify providers of identified CPSEs, as directed above, including any other appropriate methods such as phone calls, emails, etc.

i. Non-CPSE Errors

i. The MCOP must correct errors in provider payments that do not meet the definition of claims payment systematic errors per this appendix within 30 calendar days from the date of identification of the error.

j. Software Updates

i. The MCOP's claims adjudication systems must apply software updates based on a validated risk analysis and no less frequently than quarterly. The MCOP must implement major software version releases based on a validated risk analysis and not more than 180 calendar days from release date. If the MCOP maintains its own software, the schedule and description of changes for future updates must be provided to ODM for review.

k. Implementing ODM Rate Changes

i. The MCOP must load ODM rate changes into applicable systems by either the rate change implementation date or within 20 calendar days of being notified by ODM of the change, whichever date is later. The effective date of the rate change must be the date specified by ODM, regardless of when the MCOP's system(s) are updated. If necessary, the MCOP must back date the effective date and reprocess claims to ensure any claim received after the specified date of the rate change is adjudicated accurately. If the MCOP is unable to load rate changes timely, the MCOP must report the issue on the CPSE report. Reporting the inability to load rate changes timely on the CPSE report does not negate the MCOP’s failure to comply with the requirement to load rate changes on a timely basis.

l. Processing Delays

i. The MCOP must not engage in any practice that unfairly or unnecessarily delays the processing or payment of any claim for services to a member.

m. Notice to Providers

i. The MCOP must provide a 30 calendar day advance notice to providers of any new edits or system changes related to claims adjudication or payments processing.

ii. The MCOP must provide a notice of intent to recover an overpayment in accordance with Appendix G, Program Integrity.

6. Electronic Data Interchange

a. The MCOP's technology strategy and systems must have the capability to accept and transmit real-time transactions as directed by ODM.

b. The MCOP must comply with all applicable provisions of HIPAA, including EDI standards for code sets, and must be able to process the following electronic transactions consistent with EDI processing specifications in the transaction implementation guides and in conformance with the Companion Guides issued by ODM:

i. ASC X12 837 — Health care claims (institutional, professional, and dental);

ii. ASC X12 837/PACDR Post-adjudicated claims data reporting — Health care claims (institutional, professional, and dental);

iii. ASC X12 277 — Data reporting acknowledgement (DRA);

iv. TA1 — Interchange/Transmission acknowledgement;

v. ASC X12 999 — Implementation/File acknowledgement;

vi. ASC X12 270/271 — Eligibility and benefit verification and response;

vii. ASC X12 276/277 — Health care claim status request and response;

viii. ASC X12 277CA — Claim acknowledgement;

ix. ASC X12 274 — Health care provider information/directory (implementation date to be determined; however, when ODM adopts this transaction, the MCOP must also adopt it);

x. ASC X12 275 — Claim attachment;

xi. NCPDP — Claim adjudication request and response (B1);

xii. NCPDP — Claim reversal/void request and response (B2);

xiii. NCPDP — Claim rebill/resubmission request and response (B3);

xiv. NCPDP — Eligibility verification request and response (E1); and

xv. NCPDP — Pre-determination of benefits verification and response (D1).

xvi. ASC X12 820 — Payroll deducted and other group premium payment for insurance products;

xvii. ASC X12 824 — Application advice;

xviii. ASC X12 834 — Benefit enrollment and maintenance; and

xix. ASC X12 835 — Health care payment and remittance status (or electronic funds transfer).

c. The MCOP must implement EDI transactions in conformance with the appropriate version of the transaction implementation guide, as specified by applicable federal requirements.

d. The MCOP must be able to accept, send, and process multiple versions of X12 transactions concurrently.

e. The MCOP must comply with the HIPAA-mandated EDI transaction standards and code sets as set forth in federal requirements. The MCOP must keep codes up to date and meet all implementation dates as directed by ODM.

f. The MCOP is not required to use the ASC X12 278 (Authorization/referral request and response) for service authorizations. However, the MCOP must develop and maintain an ODM-approved electronic process to support service authorization request and response. See Section 11 of this Appendix, Interoperability.

g. The capacity of the MCOP and/or applicable trading partners and business associates to electronically conduct claims processing and related transactions must be demonstrated to the satisfaction of ODM.

h. The MCOP must complete and submit to ODM an EDI trading partner agreement by the timeframe and in a format specified by ODM.

i. If the MCOP fails to identify an error on its behalf with EDI transactions within two business days and/or correct it within three months, it may be liable for the cost incurred by ODM for additional transaction fees if it must correct and retransmit EDI transactions due to the error at any time thereafter.

j. The MCOP must connect a production mirror to the EDI CERT Region by January 1, 2026. If the MCOP is new to Ohio Medicaid, it must connect a production mirror to the EDI CERT Region within six months of the start date of this Agreement. The EDI CERT Region will be used to add new trading partners and to allow trading partners to test in accordance with OAC rule 5160-1-20 requirements before they are authorized for production (PROD). The MCOP must collaborate with ODM for adequate testing and validation for new transactions, policy changes, and other changes before running in PROD.

7. Encounter Data Submission Requirements

a. The MCOP must collect data on services furnished to members through a claims system and must report encounter data to ODM. For dual benefit members, the data must include both Medicare and Medicaid services. The MCOP must submit encounter electronically to ODM as specified in this appendix.

b. Information concerning the proper submission of EDI encounter transactions is available on ODM's website. ODM's website contains Encounter Data Companion Guides for the Managed Care 837 dental, professional, and institutional transactions and the current National Council for Prescription Drug Programs (NCPDP) D.0 pharmacy transactions. Additional Companion Guides for transactions that should be used in conjunction with encounters, including the 277CA Claim Acknowledgement, the 824 Application Advice, and the TA1 Transmission Acknowledgement are also available on

ODM's website. The MCOP must use the Encounter Data Companion Guides in conjunction with the X12 Implementation Guides for EDI transactions.

c. The MCOP must submit a test file in the ODM-specified medium in the required formats as directed by ODM. Test files must be submitted, reviewed, and approved by ODM prior to the MCOP submitting PROD encounter data files.

d. For subcontracted payment arrangements in which the subcontractor directly pays particular claims (i.e., delegated arrangements in which the delegate is responsible for paying claims on behalf of the MCOP to providers), the MCOP must submit encounters that include the amounts paid by the subcontractor to the provider and include claim-level detailed information.

e. For subcapitated payment arrangements (i.e., the vendor/provider is paid a fixed amount regardless of whether or what services are rendered), the MCOP must shadow price the encounter and submit encounters that include the amount that would have been paid if the vendor/provider was not capitated and include claim-level detailed information.

f. The MCOP must submit encounters no later than seven calendar days from completion of the claim (i.e., remittance advice generated). The MCOP must submit encounters for capitated providers within seven calendar days of receipt of the encounter.

g. As specified in Appendix G, Program Integrity, in accordance with 42 CFR 438.604 and 42 CFR 438.606, the MCOP must submit a certification letter with the submission of an encounter data file.

h. The MCOP must submit valid encounter submissions that include the application of specific edits, including checking for member eligibility, MCOP enrollment, valid current procedural terminology (CPT) codes, cross field editing, and include valid line-level detail with meaningful claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) accurately reflecting the data submitted to the provider indicating final status of adjudication. ODM reserves the right to direct the MCOP's editing and payment.

i. The MCOP must submit valid claim and line-level denials that reflect the data submitted on the claim and accurately reflect the adjudication results.

j. The MCOP must submit encounters for all claim activities, including instances when the MCOP applies adjustments at the individual line level or in a mass adjustment update. Encounter submissions must reflect all claims activity.

k. The MCOP must have software edits that check for and prevent duplicates on encounter data submissions.

l. The MCOP must follow the 837 Post-Adjudicated Claims Data Reporting (PACDR) standards for dental, professional, and institutional encounter data submissions, including allowed amount and paid amount in accordance with 42 CFR 438.242(c)(3).

m. The MCOP must have processes and staffing to ensure that if ODM discovers errors or a conflict with a previously adjudicated encounter or claim, the MCOP is able to adjust or void the encounter within the specified number of days as directed by ODM.

n. The MCOP must comply with the encounter data quality measures as calculated by ODM. Information concerning ODM's encounter data quality measures, including the methodology, is

available in the Methodology for MyCare Ohio Encounter Data Quality Measures document located on the ODM website. ODM reserves the right to revise this document as needed.

o. Exceptions to any of the requirements in this section must be prior approved by ODM.

8. Non-Claims Data Submission Requirements

a. All data on any services provided to members that are not reflected as claims or encounters will be submitted through the MyCare Ohio Value- Added Services Reporting Template. This includes but is not limited to care coordination, non-emergency transportation, Medicare supplemental benefits, and other value-added or additional services.

b. The MCOP must collaborate with the state's OMES systems integrator for the integration of the MCOP's non-claims related information. The OMES has the capability to accept the following file and transmission protocol types:

i. EDI via web services or batch file transmissions or FTP;

ii. Large or batch files using SFTP; and

iii. Web services utilizing industry standard technologies or large file batches over SFTP directly to the systems integrator.

9. Electronic Health Records

a. The MCOP must encourage, support, and facilitate its network providers' adoption and effective use of electronic health records (EHRs), including for population health and quality improvement.

b. The MCOP must identify which network providers have or have not adopted EHRs and how effectively they use EHRs, including for population health and quality improvement.

c. As specified in Appendix P, Chart of Deliverables, the MCOP must submit a report (Network Provider EHR Adoption Report) to ODM summarizing the number and percentage of network providers, by provider type, that have adopted EHRs and how effectively they use EHRs, and the MCOP's activities to support provider adoption and effective use of EHRs.

10. Health Information Exchange

a. The MCOP must participate with Ohio's health information exchange (HIE) and be capable of exchanging PHI, connecting to inpatient and ambulatory EHRs, connecting to care coordination information technology system records, and supporting secure messaging or electronic querying between providers, patients, and the MCOP. This must include but is not limited to using the HIE for admission, discharge, and transfer (ADT) data and closing referral loops for social determinants of health (SDOH).

b. The MCOP must support and facilitate its network providers' exchange of data with Ohio's HIE.

c. The MCOP must require its network hospitals to provide admission, discharge, and transfer (ADT) data to Ohio's HIE.

d. As specified in Appendix P, Chart of Deliverables, the MCOP must submit a report (Network Provider HIE Participation Report) to ODM providing the number and percentage of network providers, by provider type, connected to Ohio's HIE and the type of participation.

e. As specified in Appendix P, Chart of Deliverables, the MCOP must submit to ODM a plan to support use of Ohio's HIE (HIE Provider Support Plan), including, but not limited to, collaborative MCOP efforts that facilitate and support consistent and accurate data submission from health care providers to the HIE.

11. Interoperability

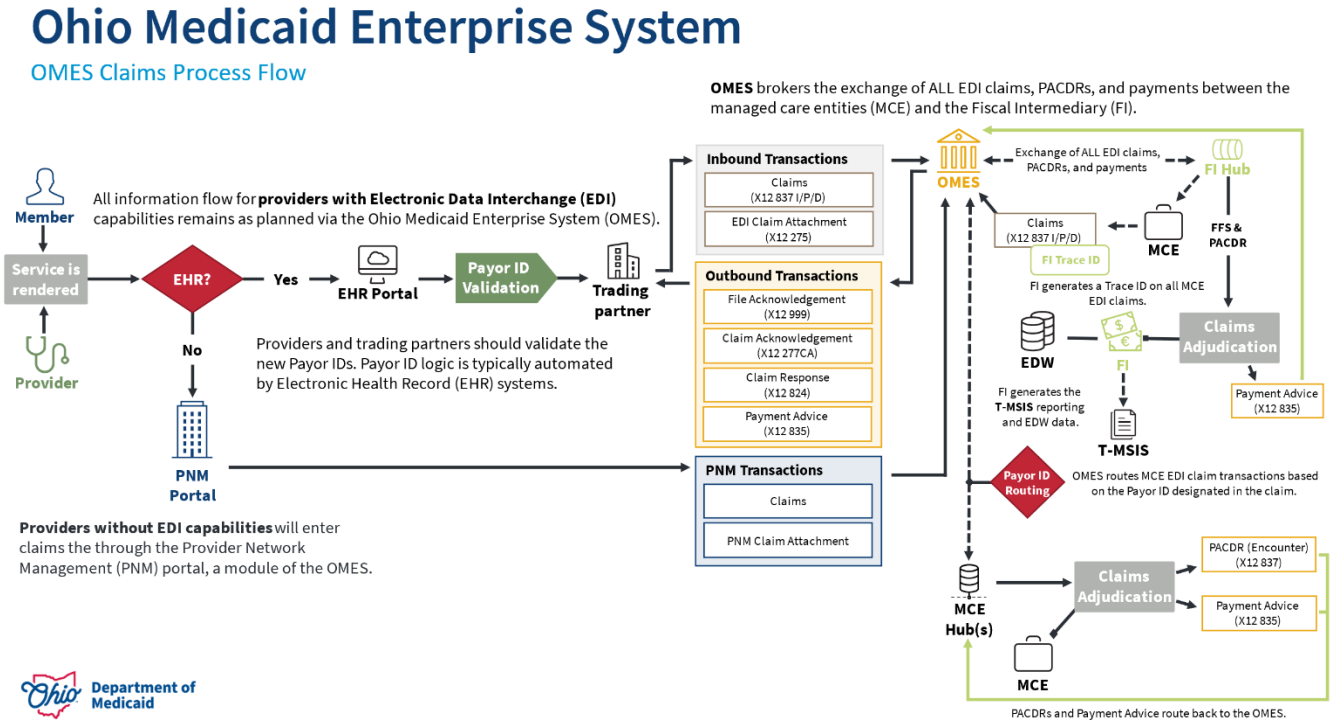
a. In accordance with 42 CFR 438.242, the MCOP must implement and maintain a patient access application programming interface (API) that permits third party applications to retrieve, with the approval and at the direction of a member, member health information and data maintained by the MCOP.

b. In accordance with 42 CFR 438.242, the MCOP must implement and maintain a payer-to-payer API for the electronic exchange of the United States core data for interoperability (USCDI) data classes and elements and other specified data with other MCOPs, the OhioRISE Plan, ODM, and any other payer designated by the member.

c. In accordance with 42 CFR 438.242, the MCOP must implement and maintain a prior authorization API for the electronic exchange of prior authorizations.

d. In accordance with 42 CFR 438.242, the MCOP must implement and maintain a provider access API for the electronic exchange of the USCDI data classes and elements and other specified data with providers serving the member and with community organizations providing care coordination to the member.

