

REQUEST FOR APPLICATIONS
Ohio Resilience through Integrated Systems and
Excellence (OhioRISE) Program

RFA Number: ODMR-2021-0025

Date Issued: October 28, 2020

Application Due Date: December 16, 2020

TABLE OF CONTENTS

SECTION 1: INTRODUCTION AND BACKGROUND	1
1.1 Introduction	1
1.2 Background	1
1.3 Summary of Scope of Work	7
1.4 Statewide	7
1.5 Request for Application Resource Library	7
1.6 Request for Application Glossary	8
SECTION 2: SCHEDULE OF EVENTS.....	9
2.1 Anticipated RFA Schedule	9
2.2 Issuance of RFA.....	9
2.3 Pre-Application Conference.....	10
2.4 Actuarial Conference for Potential Applicants	10
2.5 Question and Answer Period	10
2.6 RFA Revisions	12
2.7 Notification of Intent to Apply	12
2.8 Submission of Application.....	12
2.9 Application Evaluation	13
2.10 Oral Presentations	13
2.11 Notification of Award	13
2.12 Protest Procedure	13
2.13 Provider Agreement Execution.....	15
2.14 Readiness Reviews.....	15
SECTION 3: APPLICATION REQUIREMENTS	16
3.1 Number of Applications.....	16
3.2 Application Format Requirements	16
3.3 Application Organization.....	17
3.4 Submission Requirements.....	17
SECTION 4: EVALUATION AND SELECTION	32
4.1 Evaluation Process	32

4.2	Phase I: Review of Mandatory Qualifications	32
4.3	Phase II: Review of Responses to Application Questions	33
4.4	Phase III: Oral Presentations.....	34
4.5	Phase IV: Selection	34
SECTION 5: CONDITIONS AND OTHER REQUIREMENTS		35
5.1	Communication Prohibitions	35
5.2	Sensitive Personal Information	35
5.3	Cost of Application Preparation and Readiness Review	36
5.4	Amended Applications.....	36
5.5	Application Offer Firm	36
5.6	Review Process Exceptions	36
5.7	Start Work Date	36
5.8	Trade Secrets Prohibition; Public Information Disclaimer.....	36
5.9	Model OhioRISE Plan Provider Agreement.....	37
5.10	Public Release of Evaluations and/or Reports	37
5.11	Ethical & Conflict of Interest Requirements	37
5.12	Mandatory Contract Performance Disclosure.....	38
5.13	Mandatory Disclosures of Governmental Investigations.....	38
5.14	No Obligation to Award.....	38
5.15	Request for Application Cancellation and Re-Procurement Authority	39
SECTION 6: ATTACHMENTS.....		40
Attachment A: Model OhioRISE Plan Provider Agreement		
Attachment B: Letter of Transmittal Template		
Attachment C: Application Checklist		
Attachment D: Exceptions		
Attachment E: Conflict of Interest		
Attachment F: Location of Business and Offshore Declaration Form		
Attachment G: Affidavit of Non-Collusion		
Attachment H: Certification of Compliance with Special Conditions		
Attachment I: Draft OhioRISE Rules and Managed Care Rule		

SECTION 1: INTRODUCTION AND BACKGROUND

1.1 Introduction

The Ohio Department of Medicaid (ODM) is releasing this Request for Applications (RFA) to procure a single statewide behavioral health managed care plan to assist the State to implement the Ohio Resilience through Integrated Systems and Excellence (OhioRISE) Program for children and youth involved in multiple state systems or children and youth with other complex behavioral health needs.

ODM intends to select a statewide OhioRISE Plan that will be responsible for developing and managing a full continuum of behavioral health network providers to include local services, providers, and regional care management entities (CMEs) with demonstrated expertise necessary to effectively serve these populations.

1.2 Background

The State of Ohio is in the process of transforming its approach to children, youth, and their families who require support from multiple state systems, or whose behavioral health needs are complex and require intensive care coordination (ICC). With leadership from the Governor's Office of Children's Initiatives, the following multi-agency activities (available in the RFA Resource Library) are currently targeted at these populations:

- Specific new programs began in 2019 to provide state-level technical assistance and funding for services to prevent custody relinquishment for some of Ohio's highest need children and youth.
- The Ohio Department of Job and Family Services (ODJFS) is leading a robust multi-agency effort to plan for implementation of the Family First Prevention Service Act (FFPSA).
- Governor DeWine recently formed a Children Services Transformation Advisory Council, which held 10 Foster Care Forum listening sessions across the state; this group will issue recommendations to transform the child protection system by the end of Q2 2020.
- Ohio Family and Children First released a Multi-System Youth (MSY) Action Plan at the end of 2019; the Ohio Family and Children First (OFCF) Cabinet Council is tasked with implementing this action plan in the coming months and years.

As part of the Governor's overarching goal to improve care for children and adults with complex needs, the State of Ohio is designing a reimagined Medicaid system and structure to serve MSY and other children and youth with complex behavioral health needs. Ohio's approach to achieve this goal is through implementation of the OhioRISE Program. The OhioRISE Program will facilitate Ohio's goals by:

- Creating a seamless delivery system for children, families, and system partners;

- Providing a “locus of accountability” by offering ICC through regional CMEs; and
- Expanding access to critical services needed for this population and assisting families, state and local child-serving agencies, and other health providers to locate and use necessary services.

The new structure will include use of an ICC model and High Fidelity Wraparound approach to improve service delivery and timeliness of care coordination. The Wraparound approach has been proven to:

- Reduce unnecessary hospitalizations;
- Decrease involvement with the juvenile justice and corrections systems;
- Reduce out-of-home and out-of-state placements (residential care and foster care);
- Increase school attendance and performance; and
- Reduce custody relinquishment for children, youth, and families.

The design of the OhioRISE Program was also informed by stakeholder input. Through issuance of two rounds of Requests for Information (RFIs) ODM received input from individuals receiving Medicaid services and their families, advocates, providers, provider associations, partner state agencies, and other persons or organizations about recommended improvements to Ohio’s Medicaid managed care program (RFI #1) and additional input from other interested parties, including managed care organizations (MCOs) (RFI #2), which helped further refine ODM’s approach to Medicaid managed behavioral health services for children and youth involved in multiple state systems or with other complex behavioral health needs.

Responses to RFI questions about services for children and youth involved in multiple state systems or with complex behavioral health needs revealed some stakeholders perceive the current system as too disjointed for MSY, leading to confusion and movement of foster children from family to family and causing disruption in care (e.g., a child’s history does not follow the child during periods of transition).

For example, one respondent suggested “the state should review its requirements for care coordination and managed care to ensure that children and youth are not overlooked due to higher risk adult populations. It should be mandated that administrative funds designated to provide services for children and youth be directed to that population.” An additional respondent suggested care coordination should be used to secure “behavioral health services...for very intense, multi-system youth,” and should “be able to identify and secure services that would assist with preventing placements.” These and other important enhancements are reflected in this RFA.

Overview of Ohio’s Current Medicaid Program

Approximately 90% of persons insured by Ohio Medicaid are enrolled in an MCO. Specifically, in State Fiscal Year (SFY) 2019 (July 1, 2018 through June 30, 2019), Ohio Medicaid’s monthly enrollment in managed care was approximately 2.46 million individuals, out of a total 2.73 million full benefit individuals. (The entire Medicaid monthly enrollment for SFY 2019 was 2.87 million). ODM’s monthly managed care

enrollment reports can be accessed at <https://medicaid.ohio.gov/RESOURCES/Reports-and-Research/Medicaid-Managed-Care-Plan-Enrollment-Reports>. The monthly enrollment report breaks down enrollment by eligibility category by current Medicaid MCO and region.

ODM currently contracts with five MCOs selected through a competitive procurement process in 2012. The MCOs are responsible for covering all Ohio Medicaid state plan medical benefits, including behavioral health services and prescription drugs for individuals enrolled in the MCO. MCOs must also offer additional benefits, such as member services and care management.