Exhibit K.1 Claims High-Level Message Flow



APPENDIX L – PAYMENT AND FINANCIAL PERFORMANCE

1. Monthly Premium Payment

a. ODM will remit payment to the MCOP via an electronic funds transfer (EFT), or at the discretion of ODM, by paper warrant.

b. ODM will confirm all premium payments paid to the MCOP during the month via a monthly remittance advice.

c. ODM will provide a record of each recipient detail level payment via Health Insurance Portability and Accountability Act (HIPAA) compliant 820 transactions.

2. Institution for Mental Disease Stays

a. If a member age 21 through 64 has an Institution for Mental Disease (IMD) stay exceeding 15 calendar days per calendar month, ODM will recover a percentage of the MCOP's monthly capitation payment based on the total number of calendar days the member was in the IMD.

3. Submission of Financial Statements

a. National Association of Insurance Commissioners Financial Statements

i. As specified in Appendix P, Chart of Deliverables, the MCOP must submit quarterly and annual National Association of Insurance Commissioners (NAIC) financial statements (NAIC Quarterly Financial Statement and NAIC Annual Financial Statement) to ODM.

ii. The NAIC financial statements must include all required filings, schedules, exhibits, and components as stated in the NAIC health statement instructions.

iii. The MCOP must provide ODM with an electronic copy of the NAIC statements in the NAIC-approved format.

iv. The MCOP must submit NAIC financial statements to ODM even if the Ohio Department of Insurance (ODI) does not require the MCOP to submit these statements to ODI.

b. Annual Audit Report

i. As specified in Appendix P, Chart of Deliverables, the MCOP must submit a copy of its annual audit report (Annual Audit Report) required by ODI in accordance with ORC section 1751.321.

c. NAIC/Cost Report Reconciliation

i. As specified in Appendix P, Chart of Deliverables, the MCOP must submit an annual NAIC/Cost Report Reconciliation.

d. Health Insuring Corporation Tax

i. As specified in Appendix P, Chart of Deliverables, the MCOP must submit Health Insuring Corporation (HIC) tax reports (HIC Tax Report) to ODM.

e. Other Financial Reports and Information

i. The MCOP must submit to ODM a copy of all Medicare financial data and reports submitted to CMS, including but not limited to the MCOP's Medicare bid package and medical loss ratio (MLR) report.

ii. The MCOP must maintain a system to evaluate and monitor the financial viability of all risk bearing subcontractors, first tier, downstream, and related entities (FDRs), or network providers, including but not limited to accountable care organizations (ACOs), health maintenance organizations (HMOs), independent physician/provider associations (IPAs), medical groups, and federally qualified health centers (FQHCs).

iii. The MCOP must provide any financial reports and information as deemed necessary by ODM, in a format determined by ODM, to properly monitor the financial condition of the MCOP, its subcontractors, FDRs, and network providers.

4. Financial Performance Measures and Standards

a. The MCOP must comply with the following financial performance measures and standards.

i. *Current Ratio*

1. The MCOP's current ratio, calculated in accordance with the *ODM Methods for Financial Performance Measures*, must not fall below 1.00.

ii. *Medical Loss Ratio*

1. As specified in Appendix P, Chart of Deliverables, the MCOP must submit a medical loss ratio (MLR) reporting tool and documentation (MLR Reporting Tool and Documentation).

2. The MCOP's MLR, calculated in accordance with 42 CFR 438.8 and ODM directives, must not fall below 86%.

iii. *Administrative Expense Ratio*

1. The MCOP's administrative expense ratio, calculated in accordance with the *ODM Methods for Financial Performance Measures*, must not exceed 15%.

iv. *Defensive Interval*

1. The MCOP's defensive interval, calculated in accordance with the *ODM Methods for Financial Performance Measures*, must not fall below 30 calendar days.

5. Insurance Requirements

a. General

i. The MCOP must procure and maintain, for the duration of this Agreement, insurance against claims for injuries to persons or damages to property that may arise from or in connection with the MCOP's performance under this Agreement.

ii. The MCOP must procure and maintain, for the duration of this Agreement, insurance for claims arising out of its performance under this Agreement, including but not limited to loss, damage, theft, or other misuse of data, infringement of intellectual property, invasion of privacy, and breach of data.

b. Minimum Scope and Limit of Insurance

i. The MCOP's coverage must be at least as broad as:

1. Commercial General Liability (CGL): written on an "occurrence" basis, including products, completed operations, property damage, bodily injury, and personal and advertising injury with limits no less than $1,000,000 per occurrence. If a general aggregate limit applies, either the general aggregate limit must apply separately to this Agreement or the general aggregate limit must be twice the required occurrence limit. Defense costs must be outside the policy limit.

2. Automobile Liability: covering Code 1 (any auto), or if the MCOP has no owned autos, Code 8 (hired) and 9 (non-owned), with a limit no less than $1,000,000 per accident for bodily injury and property damage.

3. Workers' Compensation insurance: as required by the state of Ohio, or the state in which the work will be performed, that meets statutory limits, and employer's liability insurance with a limit of no less than $1,000,000 per accident for bodily injury or disease. If the MCOP is a sole proprietor, partnership, or has no statutory requirement for workers' compensation, the MCOP must provide a letter stating that it is exempt and agreeing to hold the state of Ohio harmless from loss or liability for such.

4. Professional Liability insurance: covering all staff with a minimum limit of $1,000,000 per incident and a minimum aggregate of $3,000,000. If the MCOP's policy is written on a "claims made" basis, the MCOP must provide ODM with proof of continuous coverage at the time the policy is renewed. If for any reason the policy expires, or coverage is terminated, the MCOP must purchase and maintain "tail" coverage through the applicable statute of limitations.

5. Technology Professional Liability (Errors and Omissions) insurance: appropriate to the MCOP's professional services provided under this Agreement, with limits not less than $2,000,000 per occurrence or claim, $2,000,000 aggregate. Coverage must be sufficiently broad to respond to the duties and obligations as is undertaken by the MCOP in this Agreement and must cover all applicable MCOP personnel who perform professional services under this Agreement.

6. Cyber Liability (first and third party): coverage, with limits not less than $5,000,000 per claim, $10,000,000 aggregate, must be sufficiently broad to respond to the duties and obligations as is undertaken by the MCOP in this Agreement and must include but not be limited to claims involving infringement of intellectual property, including but not limited to infringement of copyright, trademark, trade dress, invasion of privacy violations, information theft, damage to or destruction of electronic information, release of private information, alteration of electronic

information, extortion, and network security. The coverage must provide for breach response costs, as well as regulatory fines and penalties and credit monitoring expenses, with limits sufficient to respond to these obligations.

ii. The insurance obligations under this Agreement are the minimum insurance coverage requirements and/or limits for this Agreement. Any insurance proceeds, in excess of or broader than the minimum required coverage and/or minimum required limits, which are applicable to a given loss, must be available to ODM.

iii. No representation is made that the minimum insurance requirements of this Agreement are sufficient to cover the obligations of the MCOP under this Agreement.

c. Required Provisions

i. The MCOP's insurance policies must contain, or be endorsed to contain, the following provisions:

1. *Additional Insured Status*

a. Except for Workers' Compensation and Professional Liability insurance, the state of Ohio, its officers, officials, and employees must be covered as additional insureds with respect to liability arising out of work or operations performed by or on behalf of the MCOP under this Agreement, including materials, parts, or equipment furnished in connection with such work or operations.

b. Coverage can be provided in the form of an endorsement to the MCOP's insurance.

2. *Primary Coverage*

a. For any claims related to this Agreement, the MCOP's insurance coverage must be primary insurance. Any insurance or self-insurance maintained by the state of Ohio, its officers, officials, and employees must be in excess of the MCOP's insurance and must not contribute with it.

3. *Umbrella or Excess Insurance Policies*

a. The MCOP may use umbrella or excess commercial liability policies in combination with primary policies to satisfy the limit requirements above. Such umbrella or excess commercial liability policies must apply without any gaps in the limits of coverage and be at least as broad as and follow the form of the underlying primary coverage required above.

d. Notice of Cancellation

i. The MCOP must provide ODM with a written notice of cancellation or material change to any insurance policy required above 30 calendar days in advance, except for non-payment cancellation.

ii. Material change is defined as any change to the insurance limits, terms, or conditions that would limit or alter ODM's available recovery under any of the policies required above.

iii. A lapse in any required insurance coverage during this Agreement will be a breach of this Agreement.

e. Waiver of Subrogation

i. The MCOP must grant to the state of Ohio a waiver of any right to subrogation which any insurer of the MCOP may acquire against the state of Ohio by virtue of the payment of any loss under such insurance.

ii. The MCOP must obtain any endorsement necessary to affect this waiver of subrogation; however, the waiver of subrogation provision applies regardless of whether the state of Ohio has received a waiver of subrogation endorsement from the insurer.

f. Deductibles and Self-Insured Retentions

i. Deductibles and self-insured retentions must be declared to and approved by ODM. ODM may require the MCOP to provide proof of ability to pay losses and related investigations, claims administration, and defense expenses within the retention. The policy language must provide, or be endorsed to provide, that the deductible or self-insured retention may be satisfied by either the named insured or ODM.

g. Claims Made Policies

i. If any of the required policies provide coverage on a claims-made basis:

1. The retroactive date must be shown and must be before the date of this Agreement or the beginning of performance under this Agreement.

2. Insurance must be maintained, and evidence of insurance must be provided for at least five years after completion of this Agreement.

3. If coverage is canceled or non-renewed, and not replaced with another claims-made policy form with a retroactive date prior to effective date of this Agreement, the MCOP must purchase "extended reporting'' coverage for a minimum of five years after completion of performance under this Agreement. The discovery period must be active during the extended reporting period.

h. Verification of Coverage

i. The MCOP must furnish ODM with original certificates and amendatory endorsements or copies of the applicable policy language effecting coverage required by this section.

ii. All certificates and endorsements must be received and approved by ODM before work commences under this Agreement. However, failure to obtain the required documents prior to the work beginning will not waive the MCOP's obligation to provide them.

iii. ODM reserves the right to require complete, certified copies of all required insurance policies, including endorsements required by this section, at any time.

i. Subcontractors

i. The MCOP must require and verify that all subcontractors maintain insurance meeting all the requirements stated herein, and the MCOP must ensure that ODM is an additional insured on insurance required from subcontractors.

j. Special Risks or Circumstances

i. ODM reserves the right to modify these requirements, including limits, based on the nature of the risk, prior experience, insurer, coverage, or other special circumstances.

6. Reinsurance Requirements

a. General

i. The MCOP must carry reinsurance coverage from a licensed commercial carrier to protect against catastrophic inpatient-related medical expenses incurred by members.

ii. To the extent that the risk for inpatient-related medical expenses is transferred to a subcontractor, the MCOP must provide proof of reinsurance coverage for that subcontractor or FDR.

iii. The MCOP's reinsurance coverage must remain in force during the term of this Agreement and must contain adequate provisions for contract extensions.

iv. In the event of termination of the reinsurance agreement due to insolvency of the MCOP or the reinsurance carrier, the MCOP must be fully responsible for all pending or unpaid claims, and any reinsurance agreements that cover expenses to be paid for continued benefits in the event of insolvency must include Medicaid members as a covered class.

b. Deductible and Coverage

i. The MCOP's annual deductible or retention amount for such insurance must be specified in the reinsurance agreement and must not exceed $100,000, unless ODM has provided the MCOP with prior approval in writing for a higher deductible amount or alternate reinsurance arrangement. Except for transplant services, the MCOP's reinsurance must cover, at a minimum, 80% of inpatient costs incurred by one member in one year in excess of $100,000, unless ODM has provided the MCOP with prior approval in writing for a higher deductible amount or alternate reinsurance arrangement. The MCOP may request a higher deductible amount and/or that the reinsurance cover less than 80% of inpatient costs in excess of the deductible amount. If the MCOP has less than one year of Ohio Medicaid managed care contracting experience, the MCOP must demonstrate sufficient capital resources, as determined by ODM.

c. Transplant Services

i. For transplant services, the MCOP's reinsurance must cover, at a minimum, 50% of inpatient transplant related costs incurred by one member in one year, in excess of $100,000, unless ODM has provided the MCOP with prior approval in writing for a higher deductible amount or alternate reinsurance arrangement. The MCOP may request a higher deductible amount and/or that the reinsurance cover less than 50% of inpatient costs in excess of the

deductible amount. If the MCOP has less than one year of Ohio Medicaid managed care contracting experience, the MCOP must demonstrate sufficient capital resources, as determined by ODM.

d. Reinsurance Documentation Requirements

i. In determining whether or not a change in reinsurance is required or a request for alternate reinsurance requirements will be approved, ODM may consider:

1. Whether the MCOP has sufficient reserves available to pay unexpected claims;
2. The MCOP's history in complying with financial indicators as specified in this appendix;
3. The number of members covered by the MCOP;
4. The length of time the MCOP has been covering Medicaid, dual eligibles, or other members on a full risk basis;
5. A risk-based capital ratio greater than 2.5 or higher calculated from the last annual ODI financial statement; and/or
6. A scatter diagram or bar graph from the last calendar year that shows the number of reinsurance claims that exceeded the current reinsurance deductible graph/chart showing the claims history for reinsurance above the previously approved deductible from the last calendar year.

e. ODM Notification of Claims

i. If directed by ODM, the MCOP must provide documentation specifying the dates of admission, diagnoses, and estimates of the total claims incurred for all Medicaid members for which reinsurance claims have been submitted.

f. Submission of Reinsurance Agreements to ODM

i. The MCOP must submit fully executed reinsurance agreements to ODM prior to the effective date of this Agreement.

ii. The MCOP must submit any proposed changes or modifications to a reinsurance agreement to ODM in writing for review and approval 30 calendar days prior to the intended effective date and must include the complete and exact text of the proposed change. The MCOP must provide copies of new or modified reinsurance agreements to ODM within 30 calendar days of execution.

7. Prompt Pay Requirements

a. Standard

i. In accordance with 42 CFR 447.46 and this Agreement, except if the MCOP and its network provider has established an alternative payment schedule mutually agreed upon and described in the provider contract, the MCOP must comply with the following standards:

1. Claims from independent (non-agency) providers for MyCare Ohio Home- and Community-Based Services (HCBS) Waivers services and private duty nursing (PDN):

    a. Pay or deny 90% of all submitted clean claims within 14 calendar days of the date of receipt of the claim;

    b. Pay or deny 99% of clean claims within 30 calendar days of the date of receipt of the claim; and

    c. Pay or deny 100% of all claims within 60 calendar days of receipt of the claim.

2. All other claim types (excluding claims from independent providers):

    a. Pay or deny 90% of all submitted clean claims within 21 calendar days of the date of receipt of the claim;

    b. Pay or deny 99% of clean claims within 60 calendar days of the date of receipt of the claim; and

    c. Pay or deny 100% of all claims within 90 calendar days of receipt of the claim.

b. Separate Measurement

    i. The MCOP must measure and comply with the prompt payment standards by the claim types specified below:

        1. Nursing facility claims;

        2. Nursing facility/hospice room and board claims;

        3. Behavioral health claims;

        4. Claims from independent providers;

        5. MyCare Ohio HCBS Waiver service claims from agency providers;

        6. Pharmacy claims; and

        7. All other claim types (excluding nursing facility, nursing facility/hospice room and board, behavioral health, independent provider, MyCare Ohio HCBS Waiver agency, and pharmacy claims).

c. Application

    i. The MCOP must comply with the prompt pay requirement for all claims, including both network and out-of-network providers.

d. Reporting

    i. As specified in Appendix P, Chart of Deliverables, the MCOP must submit prompt pay reports (Prompt Pay Report) to ODM.

8. Physician Incentive Plan Requirements

a. If the MCOP operates a physician incentive plan, it must operate the plan in accordance with 42 CFR 438.3(i), 42 CFR 422.208, and 42 CFR 422.210.

b. In accordance with 42 CFR 422.208, if the MCOP operates a physician incentive plan, no specific payment must be made directly or indirectly under the physician incentive plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

c. In accordance with 42 CFR 422.208, if the MCOP's physician incentive plan places a physician or physician group at substantial financial risk for services that the physician or physician group does not furnish itself, the MCOP must ensure all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection.

d. In accordance with 42 CFR 422.210, the MCOP must provide assurance satisfactory to ODM that the requirements of 42 CFR 422.208 are met. In addition, the MCOP must provide additional documentation and information about its physician incentive plans to ODM upon request.

e. In accordance with 42 CFR 428.10 and 42 CFR 422.210, and as specified by this Agreement, upon request by a member, and no later than 14 calendar days after the request, the MCOP must provide the following information to the member:

   i. Whether the MCOP uses a physician incentive plan that affects the use of referral services;

   ii. The type of incentive arrangement; and

   iii. Whether stop-loss protection is provided.

9. Third Party Liability Requirements

a. The MCOP must comply with OAC rules 5160-1-08, 5160-58-01.1 and 5160-26-09.1 related to tort recovery, coordination of benefits (COB), and reporting to ODM.

b. Pursuant to OAC rules 5160-58-01.1 and 5160-26-09.1, the MCOP must notify ODM of requests for information and provide ODM copies of information released pursuant to a tort action.

c. In performing its third party liability (TPL) responsibilities, the MCOP must accept and use ODM's TPL information as specified in Appendix K, Information Systems, Claims, and Data, of this Agreement.

d. If a member has third party insurance through a commercial or Medicare payer (third party payer), the MCOP must help the member find a provider that is a network provider for both the MCOP and the third party payer or cover the COB portion of the claim as if the provider were an MCOP network provider. If the member uses an MCOP network provider that is out-of-network with the third party

payer, the MCOP must follow COB procedures outlined in OAC rules 5160-58-01.1 and 5160-26-09.1 and pay the claim if there is a valid reason for non-payment by the third party payer.

e. The MCOP must coordinate with its COB/TPL vendor to ensure provider recoupments are not taken back by both the MCOP and its COB/TPL vendor resulting in a loss for the provider.

f. As specified in Appendix P, Chart of Deliverables, the MCOP must provide ODM with TPL information, including a change file based on reconciliation with ODM's data (Third Party Liability Data File).

10. Submission of Cost Reports

a. As specified in Appendix P, Chart of Deliverables, the MCOP must submit quarterly and annual cost reports (Quarterly Cost Report and Annual Cost Report) using the cost report template provided by ODM. ODM may make modifications to the cost report template that the MCOP must use at any time.

b. The MCOP must complete the cost reports in accordance with this Agreement and the cost report instructions provided by ODM.

c. The MCOP must submit the cost reports in accordance with the timeframes specified by ODM in the cost report instructions.

d. The MCOP must revise its cost reports in accordance with the observation log prepared by ODM's actuary and/or ODM instructions. The MCOP must address and submit responses to all comments from either ODM or ODM's actuary within the timeframe specified by ODM.

11. Sharing Data with ODM's Actuary

a. Upon ODM's request, the MCOP must share data with ODM's actuary. ODM represents and warrants that a Business Associate Agreement that complies with HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH), and the implementing federal regulations under both Acts, has been executed by ODM's actuary, is currently in effect, and will remain in effect for the term of this Agreement.

12. Notification of Regulatory Action

a. If the MCOP is notified by ODI of proposed or implemented regulatory action, the MCOP must report such notification and the nature of the action to ODM no later than one business day after receipt from ODI. Upon ODM's request, the MCOP must provide any additional information as necessary to ensure continued satisfaction of the requirements of this Agreement. The MCOP may request that information related to such actions be considered proprietary in accordance with Article VII of the Baseline Provider Agreement.

APPENDIX M – RATE METHODOLOGY

APPENDIX N – COMPLIANCE ACTIONS

1. General Requirements

a. Pursuant to Ohio Administrative Code (OAC) rules 5160-58-01.1 and 5160-26-10 and 42 CFR 438 Subpart I, ODM may impose the compliance actions described in this appendix against the MCOP if ODM finds that the MCOP has failed to comply with the terms of this Agreement or any other federal or state requirements. Compliance actions include but are not limited to the administrative actions and sanctions described in this appendix. The compliance actions are not exclusive, meaning that ODM's imposition of any particular compliance action does not preclude ODM from taking additional compliance actions available under this Agreement or state and federal law.

b. The requirements within this appendix do not limit ODM's authority to investigate fraud, waste, and abuse, conduct audits, or pursue legal remedies arising from those investigations and audits.

c. ODM, at its sole discretion, will determine and impose the most appropriate compliance action based on considerations that include the severity of the noncompliance, a pattern of repeated noncompliance, and the number of eligible individuals and members affected. ODM will consider evidence provided by the MCOP that the noncompliance was beyond its control and could not have reasonably been foreseen (e.g., a construction crew severs a phone line, a lightning strike disables a computer system) as a mitigating factor in determining a compliance action. ODM will not consider MCOP subcontractor noncompliance to be beyond the MCOP's control, unless the noncompliance was beyond the subcontractor's control.

d. The MCOP must take immediate action to correct noncompliance identified by the MCOP or ODM. The MCOP's responsibility to correct noncompliance is not dependent upon ODM identification of noncompliance or compliance actions therefrom.

e. The MCOP must report to ODM within one business day, the MCOP’s awareness of any noncompliance that could impair a member's ability to obtain correct information regarding services, impair member rights, affect the ability of the MCOP to deliver covered services, or affect a member's ability to access covered services.

f. The MCOP is singularly responsible for fully complying with all terms in this Agreement. The MCOP is precluded from using ODM technical assistance to help the MCOP achieve compliance with this Agreement as a defense for MCOP noncompliance.

g. ODM will issue Notices of Compliance Actions in writing to the MCOP contact identified in the Baseline Provider Agreement of this Agreement.

2. Administrative Actions

a. <u>Notice of Noncompliance</u>

i. ODM may issue a written Notice of Noncompliance to the MCOP when ODM identifies MCOP noncompliance and does not require any other compliance action (e.g., MCOP developed corrective action plan [CAP], directed CAP).

ii. The MCOP must take immediate action to correct the identified noncompliance and notify ODM of the action taken to address noncompliance.

b. Corrective Action Plans

i. *General*

1. If ODM determines that the MCOP is not in compliance with one or more requirements in this Agreement, including those requirements established by a transition plan in accordance with Appendix O, MCOP Termination and Non-Renewal, ODM may issue a Notice of Compliance Action, identifying the deficiency or deficiencies and required MCOP follow-up for each. The MCOP follow-up may come in the form of an MCOP-developed CAP or a Directed CAP. ODM will also issue a Notice of Compliance Action when ODM determines that sanctions are necessary.

2. A CAP is a structured activity, process, or quality improvement (QI) initiative implemented by the MCOP to address noncompliance. The MCOP must submit all CAPs as specified by ODM. The MCOP's CAP must, at a minimum, identify:

a. The root cause or causes of a deficiency;

b. The goals, objectives, methodologies, and actions/tasks to be taken to achieve compliance; and

c. The staff responsible to carry out the CAP within the established timelines.

3. A CAP will remain in effect until the MCOP has provided evidence to ODM's satisfaction that the MCOP has fulfilled the requirements of the CAP to achieve and sustain compliance. Failure of the MCOP to achieve compliance within the timeframes established within the CAP and sustain compliance thereafter may result in an escalation of compliance actions as provided in this appendix.

c. MCOP-Developed Corrective Action Plan

1. When directed by ODM, the MCOP must submit a proposed CAP as specified in the Notice of Compliance Action for any instance of noncompliance with this Agreement or any federal or state requirement. The MCOP's proposed CAP is subject to ODM approval.

d. Directed Corrective Action Plan

1. When directed by ODM in a Notice of Compliance Action, the MCOP must comply with an ODM-developed or "directed" CAP when ODM has determined the specific action that the MCOP must implement.

2. ODM may also issue a directed CAP if the MCOP fails to submit a CAP.

3. Sanctions

a. Pre-Determined Financial Sanctions

i. In addition to other compliance actions available to ODM, ODM may impose the following pre-determined financial sanctions in accordance with Table N.1 below.