In addition to individuals enrolled in these MCOs, approximately 120,000 individuals are enrolled in MyCare Ohio, which is a managed care demonstration program designed for Ohioans age 18 and older who are eligible for both Medicaid and Medicare and reside in one of 29 Ohio counties. These individuals are enrolled in MyCare Ohio Plans, which coordinate their physical, behavioral, and long-term care services.

There are also a number of children and youth under the age of 21 who participate in ODM's fee-for-service program. These individuals are not enrolled in an existing MCO or MyCare Ohio Plan, but are either dually eligible for Medicaid and Medicare and/or are participating in one of the state's home and community-based services 1915(c) waivers.

Other state agencies, including the Ohio Department of Aging, the Ohio Department of Mental Health and Addiction Services, the Ohio Department of Health, the ODJFS, and the Ohio Department of Developmental Disabilities, administer various programs for children and youth involved in multiple state systems or children and youth with other complex behavioral health needs. Children and youth in the Medicaid program may also receive services delivered in coordination with one or more of these agencies or their local counterparts.

Ohio's Child-Serving System

The ODJFS is responsible for the State's child abuse and neglect prevention, adoption, and foster care programs. The agency is also responsible for developing and overseeing Ohio's public assistance, workforce development, adult protective services, childcare, child support, and unemployment insurance programs.

Many ODJFS programs, including adoption and foster care, are supervised by the State and administered by county or local agencies, including 88 County Departments of Job and Family Services (CDJFS), separate public children services agencies (PCSAs), separate child support enforcement agencies, and workforce development boards.

In addition to ODJFS, Ohio's child-serving agencies and local entities include but are not limited to: the Department of Developmental Disabilities (DODD); Ohio Department of Education (ODE); Ohio Department of Health (ODH); Ohio Department of Mental Health and Addiction Services (OhioMHAS); Ohio Department of Rehabilitation and Correction (ODRC); Ohio Department of Youth Services (DYS); OFCF; County Alcohol, Drug and Mental Health Boards (ADAMH); County Boards of Developmental Disabilities (BDD);

CDJFS; County Juvenile Courts; Educational Service Centers (ESCs); Family and Children First Councils (FCFCs); and School Districts.

Medicaid Data Findings Concerning Multi-System Youth

Analysis of Medicaid data reveals Ohio currently may not have the infrastructure to care for children and youth involved with multiple systems and/or with the most complex behavioral health needs. ODM understands a “one size fits all” approach is not appropriate for complex needs populations as evidenced by the following:

- Youth family risk factors indicate that among all Medicaid youth age 20 and under:
 - 38% have family members with a history of opiate use disorder (OUD) and/or a primary diagnosis of serious mental illness;
 - 19.9% have family members with a history of OUD or substance use disorder (SUD);
 - 18.3% have a parent or caregiver with a primary SUD diagnosis;
 - 17.3% have a parent or caregiver with a primary serious mental illness diagnosis;
 - 7.2% have a parent or caregiver receiving medication assistance treatment (MAT) for treatment of an OUD; and
 - 11.9% have a parent or caregiver with a primary or secondary diagnosis for OUD or receiving MAT for OUD.
- Medicaid spending differs by youth sub-populations. In SFY 2019, the percent of Medicaid behavioral health versus total spending indicated:
 - 63% of total Medicaid spending for children and youth in foster care was behavioral health related;
 - 45% of total Medicaid spending for children and youth eligible for adoption assistance was behavioral health related;
 - 57% of total Medicaid spending for children and youth diagnosed with SUD was behavioral health related; and
 - 56% of total Medicaid spending for children and youth with serious mental illness was behavioral health related.

Ohio’s Future Medicaid Managed Care Program for Multi-System Youth

In designing the OhioRISE Program for MSY children and youth, ODM and partnering agencies noted the need to address unevenness in the availability of services needed by multi-system youth and their caregivers. With this OhioRISE Plan procurement, including phases of activities following contract implementation, ODM and its partner state agencies will continue to customize the structure and design of the OhioRISE Program approach to focus on the needs of MSY children and youth.

This OhioRISE Program is intended to address the behavioral health service and support needs of approximately 50,000 to 60,000 children and youth. Children and youth will be eligible for the OhioRISE Program if they meet a threshold score on the Child and

Adolescent Needs and Strengths (CANS). The CANS is a national, evidenced based tool developed for children's services to support clinical and service decision-making. The CANS will also be used to determine initial and ongoing level of need for the OhioRISE Program and for determining initial and ongoing level of need for OhioRISE services.

The State team envisions a delivery system structure for children and youth where the State, the OhioRISE Program, a network of regional CMEs, behavioral health providers, and MCOs work together to create a seamless delivery system for children, youth, families, and system partners. For instance, many children and youth enrolled in the OhioRISE Plan will also be enrolled in MCOs and will continue to receive medical services through the MCO. For children and youth enrolled with an MCO, the OhioRISE Plan will work in partnership with each MCO and develop written agreements, which document the respective responsibilities, expectations, and coordination between the OhioRISE Plan and the MCOs. Children and youth who are not enrolled with an MCO will continue to receive their physical health services through fee-for-service.

The redesigned delivery system will consist of:

- **A Single Statewide OhioRISE Plan** responsible for children and youth involved in multiple state systems or with other complex behavioral health needs. The OhioRISE Plan will:
 - Be responsible for developing and managing a full continuum of behavioral health network providers, to include regional CMEs, with the specific expertise necessary to effectively serve this population;
 - Develop the necessary data infrastructure to support providers and coordinate with the MCOs, the single pharmacy benefit manager (SPBM), and any applicable fee-for-service systems to ensure integration of physical health and behavioral health services; and
 - Contract for care coordination through the CMEs and other services with local service providers.
- **Child-Serving Agencies** collaborating to implement and oversee the OhioRISE Plan;
- **A Network of Regionally Located CMEs** that will serve as the “locus of accountability” for children and youth with complex challenges and their families who are involved in navigating multiple state systems. The OhioRISE Plan will select CMEs with demonstrated expertise providing ICC using High-Fidelity Wraparound and with sufficient capacity to serve OhioRISE Plan members. The CMEs will:
 - Offer two tiers of care coordination: one for individuals who need ICC using a High Fidelity Wraparound approach, and additional tier for children, youth and families that offer a more moderate level of care coordination;
 - Provide or coordinate the provision of community-based and in-home services, and other services and supports to improve health outcomes; and

- Be aligned to the care coordination capacity needed to serve OhioRISE Plan members, taking into account both geographic and service considerations.
- **Service Providers and Local Efforts** that address the needs of these children, youth, and their families through a delivery system where providers are supported by the OhioRISE Plan and Centers of Excellence (COEs) to cultivate new community-based services:
 - The State team has identified the types of services children and youth involved in multiple systems need to be healthy and successful in their lives and communities. In addition to intensive and moderate care coordination services provided by CMEs, these other services include: Mobile Response and Stabilization Services (MRSS), Intensive Home Based Treatment (IHBT), inpatient behavioral health services, psychiatric residential treatment facilities (PRTF), SUD services, psychiatry services, and other behavioral health services.
 - The State will be leading a stakeholder engagement process to fully develop service standards and specifications that ultimately will be implemented in OhioRISE Program.
 - Significant work is being done to align FFPSA services with those offered through the new delivery system.
 - The OhioRISE plan will support providers by identifying and implementing strategies to develop the network of new services or enhance the development of existing services in the OhioRISE Program including:
 - Initiatives that will assist providers in identifying and recruiting staff for key supervisory and direct service positions;
 - Creating opportunities for network providers to locate formal and informal supports for OhioRISE members with unique services and support needs; and
 - Partnering with providers to develop and implement innovative approaches to workforce and network development including new service and payment strategies.
- **COE(s)** to support development of evidence-based practices and services, ongoing fidelity reviews, and workforce development. As a foundational part of the redesigned delivery system, the COE(s) will:
 - Work in collaboration with OhioMHAS, ODJFS, ODM, DYS, DODD, DOH, and OFCF to build and sustain a comprehensive standardized assessment process, effective services, and care coordination approaches for children with complex behavioral health needs and their families;
 - Assist the State in system transformation efforts by providing the orientation, training, coaching, mentoring, and other functions/supports needed by the provider network in order to build and sustain capacity in

- delivering evidence-based practices to fidelity within a system of care framework; and
 - Support services funded through the Medicaid program, as well as other child-serving agencies, and include prevention and early intervention services that will need to be in place to implement the Family First Prevention Services Act.
- **Medicaid MCOs** responsible for physical health services for their enrollees, as well as behavioral health services and care coordination for children and youth with less intense behavioral health needs. Members enrolled in OhioRISE Plan and not enrolled in an MCO will continue to receive their physical health services through fee-for-service;
- **An SPBM** responsible for processing all pharmacy claims for MCO and fee-for-service members.

1.3 Summary of Scope of Work

The Contractor selected as a result of this RFA will be responsible for providing covered services (see Appendix B of Attachment A, Model OhioRISE Plan Provider Agreement) and complying with all applicable state and federal Medicaid managed care requirements, including but not limited to those in the Model OhioRISE Plan Provider Agreement (Attachment A, Model OhioRISE Plan Provider Agreement). The Contractor must deliver services and perform their responsibilities in a manner consistent with achieving ODM's goals listed above and in accordance with ODM's population health principles and strategies.

1.4 Statewide

Ohio's OhioRISE Program will be statewide and not regionally based. To align with certain structures in Ohio's Medicaid managed care program, the OhioRISE Plan must have regional staff as set forth in Attachment A of this RFA (Attachment A, Model OhioRISE Plan Provider Agreement).

1.5 Request for Application Resource Library

ODM has established an RFA resource library, which may be accessed on the Department of Administrative Services (DAS) website dedicated to this RFA.

The RFA resource library contains reference material intended to assist Applicants to prepare a response to this RFA, including but not limited to ODM policies and procedures and a data book with information on members and costs.

The materials in the RFA resource library are incorporated by reference into this RFA. Accordingly, Applicants are responsible for reviewing the contents of the RFA resource library as if the materials were printed in full herein. ODM may continue to update the materials in the RFA resource library after this RFA is released; however, Applications

will be evaluated based upon the content contained in the RFA resource library as of the final date for ODM to post responses to submitted questions (see Section 2.1, Anticipated RFA Schedule).

1.6 Request for Application Glossary

Definitions and acronyms in the Definitions and Acronyms section of Attachment A, Model OhioRISE Plan Provider Agreement, apply to define the terms used throughout this RFA. Additional terms used in the body of this RFA are as follows:

Applicant refers to any person, corporation, or partnership that submits an Application in response to this RFA.

Application refers to a response to this RFA.

Contractor means a successful Applicant who executes an OhioRISE Plan Provider Agreement with ODM. Also referred to as the OhioRISE Plan.

ET means Eastern Time.

Evaluation Committee means a body appointed by ODM to review and score Applications.

Go-Live means the date on which the Contractor assumes responsibility for the provision of covered services to members.

SECTION 2: SCHEDULE OF EVENTS

This section of the RFA contains the anticipated RFA schedule, and describes the major procurement events.

2.1 Anticipated RFA Schedule

The RFA schedule set forth below represents ODM's best estimate of the schedule that will be followed. ODM reserves the right to revise this schedule if needed and/or to comply with the State of Ohio procurement procedures and regulations. If a component of this schedule is delayed, the rest of the schedule will likely be shifted by the same number of days.

Date	Event/Activity
October 28, 2020	ODM issues RFA; Question and answer (Q&A) period opens
November 9, 2020, 9:00 a.m. ET	Pre-Application conference
November 9, 2020, 1:00 p.m. ET	Actuarial conference
November 20, 2020, 4:00 p.m. ET	Q&A period closes
November 24, 2020, 4:00 p.m. ET	Deadline for submitting notification of intent to apply
December 8, 2020, 4:00 p.m. ET	ODM's final date to post responses to submitted questions
December 16, 2020, 3:00 p.m. ET	Deadline to file protest related to information contained in or known from this RFA or other event preceding deadline for submission of Applications
December 16, 2020, 4:00 p.m. ET	Deadline for submission of Applications to ODM
February 1-5, 2021	Oral presentations
February 19, 2021	ODM issues contract award notification letters
March 1, 2021	Deadline to file protest regarding ODM's award selection
March 8, 2021	Estimated Provider Agreement execution
From award to go-live	Readiness review
January 5, 2022	Go-live

2.2 Issuance of RFA

Upon ODM's release of the RFA on the ODM website, the RFA becomes active, and potential Applicants may access the RFA and the RFA resource library and may submit questions to ODM (see Section 2.5, Question and Answer Period).

2.3 Pre-Application Conference

ODM will hold a pre-Application conference for potential Applicants. While attendance is encouraged, attendance at the conference is not a prerequisite for submitting an Application.

The conference will be held virtually at the date and time specified in Section 2.1, Anticipated RFA Schedule.

To participate in this conference, potential Applicants must register at <https://attendee.gotowebinar.com/register/5592433208529808907>

The purpose of the pre-Application conference is to discuss ODM's vision for OhioRISE Program, the RFA scope of services, and the procurement process. Potential Applicants may ask clarifying questions regarding the RFA at the pre-Application conference; however, ODM's verbal response to any question at the pre-Application conference is preliminary and non-binding. Potential Applicants should submit written questions in accordance with Section 2.5, Question and Answer Period.

2.4 Actuarial Conference for Potential Applicants

ODM will hold an actuarial conference for potential Applicants. While attendance is encouraged, attendance at the conference is not a prerequisite for submitting an Application.

The conference will be held virtually at the date and time specified in Section 2.1, Anticipated RFA Schedule.

To participate in this conference, potential Applicants must register at <https://attendee.gotowebinar.com/register/7512817127859226891>

The purpose of the actuarial conference is to discuss the rate setting methodology and the data book. Potential Applicants may ask clarifying questions regarding the rate setting methodology and the data book at the actuarial conference; however, ODM's verbal response to any question at the actuarial conference is preliminary and non-binding. Potential Applicants should submit written questions in accordance with Section 2.5, Question and Answer Period.

2.5 Question and Answer Period

Potential Applicants may submit clarifying questions regarding this RFA during the Q&A Period as outlined in Section 2.1, Anticipated RFA Schedule, by using the following Internet process:

- Access the ODM Web Page at <http://medicaid.ohio.gov/>;
- Go to the "Resources" tab and select "Legal and Contracts";
- Select "RFPs," then under "Current Solicitation" select the appropriate posting;

- Provides access to the posting on the Department of Administrative Services (DAS) website;
- Select the “Submit Inquiry” option button; and
- Provide requested information and submit question.

The purpose of the Question and Answer process is to enable potential Applicants to obtain clarification about the RFA requirements in order to prepare an Application. ODM may choose not to answer questions submitted for reasons other than to obtain clarifications regarding the RFA requirements. Comments and feedback not seeking clarification are welcome and may be submitted to the managed care procurement mailbox, mcprocurement@medicaid.ohio.gov.

Questions about this RFA must reference the relevant part of the RFA, the heading for the provision under question, and the page number where the provision can be found. The name of a representative of the potential Applicant (or other interested party), the company name, phone number, and e-mail address must be provided to submit an inquiry. ODM may, at its option, disregard any questions that do not appropriately reference an RFA provision or location within the RFA, or that do not include identification of the originator of the question. Questions submitted after the deadline (date and time) for submitting questions to ODM (see Section 2.1, Anticipated RFA Schedule, Q&A Period Closes) will not be answered.

ODM’s responses to questions asked via the Internet will be posted on the DAS website dedicated to this RFA for public reference by any interested party. ODM will not provide answers directly to the potential Applicant (or any interested party) that submitted questions. ODM is under no obligation to acknowledge or respond to questions submitted through the Q&A process if those questions are not in accordance with these instructions.