Table N.117 Pre-Determined Financial Sanctions

	Noncompliance	Financial Sanction
1.	Failure to demonstrate readiness within the timeframe established by ODM as part of the MCOP's readiness review, as specified in Appendix A, General Requirements.	• $2,000 per calendar day for each readiness requirement until the MCOP demonstrates readiness to ODM's satisfaction
2.	Failure to comply with staffing requirements, as specified in Appendix A, General Requirements.	• $1,000 per calendar day per position
3.	Failure to have appropriate MCOP staff members attend meetings as requested by ODM, as specified in Appendix A, General Requirements.	• $1,000 per appropriate staff person, per meeting occurrence or portion thereof
4.	Failure to meet call center requirements and have appropriately trained medical personnel for the MCOP's 24/7 medical advice call line, as specified in Appendix A, General Requirements.	• $5,000 per calendar day for failure to operate each line (i.e., medical advice line; behavioral health crisis; care management support services; prior authorization, coverage determinations and appeals call center; member services; provider services; and pharmacy technical health call center) OR • $5,000 per calendar day for failure to have appropriately trained medical personnel for the MCOP's 24/7 medical advice line
5.	Failure to meet monthly call center metrics, as specified in Appendix A, General Requirements.	•$10,000 per month, per metric, per line
6.	Failure to secure protected health information as defined by Health Insurance Portability and Accountability Act (HIPAA), as specified in Appendix A, General Requirements.	• $1,000 per member, per occurrence AND • Costs associated with credit monitoring and/or identity theft, safeguard services, as determined necessary by ODM
7.	Failure to resolve at least 98% of expedited appeals within required timelines, as specified in Appendix A, General Requirements.	• $10,000 per month

	Noncompliance	Financial Sanction
8.	Failure to resolve at least 95% of standard appeals within required timelines, as specified in Appendix A, General Requirements.	• $10,000 per month
9.	Failure to resolve at least 98% of access related member grievances and 95% of non-access related member grievances within required timelines, as specified in Appendix A, General Requirements.	• $10,000 per month.
10.	Failure to continue services during a pending appeal or state hearing, as specified in Appendix A, General Requirements.	• Cost of services that should have been continued as determined by ODM AND • $500 for each calendar day the service should have been continued
11.	Failure to authorize services after receiving a reversal of MCOP decision resulting from an appeal or state hearing, as specified in Appendix A, General Requirements.	• Cost of services that should have been authorized as determined by ODM AND • $500 for each calendar day the service should have been authorized
12.	Failure to ensure appropriate MCOP representatives attend state hearings as scheduled, as specified in Appendix A, General Requirements.	• $2,500 per occurrence
13.	Failure to provide necessary witnesses or evidentiary materials for state hearings, as specified in Appendix A, General Requirements.	• $1,000 per occurrence
14.	Failure to comply with HealthTrack complaint requirements and outreach providers within the required timeline, as specified in Appendix A, General Requirements.	• $100 per business day
15.	Failure to comply with First Tier, Downstream, and Related Entities (FDR) notification requirements for newly established or amended FDR agreements, as specified in Appendix A, General Requirements.	• $15,000 for notifications less than 45 days before the execution of a newly established or amended FDR agreement • $100,000 for notifications after the execution of a newly established or amended FDR agreement

	Noncompliance	Financial Sanction
16.	Failure to comply with timeframes for at least 98% of expedited service authorization requests, as specified in Appendix B, Coverage and Services.	• $10,000 per month
17.	Failure to comply with timeframes for at least 95% of standard service authorization requests, as specified in Appendix B, Coverage and Services.	• $10,000 per month
18.	Failure to follow ODM or ODM-approved clinical coverage policies as specified in Appendix B, Coverage and Services.	• $2,500 per occurrence, per member
19.	Failure to submit clinical coverage policies and any subsequent proposed changes to ODM for review and prior approval prior to implementation, as specified in Appendix B, Coverage and Services.	• $10,000 per occurrence AND • $1,000 for each calendar day the policy or policy change is in effect before being submitted to ODM
20.	Failure to notify network and out-of-network providers of changes to clinical coverage policies at least 30 calendar days prior to implementation, as specified in Appendix B, Coverage and Services.	• $10,000 per occurrence AND • $1,000 for each calendar day of the MCOP's noncompliance with the 30 calendar day prior notification requirement
21.	Failure to provide a timely and content-compliant Notice of Action as required by OAC rule 5160-58-08.4 and Appendix B, Coverage and Services.	• $500 per calendar day, per person
22.	Failure to authorize and provide timely access to covered services, as specified in Appendix B, Coverage and Services.	• $500 per calendar day, per member, per service
23.	Failure to meet transportation requirements, as specified in Appendix B, Coverage and Services.	• $1,000 per member, per occurrence
24.	Failure to comply with requirements related to abortion and sterilizations, as specified in Appendix B, Coverage and Services.	• $2,000 per occurrence
25.	Failure to cooperate with ODM's external quality review organization (EQRO), as specified in Appendix C, Population Health and Quality.	• $5,000 per occurrence

	Noncompliance	Financial Sanction
26.	Failure to actively participate in QI projects or performance improvement projects facilitated by ODM and/or the EQRO, as specified in Appendix C, Population Health and Quality.	• $5,000 per occurrence
27.	Failure to complete a required assessment (e.g., comprehensive risk assessment, home- and community-based services [HCBS] waiver annual assessment), develop a person-centered care plan or waiver service plan, or authorize or initiate all services specified in the person-centered services or care plan for a member within specified timelines, as specified in Appendix D, Care Coordination.	• $500 per member, per calendar day, per service AND • Cost of services not provided, as determined by ODM
28.	Failure to submit required documentation for care management reviews, as specified in Appendix D, Care Coordination.	• $100 per occurrence, per day until documentation is received
29.	Failure to complete a critical incident investigation and/or critical incident prevention plan within required timelines, as specified in Appendix D, Care Coordination.	• $100 per occurrence, per day until documentation is received
30.	Failure to meet member safeguard requirements, as specified in Appendix D, Care Coordination, placing a member at risk for a negative health outcome or jeopardizing the member's health, safety, or welfare.	• $50,000 per occurrence
31.	Failure to comply with transitions of care requirements, as specified in Appendix D, Care Coordination.	• $500 per calendar day, per member AND • The value of the services the MCOP failed to cover during the applicable transition of care period, as determined by ODM
32.	Engaging in prohibited marketing activities or discriminatory practices or failure to market in the entire service area, as specified in Appendix E, Marketing and Member Materials.	• $5,000 per occurrence AND • An additional $5,000 per occurrence if determined to be a discriminatory practice
33.	Failure to obtain ODM's approval prior to using marketing or member materials that require ODM's approval prior to distribution, as specified in Appendix E, Marketing and Member Materials.	• $500 for every calendar day the unapproved materials are used

	Noncompliance	Financial Sanction
34.	Failure to cease use of any member or marketing material within the timeframe established by ODM, as specified in Appendix E, Marketing and Member Materials.	• $500 for every calendar day the materials continue to be used past the ODM established deadline
35.	Failure to comply with the timeframes for providing member materials, as specified in Appendix E, Marketing and Member Materials.	• $1,000 per occurrence
36.	Failure to notify ODM and impacted members of provider termination of network provider within required timeframes, as specified in Appendix F, Provider Network.	• $250 per calendar day, per member, for ODM notification • $100 per calendar day, per member, for member notification
37.	Failure to provide timely notification to ODM of network changes, as specified in Appendix F, Provider Network.	• $5,000 per occurrence
38.	Failure to meet minimum provider capacity standards, LTSS service delivery wait times, or achieve at least 86% of LTSS service validation measures, as specified in Appendix F, Provider Network. Standards are measured on a quarterly basis.	• $1,000 for each provider type, for each county or statewide for member to provider ratios, per quarter • $1,000 for each provider type for each county for LTSS service delivery wait times • $1,000 for failure to achieve at least 86% of LTSS service validation measures
39.	Failure to meet access (time and distance) requirements, as specified in Appendix F, Provider Network. Access compliance is measured on a quarterly basis.	• $1,000 per county, per provider type, per quarter
40.	Failure to meet provider network information performance standards, as specified in Appendix F, Provider Network.	• $50,000 for each performance standard not met
41.	Failure to respond to information or witness requests within specified timeframe, as specified in Appendix G, Program Integrity.	• $1,000 per calendar day per request
42.	Payment to a terminated or suspended provider, as specified in Appendix G, Program Integrity.	• Twice the amount of the payment made to the terminated or suspended provider
43.	Failure to report credible allegation of fraud, waste, or abuse, as specified in Appendix G, Program Integrity.	• $500 per occurrence
44.	Failure to report recoveries, as specified in Appendix G, Program Integrity.	• Twice the amount of recovery that was not reported

	Noncompliance	Financial Sanction
45.	Failure to adjust claims/encounters to reflect recovery, as specified in Appendix G, Program Integrity.	• Twice the amount of the value of the adjustment
46.	Failure to meet quality measure requirements, as specified in Appendix I, Quality and Waiver Performance Measures.	• For the first instance of noncompliance, 0.25% of the amount calculated based upon the MCOP's monthly average capitation amount for the greater of the 12 months prior to the month in which the compliance action is issued, or the 12 months of the measurement year for each established MPS, under each quality measure • For consecutive instances of noncompliance, 0.5% of the amount calculated based upon the MCOP's monthly average capitation amount for the greater of the 12 months prior to the month in which the compliance action is issued, or the 12 months of the measurement year for each established MPS, under each quality measure
47.	Failure to meet ODM-established performance thresholds for MyCare Ohio HCBS Waiver performance measures, as specified in Appendix I, Quality and Waiver Performance Measures.	• $5,000 per measure, per measurement period
48.	Failure to submit self-reported, audited Healthcare Effectiveness Data and Information Set (HEDIS) data, as specified in Appendix I, Quality and Waiver Performance Measures.	• $300,000 per occurrence
49.	Failure to submit data for measures designated as "reporting only" with self-reported, audited HEDIS data, as specified in Appendix I, Quality and Waiver Performance Measures.	• $300,000 per occurrence •
50.	Failure to submit the Annual Submission of Final HEDIS Audit Report, as specified in Appendix I, Quality and Waiver Performance Measures.	• $300,000 per occurrence •

	Noncompliance	Financial Sanction
51.	Failure to administer a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and submit the survey data to National Committee for Quality Assurance (NCQA), the CAHPS Database, and ODM's designee, as specified in Appendix I, Quality and Waiver Performance Measures.	• $300,000 per occurrence AND • The MCOP will be considered non-compliant with the standards for the CAHPS performance measure in Appendix I, Quality and Waiver Performance Measures, for the corresponding contract period
52.	Failure to meet requirements to adjudicate claims to final status, notify out-of-network providers of procedures for claims submissions when requested, and/or notify network and out-of-network providers of the status of submitted claims, as specified in Appendix K, Information Systems, Claims, and Data.	• $20,000 per calendar day for the period of noncompliance
53.	Failure to load ODM rate changes into applicable systems, as specified in Appendix K, Information Systems, Claims, and Data.	• $10,000 per calendar day for the period of noncompliance
54.	Failure to meet the encounter data volume standards for every service category in all quarters of the measurement period for each of the following populations: Aged, Blind, and Disabled (ABD) adults and Modified Adjusted Gross Income (MAGI) members, as specified in the Methodology for Encounter Data Quality Measures document referenced in Appendix K, Information Systems, Claims, and Data.	• CAP for first and non-consecutive noncompliance • 2% of the amount calculated based upon the MCOP's capitation for second consecutive noncompliance within five reporting periods • New member enrollment freeze for third consecutive noncompliance within five reporting periods
55.	Failure to meet the requirements for rejected encounters, as specified in the Methodology for Encounter Data Quality Measures document referenced in Appendix K, Information Systems, Claims, and Data.	• CAP for first and non-consecutive noncompliance • 2% of the amount calculated based upon the MCOP's capitation for second consecutive noncompliance within five reporting periods • New member enrollment freeze for third consecutive noncompliance within five reporting periods

	Noncompliance	Financial Sanction
56.	Failure to meet acceptance rate requirement, as specified in the Methodology for Encounter Data Quality Measures document referenced in Appendix K, Information Systems, Claims, and Data.	• CAP for first and non-consecutive noncompliance • 2% of the amount calculated based upon the MCOP's capitation for second consecutive noncompliance within five reporting periods • New member enrollment freeze for third consecutive noncompliance within five reporting periods
57.	Failure to meet payment accuracy measures for encounter data accuracy studies, as specified in the Methodology for Encounter Data Quality Measures document referenced in Appendix K, Information Systems, Claims, and Data.	• CAP for first time noncompliance • 1% of the amount calculated based upon the MCOP's capitation for all subsequent noncompliance
58.	Failure to meet the minimum record submittal rate for encounter data accuracy studies, as specified in the Methodology for Encounter Data Quality Measures document referenced in Appendix K, Information Systems, Claims, and Data.	• $10,000
59.	Failure to meet standards for rendering provider data for all quarters of the measurement period, as specified in the Methodology for Encounter Data Quality Measures document referenced in Appendix K, Information Systems, Claims, and Data.	• CAP for first and non-consecutive noncompliance • 2% of the amount calculated based upon the MCOP's capitation for second consecutive noncompliance within five reporting periods • New member enrollment freeze for third consecutive noncompliance within five reporting periods
60.	Failure to meet standards for National Provider Identifier (NPI) provider number usage, as specified in the Methodology for Encounter Data Quality Measures document referenced in Appendix K, Information Systems, Claims, and Data.	• CAP for first and non-consecutive noncompliance • 2% of the amount calculated based upon the MCOP's capitation for second consecutive noncompliance within five reporting periods • New member enrollment freeze for third consecutive noncompliance within five reporting periods