Questions submitted may be no more than 4,000 characters in length, but there is no limit on the number of questions, which may be submitted. ODM’s answers may be accessed by following the instructions above, but rather than selecting “Submit Inquiry,” potential Applicants and others should select “View Q and A.” ODM strongly encourages potential Applicants to ask questions early in the Q&A period. No clarifying questions will be accepted after the close of the Q&A period (date and time) as specified in Section 2.1, Anticipated RFA Schedule.

Applications in response to this RFA are to take into account any information communicated by ODM in the Q&A process for the RFA. It is the responsibility of all potential Applicants to check the DAS website dedicated to this RFA on a regular basis for responses to questions, as well as for any addenda, alerts, or other pertinent information regarding this RFA because these items become part of this RFA. Once submitted questions have been answered, responses will be clearly identified on the DAS website dedicated to this RFA.

Requests for copies of any previous RFAs, past applications, or score sheets for similar past projects are not clarification questions regarding this RFA, but are Public Records Requests (PRRs), and should be submitted to: mclegal@medicaid.ohio.gov.

If potential Applicants experience technical difficulties accessing the DAS website where the RFA and its related documents are published, they may contact the ODM Office of Contracts and Procurement (OCP), RFP Unit, at ODM_Procurement@medicaid.ohio.gov for guidance.

2.6 RFA Revisions

If it becomes necessary to revise any part of this RFA, ODM will post those revisions, addenda, etc., to the DAS website dedicated to this RFA. All potential Applicants must refer to that website regularly for addenda or other announcements. ODM will not specifically notify potential Applicants of changes or announcements related to this RFA except through the website posting. It is the sole responsibility of potential Applicants to be aware of and to fully respond to all updated information posted on the DAS website dedicated to this RFA.

2.7 Notification of Intent to Apply

All potential Applicants are requested to submit a non-binding notification of intent to submit an Application in response to this RFA. While preferred, a notification of intent to apply is not a prerequisite for submitting an Application.

ODM requests that potential Applicants submit a notification of intent via email to ODM_Procurement@medicaid.ohio.gov by the date and time identified in Section 2.1, Anticipated RFA Schedule (Deadline for submitting notification of intent to apply). The notification of intent should include the following in the subject line: Notification of Intent to Apply for RFA ODMR-2021-0025 — for the OhioRISE Program; and the body of the notification should include: the potential Applicant's name and address, the name of the potential Applicant's contact and that person's phone number and email address, and a statement that the potential Applicant intends to submit an Application in response to the RFA.

2.8 Submission of Application

Applications must meet the requirements in Section 3, Application Requirements. The Applicant's total complete submission (the original signed Application, all required copies of the Application, and the CD-ROM or USB flash drive) must be received by ODM no later than the date and time specified in Section 2.1, Anticipated RFA Schedule. Faxed or emailed submissions will not be accepted. Submissions must be addressed, for hand delivery or delivery by a private delivery company, as described below:

Office of Contracts and Procurement, RFP/RLB Unit
Ohio Department of Medicaid
50 West Town Street
Columbus, Ohio 43215

Applicants are strongly encouraged to use a delivery company capable of hand-delivering their Application directly to ODM's security desk and obtaining a date and time stamp. All

Applications must be received by ODM by the date and time specified in Section 2.1, Anticipated RFA Schedule. A postmark date prior to this deadline does not satisfy the requirement that the Application must be received by ODM prior to the deadline. No exceptions will be made. In accordance with Section 4.2, Phase I: Review of Mandatory Applications, a potential Applicant's failure to submit an Application before the deadline will cause the Application to be disqualified.

Each submission (the original signed Application, all required copies of the Application, and the CD-ROM or USB flash drive) must be sealed in a box (or boxes). The packing boxes must be numbered sequentially (e.g., Box 1 of 4, Box 2 of 4). Each box must be labeled with the following information:

- Applicant's name and address
- ODM's address (above)
- RFA title and number (ODMR-2021-0025)

2.9 Application Evaluation

ODM will evaluate Applications submitted by the deadline for Applications (date and time) as described in Section 4, Evaluation and Selection. Applications submitted after the deadline for Applications (date and time) will not be evaluated.

2.10 Oral Presentations

As described in Section 4.4, Phase III: Oral Presentations, ODM will conduct an oral presentation, interview, and/or demonstration (referred to as oral presentation) as part of the evaluation process. It is anticipated that oral presentations will occur during the time period specified in Section 2.1, Anticipated RFA Schedule.

2.11 Notification of Award

Based on ODM's selection of the successful Applicants, ODM will send all Applicants a letter stating whether their Application was selected for award. Applicant selected for award will receive an award letter. Applicants not selected for award will receive a denial letter.

2.12 Protest Procedure

A potential or actual Applicant objecting to any matter relating to this RFA may file a protest with ODM using the following guidelines:

1. Protests may be filed by a potential or actual Applicant in writing, and must contain the following information:
 - a. The name, address, and telephone number of the protestor;
 - b. The name and number of the RFA being protested;

- c. A detailed statement of the legal and factual grounds for the protest, including copies of any relevant documents;
 - d. A request for a ruling by ODM;
 - e. A statement as to the form of relief requested from ODM; and
 - f. Any other information the protestor believes to be essential to the determination of the factual and legal questions at issue in the written protest.
- 2. A timely protest will be considered by ODM if it is received by ODM as delineated below:
 - a. A protest based on alleged improprieties in the RFA apparent prior to the time set for receipt of Applications (i.e., defects in the RFA such as a term that expressly conflicts with a generally applicable statute or regulation or unduly restricts competition) or any other event preceding the deadline for submission of Applications, must be filed no later than 3:00 p.m. ET on the date for submission of Applications, as specified in Section 2.1, Anticipated RFA Schedule.
 - b. A protest based upon the award selection must be filed no later than 3:00 p.m. ET on the seventh business day after issuance of the award and denial letters (see Section 2.11, Notification of Award). The date of the postmark will be used to determine the timeliness of the protest.
- 3. A protest based on alleged improprieties in the RFA will be considered by ODM only if the Applicant submitted a question regarding the issue during the Question and Answer Period identified in Section 2.5, Question and Answer Period.
- 4. ODM has the sole and exclusive authority to determine the resolution of any protest.
- 5. An untimely protest may be considered by ODM if ODM determines that the protest raises issues significant to ODM's procurement system. An untimely protest is one received by ODM after the time periods set forth in item 2 of this section.
- 6. If a protest consists of more than 25 pages, a CD-ROM must be provided in addition to a hard copy.
- 7. All protests must be filed at the following location:

Deputy Legal Counsel, Office of Contracts and Procurement
Ohio Department of Medicaid
50 West Town Street
Columbus, Ohio 43215
- 8. When a timely protest is filed, the selection or contract process may be suspended until a decision on the protest is issued or the matter is otherwise resolved, unless the Director of ODM determines a delay will severely disadvantage ODM. ODM will notify the Applicant who received an award letter of the receipt of the protest.

9. ODM will issue written decisions on all timely protests and will notify any Applicant who filed an untimely protest as to whether or not the protest will be considered. ODM's decision whether or not to consider an untimely protest is not subject to further review.

2.13 Provider Agreement Execution

ODM intends to execute a provider agreement with the successful Applicant by the date specified in Section 2.1, Anticipated RFA Schedule. See Attachment A, Model OhioRISE Plan Provider Agreement, for the Model OhioRISE Plan Provider agreement.

The agreement period is expected to run from award through June 30, 2024, with the possibility for annual renewal provider agreements thereafter, contingent upon satisfactory performance, continued availability of funding, and all required approvals.

2.14 Readiness Reviews

As provided in Appendix A, Section 1.c of Attachment A, Model OhioRISE Plan Provider Agreement, the Contractor must demonstrate to ODM's satisfaction it is able to meet the requirements of the OhioRISE Plan provider agreement prior to providing services to members. ODM will not assign members nor make payment to a Contractor until ODM has determined the Contractor is able to meet the requirements of the OhioRISE Plan provider agreement.

SECTION 3: APPLICATION REQUIREMENTS

This section describes the format and organization of the Application. Failure to conform to these requirements may, at ODM's sole discretion, result in disqualification of the Application.

3.1 Number of Applications

Each Applicant must submit one signed original paper Application, five paper copies, and one electronic copy (CD-ROM or USB flash drive) of the Application. The original paper and the paper copies of the Application must be labeled as "Original" or "Copy" as appropriate. An electronic signature can be used to sign the original paper Application.

3.2 Application Format Requirements

3.2.1 Paper Copies

Except as needed to accommodate forms provided by ODM, paper versions of an Application must comply with the following:

1. Be printed on 8.5" x 11" paper;
2. Have one-inch margins;
3. Be double-sided;
4. Be printed in font size 12 point Times New Roman (smaller font is permissible for charts, diagrams, graphics, and similar visuals);
5. Have single line spacing within a paragraph and one blank line between paragraphs;
6. Include a header and/or footer on every page, which includes: name of Applicant, RFA title and number, and the page number; and
7. Comply with the page limits specified in Section 3.5, Application Questions.

Applications must be presented in a three-ring binder or similar binding that allows for easy removal of documents and must be organized as provided in Section 3.3, Application Organization.

3.2.2 Electronic Copy

The entire Application must be converted into one single .pdf document and provided on a CD-ROM or USB flash drive. If the Application's size necessitates more than a single .pdf document to contain the entire Application, Applicants must use the fewest separate .pdf documents possible. The .pdf document must contain a printable copy of the Application, which complies with the requirements of Section 3.2.1, Paper Copies.

It is the responsibility of the Applicant to ensure the submitted CD-ROM/USB flash drive is machine-readable, virus-free, and otherwise error-free. The Applicant must also ensure that the CD-ROM/USB flash drive is not password protected or locked.

The CD-ROM/USB flash drive must be labeled with the Applicant's name, the RFA title and number, and the Application submission deadline (date and time). The CD-ROM/USB flash drive may be used in the formal ODM Application review process, and will be used by ODM for archiving purposes and for fulfillment of future PRRs. Failure to include or to properly label the CD-ROM/USB flash drive may, at ODM's discretion, result in the rejection of the Application from any consideration.

3.2.3 Consistency of Copies

It is the Applicant's responsibility to ensure all copies and formats of its Application are identical. Any pages or documents omitted from any or all copies can negatively affect the Applicant's score and possibly result in disqualification. In the event of any discrepancies or variations between copies, ODM is under no obligation to resolve the inconsistencies and may make its scoring and Applicant selection decisions accordingly, including the decision to disqualify the Applicant.

3.3 Application Organization

The Application must consist of and be labeled with the following sections:

1. Title Page
2. Table of Contents (Tab 1)
3. Transmittal Letter (Tab 2)
4. Executive Summary (Tab 3)
5. Application Checklist (Tab 4)
6. Required Forms (Tab 5)
7. Financial Capability (Tab 6)
8. Responses to Application Questions (Tab 7)
 - a. Qualifications and Experience (Tab 8)
 - b. Care Coordination and Collaboration (Tab 9)
 - c. Population Health (Tab 10)
 - d. Quality (Tab 11)
 - e. Benefits and Service Delivery (Tab 12)

Each tab should include the name of the section (e.g., the first tab should say "Table of Contents"). The format and contents for the material to be included in each section is described in Section 3.4, Submission Requirements. Each section of the Application must include all items listed in Section 3.4, Submission Requirements, under the applicable heading in Section 3.4, Submission Requirements.

3.4 Submission Requirements

3.4.1 Title Page

The title page must include: 1) the RFA title and number; 2) the name of the Applicant, including any doing business as; 3) the Applicant's mailing address; 4) the name and title of the Applicant's designated contact person; 5) the phone

number for the Applicant's designated contact person; and 6) the Application submission deadline (date and time).

3.4.2 Table of Contents (Tab 1)

Tab 1 must be labeled "Table of Contents" and contain the table of contents of the Application. The table of contents must include all sections listed above (Tabs 1 through 12) and the corresponding page number. The table of contents must be linked to appropriate pages in the Application.

3.4.3 Transmittal Letter (Tab 2)

Tab 2 must be labeled "Transmittal Letter" and contain the Applicant's transmittal letter. The transmittal letter must comply with the requirements in Attachment B, Transmittal Letter Template.

3.4.4 Executive Summary (Tab 3)

Tab 3 must be labeled "Executive Summary" and contain the Applicant's executive summary. The executive summary must include an overview of the Applicant, its relevant experience, and a high-level description of its proposed approach to meeting program requirements. The executive summary is limited to a maximum of five pages. The Executive Summary will not be scored, but it will be reviewed by the Evaluation Committee, and may be used in whole or part by ODM in public communication following award.

3.4.5 Application Checklist (Tab 4)

Tab 4 must be labeled "Application Checklist" and contain the completed checklist provided in Attachment C, Application Checklist. This checklist will be used during Phase I of the evaluation (see Section 4.2, Phase I: Review of Mandatory Qualifications) to confirm the Applicant has produced and submitted an Application in accordance with the RFA requirements. Before submitting an Application, Applicants are strongly encouraged to use Attachment C to review their Applications for completeness and compliance with the RFA requirements.

3.4.6 Required Forms (Tab 5)

Tab 5 must be labeled "Required Forms" and must include the following completed forms:

1. Exceptions (Attachment D)
2. Conflict of Interest (Attachment E)
3. Location of Business and Offshore Declaration (Attachment F)
4. Affidavit of Non-Collusion (Attachment G)
5. Certification of Compliance with Special Conditions (Attachment H)

3.4.7 Financial Capability (Tab 6)

Tab 6 must be labeled “Financial Capability” and must include the Applicant’s Dun & Bradstreet (D&B) ratings, indicating the firm’s financial strength and creditworthiness. These ratings are assigned to most US and Canadian firms by the US firm D&B, and are based on a firm’s worth and composite credit appraisal. The Applicant must also include the Applicant’s D&B credit report, which contains the firm’s financial statements and credit payment history. If the Applicant is submitting an Application with one or more first tier, downstream, and related entities (FDRs) as described in the OhioRISE Model Provider Agreement, Appendix A, Section 9, “Subcontractual Relationships and Delegation,” the Applicant must submit a D&B rating and credit report for each FDR.

3.4.8 Responses to Application Questions (Tab 7)

Tab 7 must be labeled “Responses to Application Questions” and contain the Applicant’s response to each of the questions in this section separated by a tab for each topic area (Qualifications & Experience, Care Coordination and Collaboration, Population Health, Quality, and Benefits & Service Delivery.) For each question, the Applicant must start on a new page, include both the number of the question and the text of the question, and then provide the response. All pages for a topic area/tab must be numbered sequentially and include the topic area name and total number of pages for the topic area.

The response to each Application question must be complete, concise, and reflect an understanding of applicable requirements of the Model OhioRISE Plan Provider Agreement (Attachment A, Model OhioRISE Plan Provider Agreement), the data book (available in the RFA resource library), information available on the State of Ohio’s websites, and information in the RFA resource library (see Section 1.5, RFA Resource Library).

When referencing past or current experience in response to a question, the Applicant must indicate the name of the state or jurisdiction where the work was done, and if applicable the name of the specific contract if there is more than one in a particular state or jurisdiction.

The Applicant must list the services provided by a parent or affiliate organization, and the name of the parent or affiliate organization, as they are relevant to the Applicant's response to each question.

The Applicant should disclose all relationships with FDRs as described in the OhioRISE Model Provider Agreement, Appendix A, Section 9, “Subcontractual Relationships and Delegation.” In responding to a question, if the Applicant will use any FDRs to fulfill any part of the response, the Applicant must provide the names of the FDRs and explain how the FDRs’ performance will be no less effective than if done by the Applicant. In responding to each question, the Applicant must identify the responsible entity (e.g., the Applicant or the specific FDR) that has

fulfilled or will fulfill the functions of the OhioRISE Plan. At any time during the review of Applications and during the readiness review process, ODM may require additional information about FDRs, including but not limited to operational effectiveness and proposed financial arrangements.