	Noncompliance	Financial Sanction
61.	Failure to meet encounter submission requirements, as specified in the Methodology for Encounter Data Quality Measures document referenced in Appendix K, Information Systems, Claims, and Data.	• 1% of the amount calculated for first measurement period of noncompliance • 2% of the amount calculated for subsequent noncompliance
62.	Failure to meet encounter timeliness standards, as specified in Appendix K, Information Systems, Claims, and Data, and the Methodology for Encounter Data Quality Measures document referenced in Appendix K, Information Systems, Claims, and Data.	• 1% of the amount calculated based upon the MCOP's capitation for first measurement period of noncompliance • 2% of the amount calculated based upon the MCOP's capitation for subsequent noncompliance
63.	Failure to comply with claims payment systemic error (CPSE) policies and activities to correct CPSEs, as specified in Appendix K, Information Systems, Claims, and Data.	• $5,000 per occurrence
64.	Failure to meet medical loss ratio (MLR) requirements, as specified in Appendix L, Payment and Financial Performance.	• MCOP must remit a rebate to ODM of the difference between the calculated MLR and the target MLR multiplied by the revenue paid to the MCOP during the contract year
65.	Failure to comply with any of the following reinsurance requirements, as specified in Appendix L, Payment and Financial Performance: • Failure to maintain reinsurance coverage as required; • Failure to obtain approval from ODM for deductibles in excess of $100,000; or • Failure to obtain approval from ODM when reinsurance for non-transplant services covers less than 80% of inpatient costs in excess of the deductible incurred by one member for one year.	The lesser of: • 10% of the difference between the estimated amount of what the MCOP would have paid in premiums for the reinsurance policy if it had been in compliance and what the MCOP actually paid while it was out of compliance OR • $50,000

	Noncompliance	Financial Sanction
66.	Failure to comply with prompt pay requirements, as specified in Appendix L, Payment and Financial Performance.	• For the first instance of noncompliance, 0.04% of the amount calculated based upon the MCOP's capitation for each claim type and timeframe separately • For the second instance of noncompliance, 0.08% of the amount calculated based upon the MCOP's capitation for each claim type and timeframe separately • For additional violations during a rolling 12-month period, a new enrollment freeze of no less than three months duration or until the MCOP has attained and maintained compliance as determined by ODM
67.	Failure to comply with the third party liability (TPL) provider recoupments requirements, as specified in Appendix L, Payment and Financial Performance.	• $500 for each violation • ODM may impose additional sanctions may be assessed as determined by ODM
68.	Failure to submit a proposed Transition Plan within 10 business days of receiving notice from ODM in accordance with Appendix O, MCOP Termination and Non-Renewal.	• $5,000 per calendar day • ODM may impose additional financial sanctions if the MCOP fails to revise the proposed Transition Plan as necessary to obtain ODM approval
69.	Failure to submit a deliverable or respond to ODM's requests within the required timeframe under this Agreement.	• $100 per deliverable or request, per calendar day
70.	Failure to complete or comply with a CAP as described in this appendix.	• $500 for each calendar day the CAP is not completed, implemented, or complied with as determined by ODM

b. Pre-Determined Non-Financial Sanctions

i. In addition to other compliance actions available to ODM, ODM may impose the following pre-determined non-financial sanctions in accordance with Table N.2 below.

Table N.18 Pre-Determined Non-Financial Sanctions

	Noncompliance	Non-Financial Sanction
	Failure to maintain required accreditation status with the NCQA, as specified in Appendix A, General Requirements.	• If the MCOP receives a Provisional accreditation status, the MCOP must complete a resurvey within 12 months of the accreditation decision. If the resurvey results are in a Provisional or Denied status, ODM will consider this a material breach of this Agreement and may terminate this Agreement. • If the MCOP receives a Denied accreditation status, ODM will consider this a material breach of this Agreement and may terminate this Agreement.
	Failure to have a Medicare Advantage contract with the Centers for Medicare & Medicaid Services (CMS) as a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP), as specified in Appendix A, General Requirements.	• If the MCOP's Medicare Advantage contract with CMS as a FIDE SNP is terminated or not renewed, ODM will consider this a material breach of this Agreement and may terminate this Agreement.
	CMS imposition of suspension of the MCOP's FIDE SNP's enrollment of Medicare beneficiaries as a result of noncompliance or other program deficiencies, as specified in Appendix A, General Requirements.	• ODM may require the MCOP to complete a CAP. • MCOP's failure to demonstrate compliance by the specified date may result in a new enrollment freeze.
	Failure to submit quarterly Financial Statements to ODM, as specified in Appendix L, Payment and Financial Performance.	• ODM may require the MCOP to complete a CAP. • MCOP's failure to demonstrate compliance by the specified date may result in a new enrollment freeze.

	Noncompliance	Non-Financial Sanction
	Failure to submit annual Financial Statements to ODM, as specified in Appendix L, Payment and Financial Performance.	• ODM may require the MCOP to complete a CAP. • MCOP's failure to demonstrate compliance by the specified date may result in a new enrollment freeze.
	Failure to meet financial performance requirements, as specified in Appendix L, Payment and Financial Performance.	• ODM may require the MCOP to complete a CAP. • MCOP failure to demonstrate compliance by the specified date may result in a new enrollment freeze.
	Failure to notify ODM no later than one business day after the receipt of a proposed or implemented regulatory action by the Ohio Department of Insurance (ODI), as specified in Appendix L, Payment and Financial Performance.	• MCOP failure to comply with this requirement will result in an immediate new enrollment freeze.

c. Financial Sanctions

i. *General*

1. ODM may impose financial sanctions for noncompliance that does not fall into pre-determined sanctions. The amount of the financial sanction may vary depending upon the level of severity (i.e., Level 1, Level 2, or Level 3) of the MCOP noncompliance, repeated violations, failure to meet the requirements in a CAP, and the impact of the noncompliance to members.

ii. *Level 1 Sanctions*

1. ODM may impose a Level 1 sanction up to a maximum of $15,000 per occurrence of the MCOP's failure to comply with a term of this Agreement and federal and state requirements that does not result in a member being unable to receive a medically necessary service or in a poor health outcome for the member. Examples may include:

    a. Failure to ensure staff performing care management functions are operating within their professional scope of practice or are complying with the state's licensure/credentialing requirements;

    b. Failure to update the person-centered care plan or waiver service plan in a timely manner when the needs of the member change;

c. Failure to coordinate care for a member across providers, specialists, and team members, as appropriate;

d. Failure to adhere to a documented communication plan, including the contact schedule for in-person visits and telephone calls;

e. Failure to make reasonable attempts to obtain a discharge/transition plan from an inpatient facility; and

f. Failure to notify providers of claim reprocessing or payment recovery within the timeframe specified in Appendix K, Information Systems, Claims, and Data.

iii. *Level 2 Sanctions*

1. ODM may impose a Level 2 sanction up to a maximum of $25,000 per occurrence of the MCOP's failure to comply with a term of this Agreement and/or state and federal requirements.

2. Level 2 sanctions include but are not limited to the following types of MCOP noncompliance:

a. Noncompliance that is associated with a poor health outcome for the member;

b. Failure to provide medically necessary services that the MCOP must provide under the terms of this Agreement to its enrolled members, such as:

i. Failure to assist a member in accessing needed services in a timely manner after receiving a request from the member or when the member has an identified unmet long-term services and supports service need (as reported in the unstaffed home care report as specified in Appendix B, Coverage and Services, or through network adequacy evaluation identified in Appendix F, Provider Network);

ii. Failure to meet requirements related to discharge planning;

iii. Failure to provide services specified in the member's discharge plan;

iv. Failure to ensure staff performing care management functions are appropriately responding to a member's care management needs; and

v. Failure to complete a care gap analysis that identifies gaps between recommended care and care received by a member.

c. Assessing member premiums or charges in excess of the amounts permitted by ODM (the greater of the maximum financial sanction of $25,000 or double the amount of the excess charges);

d. Misrepresentation or falsification of information furnished to an eligible individual, member, or provider;

e. Failure to comply with physician incentive plan requirements; and

f. Distribution directly or indirectly through any agent or independent contractor, of marketing or outreach materials that have not been approved by ODM or that contain false or materially misleading information.

iv. *Level 3 Sanctions*

1. ODM may impose a Level 3 sanction up to a maximum of $100,000 per occurrence of the MCOP's failure to comply with a term of this Agreement and/or state and federal requirements.

2. Level 3 sanctions include but are not limited to the following types of MCOP noncompliance:

a. Discrimination among members on the basis of their health status or need for health care services (this includes any practice that would reasonably be expected to encourage termination or discourage selection of members or eligible individuals whose medical condition indicates probable need for substantial future medical services); and

b. Misrepresentation or falsification of information provided to ODM or CMS.

v. *Financial Sanction Calculation*

1. ODM will evaluate MCOP noncompliance and, in its sole discretion, determine the appropriate level and amount of the financial sanction to impose. ODM will consider relevant information regarding noncompliance, as well as the following aggravating and mitigating factors:

a. The extent, severity, duration, and impact of noncompliance;

b. Whether the noncompliance poses or results in a quality of care or safety concern;

c. Whether noncompliance was intentional;

d. Whether the MCOP promptly identified, reported, and remediated the noncompliance;

e. MCOP enrollment size relative to the amount of the financial sanction;

f. Financial implications to providers; and

g. Financial harm and risk to the state.

d. Compounded Financial Sanctions

i. ODM may compound pre-determined and financial sanctions if the MCOP fails to achieve compliance within the timeframe established by ODM or maintain compliance for the same requirement for a six-month timeframe after demonstrating compliance.

ii. ODM will calculate compounded financial sanctions as follows:

1. For each subsequent measurement period (e.g., daily, monthly, quarterly), ODM will assess the lesser of two times the amount of the pre-determined or financial sanction, or the maximum amount for Level 1, Level 2, or Level 3 financial sanctions, if:

a. The MCOP fails to demonstrate compliance within the timeframe identified in the Notice of Compliance Action; or

b. The MCOP fails to comply with the same requirement throughout a six-month timeframe after demonstrating compliance.

e. Collection of Pre-Determined and Financial Sanctions

i. ODM will directly deduct pre-determined and financial sanctions imposed against the MCOP from the net capitation paid to the MCOP. ODM will specify on the invoice the date ODM will deduct the funds.

ii. If ODM requests an electronic funds transfer (EFT) from the MCOP, the MCOP must pay the pre-determined and financial sanction to ODM within 30 calendar days of the date of the invoice or as otherwise directed by ODM in writing. Pursuant to Ohio Revised Code (ORC) section 131.02, ODM will certify to the Attorney General's Office payments owed by the MCOP to the state that are not received within 45 calendar days. The Attorney General's Office will impose the appropriate collection fee for MCOP payments certified to the Attorney General's Office.

iii. For pre-determined and financial sanctions calculated in accordance with this appendix, ODM will use the MCOP's average monthly net capitation, disregarding the financial sanctions for the 12 months prior to the month in which ODM issues the compliance action to the MCOP.

f. New Enrollment Freezes

i. ODM may prohibit the MCOP from receiving new enrollment through the selection of the MCOP by an eligible individual or ODM's auto-assignment process if any of the following occur:

1. The MCOP fails to implement a CAP fully within the designated timeframe.

2. Circumstances exist that potentially jeopardize member access to care, as solely determined by ODM.

3. ODM finds that the MCOP has a pattern of repeated or ongoing noncompliance, as solely determined by ODM. Examples of circumstances that ODM may consider as jeopardizing member access to care include but are not limited to the following:

    a. Failure to comply with the prompt payment or out-of-network provider payment requirements;

    b. Failure to comply with the provider network requirements specified in Appendix F, Provider Network;

    c. MCOP refusal to comply with a program requirement after ODM has directed the MCOP to comply with the specific program requirement;

    d. MCOP receipt of proposed or implemented adverse action by the ODI;

    e. Failure to provide adequate provider or administrative capacity; or

    f. Failure to provide reliable and consistent transportation as required in Appendix B, Coverage and Services.

ii. If ODM imposes an enrollment freeze, the enrollment freeze will be imposed concurrent with the Notice of Compliance Action to the MCOP.

iii. ODM will not make capitation payments to the MCOP for new members under this Agreement when and for so long as CMS denies payments for those members in accordance with the requirements in 42 CFR 438.726.