The response to each Application question must be complete and independent from information or responses provided elsewhere in the Application. The Evaluation Committee will not follow references to other sections of the Application or review information not included as part of a response. Any exhibits must be incorporated into the applicable response, but may be included at the end of the response or section. All pages of a response, including any exhibits, will be counted toward the page limits for each section, as specified in Section 3.4.8, below. The Evaluation Committee will not review information on pages that exceed the maximum number of pages specified for each section.

3.4.8.1 Qualifications and Experience (Tab 8) (Page limit: 30 pages)

1. Provide a list of the Applicant's current Medicaid managed care contracts that includes the information listed below for each contract. If the Applicant does not have any current Medicaid managed care contracts, please provide the requested information for the Applicant's most relevant contracts:
 - a. Name of state/state program;
 - b. Start and end date;
 - c. Managed care type (full-service MCO, prepaid ambulatory health plan, prepaid inpatient health plan, other);
 - d. Primary contractor or FDR and, if an FDR, name of primary contractor with the State;
 - e. Average number of member months for the most recent 12 months of the contract (or most recent period if the contract has been in place less than 12 months) by age group – birth through age 20 and age 21 and over;
 - f. Covered services (medical, pharmacy, behavioral health, transportation, long-term services and supports, and services and supports provided through Intermediate Care Facility and Developmental Disabilities [ICF/DD] and home and community-based services waivers);
 - g. Method of payment (risk-based and/or administrative services);
 - h. Covered populations similar to those covered by the OhioRISE Program (e.g., Title IV-E Foster Care; families and children;

Aged, Blind, and Disabled; and Children's Health Insurance Program);

- i. For populations in 1.h above, provide the length of time (in months) the populations are or were covered in the contract, and whether the contract required the Applicant to work with provider-based intensive care coordination entities similar to the role of CMEs envisioned for the OhioRISE Program.
 - j. Covered populations and behavioral health services similar to those included in the OhioRISE Plan Provider Agreement for multi-system children and youth specifically including children and youth involved in the child welfare and criminal and juvenile justice systems as well as children and youth with developmental/intellectual disabilities, serious emotional disturbances, and substance use/opioid use disorders; and
 - k. List and roles of FDRs for the following functions:
 - i. Care coordination;
 - ii. Marketing;
 - iii. Utilization management;
 - iv. Quality improvement;
 - v. Enrollment;
 - vi. Disenrollment;
 - vii. Claims administration;
 - viii. Provider network management; and
 - ix. Coordination of benefits.
2. Based upon the Applicant's experience managing populations and services similar to those covered under the OhioRISE Program, provide examples of the Applicant's accomplishments in achieving optimal outcomes for the population(s) and how they achieved those outcomes for its enrolled population(s). Describe how the Applicant will use its experience to achieve the program goals set forth in the OhioRISE Plan Provider Agreement.
3. Describe the Applicant's claims payment and encounter submission experience and capabilities for similar programs and the methods the Applicant will use to ensure claims payment and encounter

requirements in the OhioRISE Plan Provider Agreement will be met. In your response, include a description of how the Applicant will:

- a. Work with the Applicant's providers regarding claims, payments, and related issue resolution, including integration with ODM's Fiscal Intermediary; and
 - b. Adhere to federally qualified health centers/rural health clinics (FQHCs/RHCs) reimbursement requirements and accurate incorporation of associated encounters.
4. Describe two system-wide examples the Applicant has successfully used in administering managed care programs similar to the OhioRISE Program and how the Applicant will implement innovations to benefit OhioRISE members and their families. Include both programmatic and financial strategies used to partner with providers in the description of these innovations. Please provide information in your response regarding the State or jurisdiction where the work was done and describe similarities in the covered population with the OhioRISE Program's population. Include the implementation timeframe and anticipated impact on the OhioRISE Program.
5. Describe the following related to meeting program integrity requirements under the OhioRISE Plan Provider Agreement:
 - a. The Applicant's strategy and approach for meeting program integrity requirements;
 - b. The Applicant's resources and how the Applicant will use them to support its program integrity efforts; and
 - c. The Applicant's experience and outcomes from program integrity activities performed under other contracts with populations, services, providers, and FDRs similar to those in the OhioRISE Plan Provider Agreement.
6. Submit flowcharts and brief narrative descriptions of the Applicant's proposed information systems to meet the requirements in the OhioRISE Plan Provider Agreement, addressing, at a minimum, the functional areas listed below. In addition, describe how these functional areas are integrated and how the Applicant's system will interface and exchange data with ODM and other entities, including ODM's Fiscal Intermediary, the Applicant's CMEs, the SPBM, and ODM-contracted MCOs:
 - a. Member eligibility, enrollment, and disenrollment management;
 - b. Provider enrollment and network management;

- c. Care coordination system/portal and interface with claims and the provider and member portals;
 - d. Utilization management and service authorization;
 - e. Claims processing edits, corrections, and adjustments;
 - f. Claims payment and prompt payment guidelines;
 - g. Coordination of benefits for claims with third-party liability;
 - h. Encounter submission, including statistics for percentage accepted and denied;
 - i. Financial management and accounting; and
 - j. Any other ancillary systems/databases supporting core responsibilities under the OhioRISE Plan Provider Agreement (e.g., CANS, review of child and family centered plans, authorization for specified services, grievance and appeals, FDR performance, quality improvement, and customer service data collection and reporting).
7. Describe the Applicant's current use and support of Electronic Health Records (EHRs) and Health Information Exchanges (HIEs) and strategies to expand Applicant, CME, and provider use of EHRs and HIEs. In your response, include how the Applicant will integrate EHRs and HIEs into administrative and clinical functions (e.g., care coordination, utilization management, and population health).

3.4.8.2 Care Coordination and Collaboration (Tab 9) (Page limit: 70 pages)

8. Describe the Applicant's experience with and approach to the development and implementation of a high performing care coordination program built on Systems of Care principles and a Wraparound Approach. Include in the description the Applicant's experience with an approach to using a tiered care coordination model, which varies the intensity of care coordination to align with the strengths and needs of the members. Describe the tools that will be used to inform decisions regarding assignment of care coordination tiers.
9. Describe the Applicant's system-wide experience with and approach to developing, working with, and supporting specialized care coordination programs similar to CMEs, which provide care coordination for a member population similar to the OhioRISE population. Please provide information in your response regarding experience, the State or jurisdiction where the work was done, enrollment size and describe similarities in the covered population

with the OhioRISE Program's population. In addition, describe the Applicant's staffing and data management capabilities to support the CMEs.

10. Describe the Applicant's experience with and approach to performing care coordination for members with low intensity care coordination needs, similar to the Tier 1 Limited Care Coordination requirements set forth in the OhioRISE Plan Provider Agreement, including Tier 1 staffing ratios and types of staff.
11. Describe how the Applicant will conduct outreach and engage members and their families into the OhioRISE care coordination program. Include the Applicant's internal capacity and community partnerships the Applicant will use to engage members and families. Provide examples of effective systemic outreach and engagement strategies from the Applicant's experience with similar programs. Please provide information in your response regarding the State or jurisdiction where the work was done and describe similarities in the covered population with the OhioRISE Program's population. In the response, specifically address the Applicant's approach for:
 - a. Members assigned to the Applicant's care coordination staff;
 - b. Members assigned to CMEs for care coordination; and
 - c. Members and families that may be difficult to engage.
12. Describe the Applicant's experience and approach to working with ODM-contracted MCO care coordinators and care coordination entities (CCEs) to coordinate care for children and youth enrolled in the OhioRISE Program who have moderate, acute, or chronic physical health care needs in addition to behavioral health care needs. Please provide information in your response regarding the State or jurisdiction where the work was done, enrollment size and describe similarities in the covered population with the OhioRISE Program's population.
13. Describe the Applicant's programmatic experience with and approach to coordinating with an external pharmacy benefit manager to ensure appropriate oversight and use of medications, with particular attention to psychotropic medications for a member population similar to the population in the OhioRISE Program, including staffing and data management capacity to identify and address outlier psychotropic medication utilization among members.
14. Describe the Applicant's systemic approach to, experience with, and capacity to coordinate with key state and local child and youth-serving systems that the OhioRISE member population may be involved with, including:

- a. Coordination with the courts and correctional systems for court-involved youth and young adults (such as the Ohio Juvenile Courts and the Ohio Department of Youth Services (DYS), as well as the Ohio Department of Rehabilitation and Correction);
- b. Coordination with state and local child welfare agencies to support permanency goals and prevent placement disruption for children and youth with behavioral health challenges (such as the Ohio Department of Jobs and Family Services and local PCSAs);
- c. Coordination with state agencies (such as the Ohio Department of Youth Services) and local juvenile justice systems to support diversion or transition from detention for youth with behavioral health challenges;
- d. Coordination with the state agencies (such as the Ohio Department of Developmental Disabilities and county Boards of Developmental Disabilities [BDD]) or similar county/regional entities to serve children and youth with intellectual and developmental disabilities and children and youth with autism with co-occurring behavioral health conditions;
- e. Coordinating with the state agencies (such as the Ohio Office of Child and Family First and local Children and Family First Councils) that enhance services for children, youth, and families;
- f. Coordination with early intervention systems for the 0–3 population (such as early intervention services provided by local BDD);
- g. Coordination with the Ohio Department of Education and local school systems;
- h. Coordination with ODM specifically regarding the Ohio Home Care waiver;
- i. Coordination with state, county, and regional agencies (such as the Ohio Department of Mental Health and Addiction Services, Alcohol, Drug Addiction and Mental Health Services Boards and local behavioral health providers) to serve youth with co-occurring mental health and SUD challenges; and
- j. Coordination with in-state and out-of-state and local systems serving OhioRISE transition-age youth, aged 18–21 (such as

behavioral health, vocational rehabilitation, housing, and employment services).

15. The OhioRISE Plan is notified of an admission to an out-of-state PRTF of a 14-year-old African American youth. The youth was not previously enrolled in the OhioRISE Plan and is now re-enrolled in OhioRISE due to the PRTF admission. The admission into the PRTF was court-ordered and recommended by the PCSA. The child was placed in foster care at age 10, after experiencing physical and emotional abuse from his stepfather and neglect on the part of his mother, who was living in extreme poverty in a neighborhood plagued by violence. The youth has a history of multiple placements in residential treatment centers and group homes, authorized and paid for by the PCSAs, where he has received various types of antipsychotic medications. When not in residential settings, the youth lives with his aunt in a kinship placement, after experiencing multiple foster care placements. His aunt is a recent immigrant and is non-English speaking. His aunt wants to keep him at home but is unable to manage his behavioral health challenges, which include extreme anger, aggressive behaviors, and possible substance use. She also worries about his influence over her younger 11-year-old son. The 14-year old has had some involvement with the juvenile justice system and has had repeated trouble at school, which he often skips. Describe how the Applicant would approach this situation, including ensuring that the PRTF order is clinically appropriate, coordinating with the child welfare system and the court, responding to the needs of the member and his family, and ongoing coordination and oversight of his care.
16. The Applicant just received the enrollment of a 10-year old, white girl, who is also served by a local BDD. The member has been diagnosed with autism, anxiety, diabetes, and has uncontrollable tantrums and aggression toward other children and teachers. At the time of OhioRISE enrollment, the child is receiving Intensive Behavioral Support Services in an ICF/DD with the goal of discharging to home. Currently, the member has been prescribed several anti-psychotic and other psychotropic medications. Prior to her admission into the ICF/DD, the member was receiving Targeted Case Management (TCM) through the local BDD and receiving applied behavioral analysis through her MCO. Describe how the Applicant would coordinate with the member/family, local BDD, ICF/DD provider, TCM providers, and other state or local agencies to develop the discharge plan for this member and family.
17. The Applicant receives a referral from the MCO of a three-year old, multiracial girl, who was screened by her primary care provider (PCP) for behavioral health issues after being suspended from her pre-school program for uncontrollable tantrums and aggression toward other

children and teachers. The PCP referred the child and her mother to an outpatient mental health therapist. The family lives in a rural part of the state with few behavioral health resources. The outpatient therapist has seen the mother and her daughter twice. The mother is young, age 19, single, and feels overwhelmed trying to cope with her child's behavior. The therapist thinks the mother may be using drugs, but the therapist does not feel equipped to conduct a substance use screen. She also is concerned the child may need psychotropic medication.

- a. Describe how the Applicant would coordinate with the MCO, the PCP, providers, and other state or local agencies to ensure the mother and child receive appropriate early intervention services;
- b. Describe how the Applicant will provide consultation to the MCO, PCP, and other providers that are involved in this child's care; and
- c. Describe the implications of this scenario for helping the MCO to meet population health goals related to child behavioral health and maternal and child health.

3.4.8.3 Population Health (Tab 10) (Page limit: 25 pages)

18. Describe the Applicant's resources and approach to developing and implementing a population health approach for high-risk children and youth with behavioral health conditions who will be enrolled in the OhioRISE Plan, including how the Applicant will work with ODM, the MCOs, and the SPBM to develop cross-cutting population health and quality improvement initiatives for this population, which include the following activities:
 - a. The development and implementation of population health strategies;
 - b. The collection, analysis, and reporting of quality measures;
 - c. The identification and resolution of service system and clinical issues; and
 - d. The development and implementation of strategic initiatives and other quality improvement activities.
19. Describe the Applicant's approach to identifying the members in the OhioRISE Program who may be at higher risk for health disparities and the Applicant's approach for achieving health equity for OhioRISE members.
20. Describe how the Applicant will identify and address the social determinants of health (SDOH) affecting its membership in the context

of the Applicant's population health management strategy. Include an example of how the Applicant has systemically addressed SDOH to improve the population health outcomes of its members who are similar to population in the OhioRISE Program. Please provide information in your example regarding the State or jurisdiction where the work was done, enrollment size and describe similarities in the covered population with the OhioRISE Program's population.

21. Describe the Applicant's approach for developing its community reinvestment plan, including the Applicant's strategy for using community reinvestment funding to improve health outcomes of OhioRISE members in local communities.

3.4.8.4 Quality (Tab 11) (Page limit: 40 pages)

22. For each of the referenced measures below from Appendix I of the OhioRISE Plan Provider Agreement, describe the Applicant's experience with similar measures, how the Applicant will collect and analyze member-level and aggregate data related to these measures, and the Applicant's approach for using quality improvement strategies to address substandard performance.
 - a. Table I.1 – OhioRISE Plan Performance Measure: Foster Care Placement Disruptions Due to Behavioral Health: Rate of children who had an unplanned change in foster care placement due to a behavioral health issue per 1,000 eligible beneficiaries for each quarter of the state fiscal year and annual aggregate.
 - b. Table I.2 – Measures, which the OhioRISE Plan must report to MCOs and collaborate on improvement: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics, Total.
23. Describe the Applicant's system-wide experience collaborating with entities external to the Applicant (e.g., CMEs, other MCOs) to meet performance measures similar to those in Appendix I, Table I.3. Include in your response how the Applicant will develop and implement CME requirements to support the measures in Appendix I, Table I.3, and specific strategies and methods to require and oversee CME performance related to the following measures:
 - a. Well child and well care adolescent visits;
 - b. Dental visits; and
 - c. Graduation rates.
24. Describe the Applicant's proposed uses of CANS data to support and achieve the goals of the OhioRISE Program. Include in your response

how the Applicant will make care coordination tier assignments, child and family-centered care plan review and feedback, and outcomes measurement.