iv. Unless otherwise specified, ODM may lift new enrollment freezes issued under this appendix after ODM determines that the MCOP is in full compliance with the applicable program requirement, and MCOP noncompliance is resolved to the satisfaction of ODM.

g. Reduction of Assignments

i. ODM has discretion over how ODM makes member enrollment auto-assignments. ODM may reduce the number of auto-assignments the MCOP receives to ensure program stability, or upon a determination that the MCOP lacks sufficient capacity to meet the needs of the increased enrollment volume.

ii. ODM's determination that the MCOP has demonstrated a lack of sufficient capacity will include but is not limited to the following considerations:

    1. Failure to maintain an adequate provider network;

    2. Failure to provide new member materials by the member's effective date;

    3. Failure to meet the minimum call center requirements;

    4. Failure to meet the minimum performance standards for members with special health care needs; or

5. Failure to provide complete and accurate data files required for meeting requirements for the grievance and appeals system, primary care providers for dual benefit members, or its Care Management System files.

h. Member Disenrollment

i. ODM may require member disenrollment as a result of MCOP noncompliance. As directed by ODM, the MCOP must either:

1. Disenroll members; or

2. Notify members of their right to disenroll and permit its members to disenroll from the MCOP without cause.

ii. If ODM determines the MCOP has violated any of the requirements of Sections 1903(m) or 1932 of the Social Security Act not specifically identified within this Agreement, ODM may require the MCOP to permit any of its members to disenroll from the MCOP without cause, suspend any further new member enrollments to the MCOP, or both.

iii. The MCOP must comply with the transition of care requirements in Appendix D, Care Coordination, to transition the care for members who must or choose to disenroll.

i. Temporary Management

i. Pursuant to OAC rules 5160-58.01.1 and 5160-26-10 and 42 CFR 438.706, ODM may impose temporary management when the MCOP has repeatedly failed to comply with the requirements in this Agreement.

ii. The MCOP must bear all costs incurred from the appointment of temporary management.

iii. ODM's imposition of temporary management against the MCOP will not be delayed to provide the MCOP with an opportunity to request reconsideration. Temporary management will remain in place until ODM determines that the noncompliance will not reoccur.

j. Termination

i. In accordance with 42 CFR 438.708, ODM may terminate this Agreement if ODM determines that the MCOP has failed to carry out the substantive terms of this Agreement or failed to meet the applicable requirements in Sections 1932, 1903(m), or 1905(t) of the Social Security Act.

ii. ODM may terminate or amend this Agreement if at any time ODM determines that continuation of this Agreement is not in the best interest of members or the state of Ohio, pursuant to OAC rules 5160-58.01.1 and 5160-26-10.

iii. Nothing in this appendix precludes ODM from terminating this Agreement pursuant to Article VIII of the Baseline Provider Agreement.

4. Request for Reconsideration

a. Other than as specified below, pursuant to OAC rules 5160-58.01.1 and 5160-26-10, the MCOP may seek reconsideration of any compliance action in this appendix imposed by ODM.

   i. The MCOP may not seek reconsideration of a compliance action by ODM that results in:

      1. Changes to the auto-assignment of members; or

      2. The imposition of a Notice of Noncompliance, CAP, or directed CAP, as defined in this appendix.

         a. The MCOP may only seek reconsideration of a CAP when a CAP is required for the first violation in a series of progressive compliance actions.

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

   i. The MCOP must submit a request for reconsideration to ODM no later than ten business days after the date the MCOP receives the Notice of Compliance Action from ODM.

   ii. The MCOP's request for reconsideration must explain in detail why ODM should not impose the specified compliance action. At a minimum, the MCOP's reconsideration request must include a statement of the proposed compliance action being contested, the basis for the MCOP's request, and any supporting documentation. In considering the MCOP's request for reconsideration, ODM will review only the written material submitted by the MCOP.

   iii. ODM will take reasonable steps to issue a final written decision or request additional information within ten business days after receiving the MCOP's request for reconsideration. If ODM requires additional time, ODM will notify the MCOP in writing.

   iv. If ODM approves the MCOP's reconsideration request in whole, ODM will rescind the associated compliance actions.

   v. If ODM approves the MCOP's reconsideration request in part, ODM at its sole discretion may rescind or reduce the associated compliance actions.

   vi. If ODM denies the MCOP's reconsideration request in whole, ODM will take the compliance actions outlined in the original notification of noncompliance.

APPENDIX O – MCOP TERMINATION AND NON-RENEWAL

1. General Requirements

a. This Agreement may be terminated or not renewed in whole or part as specified in Article VIII of the Baseline Provider Agreement.

i. *MCOP-Initiated Termination and Non-Renewal*

1. When initiated by the MCOP, the MCOP must provide ODM written notice of the termination or non-renewal of this Agreement in whole or part as required in Article VIII of the Baseline Provider Agreement.

ii. *ODM-Initiated Termination for Cause*

1. If ODM initiates the proposed termination, non-renewal, or amendment of this Agreement pursuant to Ohio Administrative Code (OAC) rules 5160-58-01.1 and 5160-26-10 by issuing a proposed adjudication order pursuant to Ohio Revised Code (ORC) section 5164.38, and the MCOP submits a valid appeal of that proposed action pursuant to ORC Chapter 119, this Agreement will be extended through the issuance of an adjudication order of the MCOP's appeal under ORC Chapter 119.

2. Pursuant to OAC rules 5160-58-01.1 and 5160-26-10, ODM may notify the MCOP's members of the proposed action and inform the members of their right to immediately terminate their enrollment with the MCOP without cause. If ODM has proposed the termination, non-renewal, denial, or amendment of this Agreement and access to medically necessary covered services is jeopardized, ODM may propose to terminate the enrollment of all of the MCOP's members. The MCOP may request reconsideration of a proposed enrollment termination of members as follows:

a. ODM will notify the MCOP of the proposed enrollment termination via certified or overnight mail to the MCOP. The MCOP will have three business days from the date of receipt to request reconsideration.

b. The MCOP must submit reconsideration requests to ODM's Director by mail. ODM must receive the request by 3:00 pm Eastern Time on the third business day following the MCOP's receipt of the ODM notification of termination.

c. The MCOP's request must explain in detail why the proposed enrollment termination is not justified. ODM will not consider justification other than what is submitted in writing by the MCOP.

d. The Director will issue a final decision or request for additional information within five business days of receipt of the MCOP's request for reconsideration. ODM will notify the MCOP in writing if the Director requires additional time in rendering the final reconsideration decision.

e. The proposed MCOP enrollment termination will not occur while the reconsideration is under review and pending the Director's decision. If the Director denies the reconsideration, the MCOP enrollment termination will proceed at the first possible effective date.

iii. *Termination due to ODM MCOP Procurement Process*

1. In the event this Agreement terminates as a result of ODM's procurement of managed care organizations pursuant to ORC section 5167.10, the MCOP has no right to appeal under the authorities in ORC Chapter 119 pursuant to ORC section 5164.38. This requirement applies whether the MCOP is or is not selected as a result of the ODM procurement.

iv. *Termination or Modification of this Agreement due to Lack of Funding*

1. In the event this Agreement terminates or is modified due to a lack of available funding, the MCOP has no right to appeal under the authorities in ORC Chapter 119 pursuant to ORC section 5164.38.

b. If for any reason this Agreement is terminated or not renewed in whole or part , the MCOP must comply with the transition requirements as described in this appendix.

c. The MCOP will continue to be subject to compliance actions as specified in Appendix N, Compliance Actions, of this Agreement until ODM approves the MCOP's final report documenting that the MCOP has fulfilled all outstanding obligations.

2. Transition Requirements

a. Upon notice of the termination/non-renewal of this Agreement in whole or part the MCOP must comply with the following transition requirements:

i. *Member Care Responsibilities*

1. The MCOP must comply with all duties and obligations, including all responsibilities related to member care.

ii. *Transition Plan*

1. The MCOP must submit a proposed Transition Plan within ten business days of the notice of termination/non-renewal of this Agreement for ODM approval. The MCOP must revise the proposed Transition Plan as necessary to obtain ODM's approval. The MCOP's proposed Transition Plan must include the following:

a. The MCOP's agreement to comply with all duties and obligations incurred prior to the effective date of this Agreement termination/non-renewal, including the performance of ongoing functions, and the submission of all reports and deliverables;

b. The identification of the MCOP's Transition Coordinator, the MCOP's single point of contact responsible for coordinating the MCOP's transition activities;

c. The proposed submission timeframes for all outstanding reports and deliverables as identified by ODM;

d. If applicable, the member outreach workflow identifying the approach and timing of outreach to members impacted by the termination/non-renewal of this Agreement;

e. The MCOP's proposed communication plan, including the MCOP's written notifications and proposed timeline to notify all subcontractors, providers, and members impacted by the termination/non-renewal of this Agreement. The MCOP's proposed communication plan must include the following standardized notifications:

    i. Provider Notification

        1. If applicable, the MCOP must notify network providers impacted by the termination/non-renewal of this Agreement at least 55 calendar days prior to the effective date of the termination/non-renewal. The provider notification language and process must be approved by ODM prior to distribution.

    ii. Member Notification

        1. If applicable, unless otherwise notified by ODM, the MCOP must notify its members impacted by the termination/non-renewal of this Agreement at least 45 calendar days in advance of the effective date of termination/non-renewal. A member outreach workflow identifying the approach and timing of outreach to the members impacted must be included. The member notification language and process must be approved by ODM prior to distribution.

    iii. Prior Authorization Redirection Notification

        1. If applicable, the MCOP must create two notices to assist members and providers with prior authorization requests received or approved during the last month of enrollment. The first notice is for prior authorization requests for services to be provided after the effective date of termination/non-renewal; this notice will direct members and providers to contact the enrolling MCOP. The second notice is for prior authorization requests for services to be provided before and after the effective date of termination/non-renewal. The MCOP must use ODM model language to create the notices and receive approval by ODM prior to distribution. The notices must be mailed to

the provider and copied to the member for all requests received during the last month of MCOP enrollment.

f. The MCOP's member transition of care plan, including the transition of care narrative, timeline, and member services workflow to support an efficient and seamless transition of members from coverage under this Agreement to coverage under ODM's designee. The transition of care plan must identify at risk populations and prioritize those members. The member transition plan must include a review of prior authorized services and a plan to continue authorization of those services, excluding prescribed drugs, for 90 calendar days after the effective date of the termination/non-renewal of this provider agreement. The plan must also include a newborn reconciliation approach. The prioritization and newborn reconciliation tracking must be submitted to ODM biweekly.

iii. *Transition Plan Updates*

1. The MCOP must report Transition Plan updates to ODM detailing MCOP's progress toward completing MCOP obligations under this Agreement and the Transition Plan on a monthly basis, on the fifth day of the month following the month reported.

iv. *Fulfill Existing Duties and Obligations*

1. During the term of this Agreement and after termination/non-renewal of this Agreement, the MCOP must fulfill all duties and obligations as required under OAC Chapter 5160-58 and any provider agreements related to the provision of services for the Medicaid population during periods of time when the MCOP was under contract with ODM. MCOP duties and obligations include the performance of ongoing functions and the submission of all outstanding reports and deliverables as identified in the Transition Plan. Specific examples of functions and reporting include the following:

    a. Member Grievances and Appeals, Provider Complaints, and State Hearings

        i. The MCOP must resolve all provider complaints and member grievances and appeals related to the MCOP's decisions and responsibilities exercised under this Agreement. The MCOP must also participate in state hearings related thereto. The MCOP must provide a monthly report of:

            1. Member complaint, grievance, appeal, and state hearing information; and

            2. Provider complaint information, as outlined in the MCOP's ODM-approved Transition Plan.

    b. Claims Payment

        i. The MCOP must pay all outstanding obligations for services and benefits rendered to members during the period of time when the

MCOP was under contract with ODM in accordance with the requirements in this Agreement and OAC rules 5160-58-01.1 and 5160-26-09.1. This includes, without limitation, the payment of funds owed as a result of the concurrent risk analysis process as well as the reporting, data integration, and payment requirements related to quality improvement (QI) strategies and value-based initiatives as specified in Appendix H, Value-Based Payment, such as behavioral health care coordination requirements.

c. Encounter and Claims Data

i. As directed by ODM, the MCOP must provide encounter data, cost report data, and claims aging reports, including incurred but not reported amounts, related to time periods through the final date of service every 30 calendar days as part of the monthly Transition Plan reporting requirement. The MCOP must continue encounter reporting until all services rendered prior to the termination/non-renewal of this Agreement have reached adjudicated status and data validation of the information has been completed to the satisfaction of ODM.

d. Population Health and Performance Data

i. After the termination date of this Agreement for any reason, the MCOP must continue to provide population health, care coordination, and quality data files as specified in Appendix C, Population Health and Quality; Appendix D, Care Coordination; and Appendix I, Quality and Waiver Measures, for all periods prior to the termination of this Agreement. In addition, the MCOP must continue to provide all data files required to determine the status of the Quality Withhold after the termination date.

e. Financial Reports

i. The MCOP must provide financial reports as outlined in the MCOP's ODM-approved Transition Plan, including:

1. Audited financial statements, inclusive of a balance sheet;
2. Reinsurance audit activities on prior contract years; and
3. Finalization of any open or pending reconciliations.

v. *Cooperation*

1. The MCOP must fully cooperate with ODM, ODM's designee(s), ODM vendors, and other MCOPs as directed by ODM to support a seamless transition of members and administrative responsibilities under this Agreement. The MCOP must participate in any meetings, workgroups, or other activities as directed by ODM to support the transition, both before and after the date of termination of this Agreement for any

reason, as determined necessary by ODM. The MCOP must promptly respond to ODM requests related to the transition, including but not limited to ODM programmatic requests, ODM data requests, and ODM information technology requests and meet all deliverable timelines required by ODM.

2. ODM will offset all additional costs and expenses incurred by ODM as a result of the MCOP's failure to cooperate and/or promptly respond as set forth in this section by deducting the additional costs and expenses from the monetary assurance.

vi. *Maintenance of Financial Requirements and Insurance*

1. The MCOP must comply with financial and insurance requirements under this Agreement until ODM provides the MCOP written notice that all continuing MCOP obligations under this Agreement have been fulfilled.

vii. *Refundable Monetary Assurance*

1. The MCOP must submit a refundable monetary assurance within ten business days of receiving the invoice. This monetary assurance will be held by ODM and must be in an amount of the greater of $50,000 or 5% of the capitation amount paid by ODM subject to termination/non-renewal in the month the termination/non-renewal notice is issued.

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

3. If the monetary assurance is not received as specified above, ODM will withhold the MCOP's next month's capitation payment until such time that ODM receives documentation that the monetary assurance is received by the Treasurer of State. This transaction will be created as an accounts receivable and will show up on the remittance advice.

4. Upon ODM's approval of the MCOP's final report, ODM will refund the monetary assurance to the MCOP, less any costs and expenses as set forth above.

viii. *Quality Withhold*

1. Unreturned funds from the quality withhold program of this Agreement set forth in Appendix J, Quality Withhold, will be retained by ODM.

ix. *Final Accounting of Amounts Outstanding*

1. The MCOP must submit to ODM a final accounting list of any outstanding monies owed by ODM under this Agreement no later than six months after the

termination/non-renewal date. ODM's payment will be limited to only those amounts properly owed by ODM. Failure by the MCOP to submit a list of outstanding items, or to include all outstanding items on that list, within the timeframe will be deemed a forfeiture of any additional compensation due to the MCOP.

x. *Member Transitions*

1. The MCOP must conduct all member transition activities in accordance with the ODM-approved Transition Plan and in accordance with ODM requirements. When transitioning members to ODM and/or ODM designees (MCOPs), the MCOP is responsible for notifying ODM and/or ODM designees of pertinent information related to the special needs of transitioning members. The MCOP must transfer member data to ODM and/or ODM designees within the time period and in a file format as specified by ODM.

xi. *Data Files*

1. If applicable, in order to assist members with transition and continuity of care, the MCOP must create data files to share with each receiving ODM designee. The MCOP must provide the data files in a consistent format specified by ODM and may include information on the following: care management, prior authorizations, inpatient facility stays, primary care provider (PCP) assignments, and pregnant members. The timeline for the MCOP providing these files will be at the discretion of ODM. The terminating MCOP will be responsible for all costs associated with data sharing and for ensuring the accuracy and data quality of the files.

xii. *Program Integrity Activities*

1. The MCOP must continue program integrity activities for two years from the end of this Agreement. Program integrity activities include requesting deconfliction and abiding by the ODM response, promptly submitting fraud referrals, conducting post-payment reviews and audits, and continuing to identify overpayments and recoupment. The MCOP shall submit to ODM quarterly inventory reports on all of these activities. Each quarterly inventory report submitted, and any subsequent revision to an inventory report, must be certified as accurate by the MCOP Chief Financial Officer (CFO).

    a. Overpayment Recovery. The MCOP may recover overpayments made to providers if the overpayment is identified and the provider is notified within two years of the date the MCOP improperly paid the provider, within six months of the MFCU returning a fraud referral to the MCOP, or if ODM recovers the payment to the provider from the MCOP, whichever is later.

    b. ODM Audits. The MCOP must allow ODM to audit capitation payments made to the MCOP and payments made to providers by the MCOP, as well as recover overpayments under the time limits in ORC section 5164.57.

c. Cooperation with Law Enforcement and Record Retention. The MCOP must continue to cooperate with law enforcement and federal audits for ten years following the termination of this Agreement.

2. The MCOP must retain records for ten years and allow auditing and inspection of those records for ten years.

xiii. *MCOP Release*

1. ODM will release the MCOP from its responsibilities under the Transition Plan upon ODM's approval of the MCOP's final report documenting that the MCOP has fulfilled all outstanding obligations. Following ODM release, the MCOP will retain ongoing responsibility for providing data to support audits related to the Medicaid population served by the MCOP during the term of this Agreement.

APPENDIX P – CHART OF DELIVERABLES

1. General

a. The MCOP must submit all deliverables required by this Agreement and as requested by ODM. Deliverables include but are not limited to policies, procedures, plans, member and provider notices, member materials, notifications to ODM, data, and reports.

b. The MCOP must submit each deliverable as specified by ODM, including but not limited to the format and timeframe for submission. Format means the content, form, and manner of submission.

c. ODM may, at its discretion, change the format or timeframe for submission of a deliverable or deliverables.

d. ODM may, at its discretion, require the MCOP to submit additional deliverables in the format and timeframe specified by ODM.

e. If this Agreement or ODM otherwise requires ODM prior review or approval of a deliverable, the MCOP must receive written notice of review or approval from ODM prior to the deliverable taking effect.

f. Unless otherwise specified by ODM, the MCOP must submit deliverables to the email address provided by ODM for submission of deliverables.

g. Unless otherwise specified by this Agreement or ODM, deliverables are due by 3:00 pm Eastern Time on the due date indicated. If the due date falls on a weekend or a state holiday, the due date is 3:00 pm Eastern Time on the next business day.

h. The MCOP must review all deliverables prior to submission to ODM and ensure the MCOP submits timely, accurate, and complete deliverables to ODM.

i. The MCOP's failure to submit timely, accurate, and complete deliverables to ODM is subject to compliance actions as specified in Appendix N, Compliance Actions.

j. If ODM requests a revision to a deliverable, the MCOP must make the changes and resubmit the deliverable in the format and timeframe specified by ODM. ODM will determine the MCOP's compliance with the requirement to submit timely, accurate, and complete deliverables based on the original submission.

k. The MCOP must review the content of deliverables to determine whether performance as documented in the deliverable complies with this Agreement. If the MCOP identifies deficient performance, the MCOP, in the submission of the deliverable, must include written documentation to ODM that identifies the area or areas of deficiency, and the steps taken by the MCOP to bring performance into compliance with this Agreement. The MCOP's self-identification of a deficiency does not impact ODM's ability to take a compliance action under Appendix N, Compliance Actions;

however, ODM may consider the MCOP's self-identification when determining the appropriate compliance action.

2. Ad Hoc Deliverables

a. The MCOP must submit notifications and other ad hoc deliverables (deliverables that are not scheduled, but the MCOP must submit to ODM under specific circumstances) to ODM as specified in this Agreement or as otherwise directed by ODM.

b. The MCOP must submit to ODM any Medicare-related reports and data that are submitted to CMS, including but not limited to Medicare Healthcare Effectiveness Data and Information Set (HEDIS), grievance and appeal reports, enrollment and disenrollment data, care management data, and financial reports.

c. Unless otherwise specified by this Agreement or ODM, the MCOP must submit all notifications and other ad hoc deliverables to ODM in writing.

3. Scheduled Deliverables

a. The Chart of Scheduled Deliverables in Section 4 below summarizes the scheduled deliverables specified in this Agreement, including the reference to the applicable appendix, the deliverable name, the frequency of the deliverable, and the due date.

b. The Chart of Scheduled Deliverables is presented for convenience only and does not limit the MCOP's responsibility to provide all deliverables required by ODM in the format and frequency specified by ODM.

4. Chart of Scheduled Deliverables

Table P.119 Chart of Scheduled Deliverables

#	Provider Agreement Appendix	Deliverable Name	Frequency	Due Date
1	Appendix A	Protected Health Information (PHI) Breach Report	Annual	• January 31 for the year ending the previous December
2	Appendix A	MyCare Call Center Report	Monthly Semi-Annual	• 15th of the month • January 10 for the 6-month period ending December 31 • July 10 for the 6-month period ending June 30
3	Appendix A	Member and Family Advisory Council Report	Quarterly	• January 30 for the quarter ending December 31 • April 30 for the quarter ending March 31 • July 30 for the quarter ending June 30 • October 30 for the quarter ending September 30

#	Provider Agreement Appendix	Deliverable Name	Frequency	Due Date
4	Appendix A	Appeal and Grievance Activity Report	Monthly	• 15th of the month
5	Appendix A	Grievance and Appeal Summary Report	Quarterly	• January 30 for the quarter ending December 31 • April 30 for the quarter ending March 31 • July 30 for the quarter ending June 30 • October 30 for the quarter ending September 30
6	Appendix A	Waiver Enrollment Information	Monthly	• 15th of the month
7	Appendix A	Calendar of Provider and Subcontractor Required Training	Annual	• September 30
8	Appendix A	Provider Claims Dispute Report	Monthly	• 15th of the month
9	Appendix A	Provider Advisory Council Activity Report	Semi-Annual	• January 15 for the 6-month period ending December 31 • July 15 for the 6-month period ending June 30
10	Appendix A	MCOP Organizational and Functional Chart	Annual	• January 15
11	Appendix A	MCOP Staff Training Plan	Annual	• January 15
12	Appendix A	FDR Oversight Report	Annual	• January 15
13	Appendix A	Pharmacy Reference Guide	Quarterly	• March 20 • June 20 • September 20 • December 20
14	Appendix B	Medication Therapy Management (MTM) Program Description	Annual	• April 30
15	Appendix B	Medication Therapy Management (MTM) Program Updates	Quarterly	• January 31 for the quarter ending December 31 • April 30 for the quarter ending March 31 • July 31 for the quarter ending June 30 • October 31 for the quarter ending September 30

#	Provider Agreement Appendix	Deliverable Name	Frequency	Due Date
16	Appendix B	Unstaffed Home Care Report	Monthly	• 15th of the month
17	Appendix B	Coordinated Services Program (CSP) via "Inbound from MCO" file process	Monthly, and upon change	• No later than the last day of the month preceding enrollment for new enrollments or reenrollments • Upon change of assigned provider
18	Appendix B	PASRR Report	Monthly	• 15th of the month
19	Appendix B	Institution for Mental Diseases (IMD) for Extended Stay	Quarterly	• January 31 for the quarter ending December 31 • April 30 for the quarter ending March 31 • July 31 for the quarter ending June 30 • October 31 for the quarter ending September 30
20	Appendix B	Transportation Performance Report	Quarterly	• January 31 for the quarter ending December 31 • April 30 for the quarter ending March 31 • July 31 for the quarter ending June 30 • October 31 for the quarter ending September 30
21	Appendix B	Pilot and Trial Incentive Program Report	Annual	• January 15
22	Appendix B	Utilization Management Tracking Database (UMTD) report	Monthly	• 5th of the month
23	Appendix B	Service Authorization Report	Monthly	• 15th of the month

#	Provider Agreement Appendix	Deliverable Name	Frequency	Due Date
24	Appendix B	Mental Health Parity and Addiction Equity Act (MHPAEA) Compliance Assessment Tool and Attestation of Compliance	Annual	• December 31
25	Appendix B	Prior Authorization (Rx) Statistics Report	Quarterly	• January 31 for the quarter ending December 31 • April 30 for the quarter ending March 31 • July 31 for the quarter ending June 30 • October 31 for the quarter ending September 30
26	Appendix B	Self-Directed Member's Report	Quarterly	• Last day of the month in March, June, September, and December
27	Appendix C	Population Health Management Strategy (PHMS)	Annual	• October 15
28	Appendix C	MCOP Risk Stratification Data Submission File	Quarterly	• January 31 • April 30 • July 31 • October 31
29	Appendix C	Community Reinvestment Plan and Evaluation	Annual	• February 1
30	Appendix C	Evidence of QI Training Completion	Within 1 month of completion	• Varies
31	Appendix C	PHMS Evaluation	Annual	• October 15
332	Appendix C	QI Meeting Template	Weekly	• At least 2 business days prior to the weekly QI meeting

#	Provider Agreement Appendix	Deliverable Name	Frequency	Due Date
33	Appendix C	Report of PRAF-Identified Needs Met	Monthly	• 15th of the month
34	Appendix D	Care Coordination Program Submission	Annual	• October 15
35	Appendix D	MyCare Ohio Care Coordination Status Submission File	Quarterly	• January 31 • April 30 • July 31 • October 31
36	Appendix D	Care Coordination Contact Lists	Quarterly	• January 31 • April 30 • July 31 • October 31
37	Appendix D	Comprehensive Risk Assessment Submission File	Quarterly	• January 31 • April 30 • July 31 • October 31
38	Appendix D	Behavioral Support Plans Report	Quarterly	• 15th day of January, April, July, and October
39	Appendix E	MCOP Marketing Plan	Annual	• December 1
40	Appendix F	Network Development and Management Plan	Annual	• January 15
41	Appendix F	Medicaid Providers Enrolled in Medicare Report	Semi-Annual	• Last Friday of March • Last Friday of September
42	Appendix F	Centralized Credentialing Member Grievances	Monthly	• 15th of the month
43	Appendix F	CMS Network Results	Quarterly	• January 31 • April 30 • July 31 • October 31

#	Provider Agreement Appendix	Deliverable Name	Frequency	Due Date
44	Appendix F	LTSS Time and Distance Report	Quarterly	• First Monday of January • First Monday of April • First Monday of July • First Monday of October
45	Appendix F	LTSS Service Delivery Wait Time Report	Quarterly	• First Monday of January • First Monday of April • First Monday of July • First Monday of October
46	Appendix F	LTSS Service Delivery Validation Report	Quarterly	• First Monday of January • First Monday of April • First Monday of July • First Monday of October
47	Appendix F	Member to LTSS Service Provider Ratio Report	Quarterly	• First Monday of January • First Monday of April • First Monday of July • First Monday of October
48	Appendix F	Provider Termination Report	Monthly	• 5th of the month
49	Appendix F	Appointment Availability Report	Semi-Annual	• Last Friday of March • Last Friday of September
50	Appendix F	Telehealth Report	Annual	• January 15
51	Appendix G	Waiver Service Claims Audit Report	Semi-Annual	• January 31st & July 31st
52	Appendix G	Compliance Plan	Annual	• January 15
53	Appendix G	EOB Mailing Date	Annual	• June 30th
54	Appendix G	EOB Results	Annual	• 60 calendar days after the EOB mailing date
55	Appendix G	Fraud, Waste, and Abuse Plan	Annual	• January 15
56	Appendix G	Fraud, Waste, and Abuse Report	Annual	• February 28
57	Appendix G	Fraud, Waste, and Abuse Inventory Report	Quarterly	• January 31 • April 30 • July 31 • October 31
58	Appendix H	APM Strategies	Annual	• October 15
59	Appendix H	Value-Based Payment Progress Report	Semi-annual	• June 30
60	Appendix H	APM Data Set	Quarterly	• May 15, for January 1-March 31, and October 1-December 31 • August 15, for April 1-June 30 • November 15, for Jul 1- September 30

#	Provider Agreement Appendix	Deliverable Name	Frequency	Due Date
61	Appendix I	HEDIS IDSS Data	Annual	• Mid-June
62	Appendix I	HEDIS IDSS Data Certification Letter	Annual	• Mid-June
63	Appendix I	HEDIS Final Audit Report	Annual	• Mid-July
64	Appendix I	HEDIS Final Audit Report Certification Letter	Annual	• Mid-July
65	Appendix I	CAHPS Survey Data	Annual	• June 15
66	Appendix I	Nursing Facility 100-Day Threshold and Discharge Data		• 30 business days of the nursing facility level of care
67	Appendix K	COBA Production Status Report	Monthly	• 25th of the month
68	Appendix K	Summary of BC-DR Plan Test Results	Annual	• Within 30 days of receiving results
69	Appendix K	Systems Audit Results	Annual	• Within 2 weeks of receiving the final report
70	Appendix K	CPSE Report	Monthly	• 15th of the month
71	Appendix K	Network Provider EHR Adoption Report	Annual	• January 15
72	Appendix K	Network Provider HIE Participation Report	Annual	• January 15
73	Appendix K	HIE Provider Support Plan	Annual	• January 15
74	Appendix L	NAIC Quarterly Financial Statement	Quarterly	• May 15 • August 15 • November 15
75	Appendix L	NAIC Annual Financial Statement	Annual	• March 1
76	Appendix L	Annual Audit Report	Annual	• June 1
77	Appendix L	NAIC/Cost Report Reconciliation	Annual	• April 30
78	Appendix L	Health Insuring Corporation (HIC) Tax Report	Quarterly	• March 15 • May 15 • August 15 • November 15
79	Appendix L	MLR Reporting Tool and Documentation	Annual	• For each MLR reporting year
80	Appendix L	Prompt Pay Report	Quarterly	• 15th of the first month of the calendar quarter
81	Appendix L	Third Party Liability Data File	Weekly	• No later than 11:00 pm Eastern Time Thursday night

#	Provider Agreement Appendix	Deliverable Name	Frequency	Due Date
82	Appendix L	Quarterly Cost Report	Quarterly	• January 31 • April 30 • July 31 • October 31
83	Appendix L	Annual Cost Report	Annual	• April 30

ATTACHMENT 1

Model Agreement

Between

Ohio Department of Medicaid

And

Named Contractor

Purpose of Agreement. This Agreement is intended to meet certain Centers for Medicare & Medicaid Services (CMS) requirements for Medicare Advantage Organization Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) including requirements found in the Bipartisan Budget Act of 2018 and 42 CFR 422.107. This Agreement is subject to the review and approval of CMS.

Contractor. The Contractor is a Medicare Advantage Organization offering a FIDE SNP for dual-eligible beneficiaries eligible for Ohio's Next Generation MyCare Ohio program (MyCare Ohio). The legal name of the entity that holds the MyCare Ohio provider agreement with the Ohio Department of Medicaid (ODM) for coverage of the Medicaid benefits ("MyCare Ohio provider agreement") described in Appendix B, Coverage and Services, of the MyCare Ohio provider agreement is [specify name of entity — exact legal name of the entity]. This entity is the same legal entity as the entity that holds the Medicare Advantage contract with CMS for the dual eligible special needs plan (D-SNP) covered under this Agreement. The Contractor must provide documentation to the state and to CMS that demonstrates that the entity responsible for coverage of the Medicaid benefits described in Appendix B, Coverage and Services, of the MyCare Ohio provider agreement is the same legal entity as the entity holding the Medicare Advantage contract with CMS for the D-SNP covered under this Agreement. The Contractor must have a Medicare Advantage contract (H-contract) that only includes D-SNPs within the state of Ohio in accordance with 42 CFR 422.107(e). The Contractor may execute a separate agreement with ODM to offer a coordination-only D-SNP to dual eligible recipients who are not eligible for MyCare Ohio but will not be permitted to offer a coordination-only D-SNP to dual eligible recipients who are eligible for MyCare Ohio.

Ohio Department of Medicaid. ODM is the state of Ohio agency responsible for administering the state's Medicaid program, which includes fee-for-service Medicaid and Next Generation managed care, including the Next Generation MyCare Ohio program.

1. **Categories of Eligible Recipients.** Dual eligible recipients eligible for enrollment with the Contractor are those specified in Ohio Administrative Code (OAC) rule 5160-58-02. The Contractor may enroll only full-benefit dual eligible recipients (e.g., qualified Medicare beneficiary plus, specified low-income Medicare beneficiary plus, and other full-benefit dual eligible recipients) that meet the criteria in OAC rule 5160-58-02.

2. **Medicaid Benefits to be Covered.** The Contractor's affiliated MyCare Ohio plan must provide members the Medicaid benefits and services specified in Appendix B, Coverage and Services, of the MyCare Ohio provider agreement, pursuant to a capitated contract with ODM. The Medicaid covered benefits that must be provided by the Contractor's affiliated MyCare Ohio plan include all primary care and acute care; behavioral health services; long-term services and supports, including coverage of nursing facility services for a period of at least 180 days per year; home health services; and medical supplies, equipment, and appliances. The Contractor must cover all Medicare Part A and Part B cost-sharing (e.g., deductibles, co-payments, and

coinsurance) for all members. These cost-sharing benefits must be covered by the FIDE SNP's affiliated MyCare Ohio plan, which is part of the same legal entity as the FIDE SNP.

3. **Supplemental Benefits.** The Contractor must comply with the requirements regarding supplemental benefits in Appendix B, Coverage and Services, of the MyCare Ohio provider agreement.

4. **Service Coordination.** The Contractor must coordinate the delivery of covered Medicare and Medicaid services within the same legal entity. The Contractor must use aligned care management and specialty care network methods for high-risk members, including complying with the requirements in Appendix D, Care Coordination, of the MyCare Ohio provider agreement.

5. **Coordinated Information.** The Contractor must provide eligible individuals and members with materials that contain integrated information (information on both Medicare and Medicaid programs), as specified in Appendix E, Marketing and Member Materials, of the MyCare Ohio provider agreement. The Contractor must respond to questions from eligible individuals and members about both Medicare and Medicaid benefits, as specified in Appendix A, General Requirements, of the MyCare Ohio provider agreement.

6. **Unified Appeals and Grievance Procedures.** The Contractor must use the unified appeals and grievance procedures specified in federal regulations and Appendix A, General Requirements, of the MyCare Ohio provider agreement.

7. **Quality Improvement.** The Contractor must integrate quality improvement and comply with the requirements in the MyCare Ohio provider agreement, including Appendix C, Population Health and Quality, Appendix I, Quality and Waiver Measures, and Appendix J, Quality Withhold.

8. **Member Advisory Committee.** The Contractor must have a member and family advisory council as specified in Appendix A, General Requirements, of the MyCare Ohio provider agreement.

9. **Cost-Sharing Protections.** In accordance with Section 1852(a)(7) of the Social Security Act and 42 CFR 422.504, the Contractor and its network providers must not impose cost-sharing requirements on members that exceed the amounts permitted under the Ohio State Medicaid plan. For services that are reimbursed by both Medicare and Medicaid, such as physicians' services, for which Medicaid pays the Medicare co-payment, the Contractor must require that network providers accept the payment from the Contractor as payment in full. The FIDE SNP must comply with member cost-sharing requirements in Appendix B, Coverage and Services, of the MyCare Ohio provider agreement.

10. **Provider Network.** ODM must provide the Contractor with information on Medicaid provider participation from ODM's provider network management system, and the Contractor must conduct a daily reconciliation of its provider network and ODM's provider network management system as specified in Appendix F, Provider Network, of the MyCare Ohio provider agreement. The Contractor must have an adequate provider network capable of serving the health care needs of its members and that meets the requirements in Appendix F, Provider Network, of the MyCare Ohio provider agreement.

11. **Eligibility Verification.** Prior to enrollment in the Contractor, the Contractor must verify a potential member's Medicare and Medicaid eligibility. As a health plan, the Contractor may verify Medicaid eligibility utilizing a Health Insurance Portability and Accountability Act (HIPAA) compliant 270/271 transaction. Both transactions are real time verifications of eligibility and provide Medicaid and Medicare information as

documented in Ohio's eligibility system. The Contractor must comply with the eligibility and enrollment requirements in Appendix A, General Requirements, of the MyCare Ohio provider agreement.

12. **Exclusively Aligned Enrollment.** The Contractor must conduct enrollment of eligible individuals in accordance with this Agreement and Appendix A, General Requirements, of the MyCare Ohio provider agreement, and maintain exclusively aligned enrollment. An eligible individual's decision to enroll in the Contractor's FIDE SNP shall be voluntary. However, as a condition of eligibility for the Contractor's FIDE SNP, individuals may only enroll in the Contractor's FIDE SNP if they also simultaneously agree to enroll in the Contractor's MyCare Ohio plan.
13. **Service Area.** The service area for this Agreement and the MyCare Ohio provider agreement are the same and includes every county in the state of Ohio in accordance with Section 4, Service Area, of the Introduction of the MyCare Ohio provider agreement.
14. **Amendment.** This Agreement may be amended as specified in Article IX, Amendment and Renewal, of the Baseline Provider Agreement of the MyCare Ohio provider agreement.
15. **Contract Period.** The contract period for this Agreement is the time period specified in Article II, Time of Performance, of the Baseline Agreement of the MyCare Ohio provider agreement.
16. **Termination.** This Agreement may be terminated in accordance with Article VIII, Termination and Non-Renewal, of the Baseline Agreement of the MyCare Ohio provider agreement.
17. **Compliance with MyCare Ohio Provider Agreement.** The MyCare Ohio provider agreement is incorporated by reference, and the Contractor must comply with all the requirements of the MyCare Ohio Provider Agreement, including but not limited to the Baseline Agreement and Appendices A through P.
18. **Compliance with Federal and State Laws, Rules and Regulations.** The Contractor must comply with all federal and state laws, rules and regulations applicable to the performance of this Agreement.

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

CONTRACTOR:

BY: _____ DATE: _____
NAME OF SIGNATORY, TITLE

OHIO DEPARTMENT OF MEDICAID:

BY: _____ DATE: _____
Maureen Corcoran, DIRECTOR