25. Describe how the Applicant will use its experience and resources to design and implement value based care and payment initiatives that support the objectives of the OhioRISE Program and enhance care and outcomes for its members. Please provide information in your response regarding the experience, the State or jurisdiction where the work was done and describe similarities in the covered population with the OhioRISE Program's population.
26. Describe the Applicant's experience and approach to ensuring that child and family-centered care plans for all members in all tiers are completed, submitted for review, coordinated with service authorization, and approved by the OhioRISE Plan. Please provide information in your response regarding the State or jurisdiction where the work was done, enrollment size and describe similarities in the covered population with the OhioRISE Program's population. Include how the Applicant will monitor to ensure high performance, including:
 - a. Ensure the timeliness of care plan completion;
 - b. Confirm the comprehensiveness of the child and family-centered care plans to ensure that all necessary CME and other provider services and supports are incorporated into the child and family-centered plan of care at the needed intensity of service;
 - c. Ensure the plans adhere to and support a child and family-centered care planning process that is consistent with System of Care Principles and High Fidelity Wraparound practice; and
 - d. Incorporate lessons learned from Applicant's prior experience with similar processes.

3.4.8.5 Benefits and Service Delivery (Tab 12) (Page limit: 35 pages)

27. Describe the Applicant's experience with and approach (including methodology, timeline, and use of selective contracting) to developing and managing a qualified provider network that meets the requirements of the OhioRISE Plan Provider Agreement. Include a narrative describing the approach the Applicant will use to support network providers to deliver new and enhanced services offered by the OhioRISE Plan, the staffing and information that the Applicant will use to identify and address potential challenges, including network gaps. Please provide information in your response regarding the State or jurisdiction where the work was done and describe similarities in

the covered services between the referenced experience and the covered services for the OhioRISE Program's population.

28. Describe what resources and methods (including data analytics) the Applicant will use for adhering to network adequacy standards (i.e., access and availability) set forth in Appendix F to ensure member access to care.
29. A CME and COE has asked the Applicant for assistance with obtaining data and information that will: 1) be used to support the CME to perform care coordination responsibilities; and 2) inform the Child and Family Teams' (CFTs') assessments and development of the child and family-centered care plans. Describe the data and information sources the Applicant would target to assist the CME, the process for obtaining the information, the format the Applicant would use to provide the information to the CME, and how the Applicant would collaborate with the COE to assist the CME and CFTs to use this information when developing the child and family-centered plans.
30. Describe any value-added services the Applicant intends to offer its members, including:
 - a. How the value-added services align with the goals of the OhioRISE Program;
 - b. The scope of the benefit, including any limitations;
 - c. The desired outcome of providing the value-added services; and
 - d. How the Applicant will monitor and evaluate the value-added services.
31. Describe the Applicant's proposed approach to offering, promoting, and supporting the appropriate and effective systemic use of telehealth services to increase access and health equity for OhioRISE members. In your response, assume a post-pandemic environment where access would be balanced with appropriate utilization management.
32. The Ohio Department of Jobs and Family Services, as a requirement of the Family First Prevention Services Act, will be ensuring children and youth who are at risk for entering custody will have access to Multi-Systemic Therapy (MST). This is an existing Medicaid service, but may require additional providers to offer this service to members enrolled in the OhioRISE Plan. Describe the Applicant's experience with working with state child-serving agencies and discuss how the Applicant will work with the relevant Ohio state agencies, providers, CMEs, and COE(s) to develop additional capacity for delivering this service and how the Applicant will work with the COE(s) to ensure the

service is provided consistent with clinical guidelines. Describe specific activities and strategies the Applicant will use to support providers to deliver this service.

SECTION 4: EVALUATION AND SELECTION

This section describes ODM's evaluation and selection process.

4.1 Evaluation Process

ODM will evaluate Applications using a phased approach. The evaluation process will consist of four distinct phases:

- Phase I: Review of Mandatory Qualifications
- Phase II: Review of Responses to Application Questions
- Phase III: Oral Presentation
- Phase IV: Selection

Applicants should not assume the individuals involved in the evaluation process are familiar with any current or past work activities with ODM.

All individuals involved in the evaluation process will be required to sign disclosure forms to establish they have no personal or financial interest in the outcome of the Application review and Contractor selection process.

ODM reserves the right to request clarification from Applicants regarding any information in their Application as it deems necessary at any point in the evaluation process. Any such requests initiated by ODM and Applicant's verbal or written response will not be considered a violation of the communication prohibitions contained in Section 5.1, Communication Prohibitions. If the Applicant fails to respond to a request for clarification, the Applicant may be disqualified from further consideration and not considered for award.

4.2 Phase I: Review of Mandatory Qualifications

Applications must meet all Phase I Mandatory Qualifications to be considered for further review and possible award. No points will be awarded during this review, but failure to meet one or more of the Mandatory Qualifications may eliminate an Application from further consideration. ODM reserves the right to waive minor irregularities that would not provide one or more Applicants an advantage as compared to other Applicants.

The Mandatory Qualifications are as follows:

1. The Application was submitted prior to the deadline (date and time) for submission of Applications (see Section 2.1, Anticipated RFA Schedule).
2. The Application includes the required number of paper and electronic copies as specified in Section 3.1, Number of Applications.
3. The Application complies with the requirements in Section 3.2, Application Format Requirements.

4. The Application contains the information specified in Section 3.4, Submission Requirements, and is organized as specified in Section 3.3, Application Organization.
5. The Applicant's transmittal letter complies with the requirements in Attachment B, Transmittal Letter Template.
6. The Applicant has provided proof it is (a) licensed by the Ohio Department of Insurance (ODI) as a Health Insuring Corporation (HIC), or (b) has submitted an application to be licensed by ODI as a HIC (See Attachment B, Transmittal Letter Template).
7. The Applicant has not submitted more than one Application from organizations under a common controlling entity (see Attachment B, Transmittal Letter Template).
8. The Application includes the completed forms specified in Section 3.4.6, Required Forms, and included as Attachments D through H.
9. The Applicant's response to Attachment E demonstrates that either (a) no actual, potential, or apparent conflict of interest exists, or (b) if such a conflict of interest exists, the Applicant has provided a Mitigation Plan that eliminates or mitigates the actual, potential, or apparent conflict. ODM will, in its sole discretion, determine whether a Mitigation Plan sufficiently and appropriately eliminates or mitigates the actual, potential, or apparent conflict of interest. If the Applicant has a corporate relationship with another entity that is or may become part of Ohio's managed care system (e.g., an MCO or PBM), then this qualifies as an actual or potential conflict of interest and should be addressed in Attachment E. A sufficient and appropriate Mitigation Plan will be more than aspirations and general principles. Instead, a sufficient and appropriate Mitigation Plan must (a) specifically disclose in detail all actual, potential, or apparent conflicts of interest and (b) provide detailed procedures to eliminate or mitigate the actual, potential, or apparent conflicts of interest. The Mitigation Plan must be submitted with the Applicant's response to the RFA. The additional instructions in Attachment E must be followed.

4.3 Phase II: Review of Responses to Application Questions

All Applications that meet Phase I: Review of Mandatory Qualifications will be reviewed by the Evaluation Committee. The Evaluation Committee may use subject matter experts to review responses to specific Application questions and provide feedback for consideration by the Evaluation Committee.

The Evaluation Committee will evaluate and assign a score to the responses to the Application questions. The score assigned to a particular response will determine the points given for that response. An Applicant's Phase II score will be the sum of the points given to each of the Applicant's responses to the scored Application questions.

The questions are grouped into topic areas, and the maximum number of points available for each of the topic areas is as follows:

Topic Area	Maximum Available Points
Qualifications and Experience	160
Care Coordination and Collaboration	335
Population Health	140
Quality	185
Benefits and Service Delivery	180
Total	1,000

The evaluation of the response to each question will focus on one or more of the following evaluation criteria, which are listed in descending order of importance:

- Method of Approach;
- Experience; and
- Capability.

4.4 Phase III: Oral Presentations

All Applicants that meet Phase I: Review of Mandatory Qualifications will be invited to participate in the oral presentation process. Invited Applicants will be notified in writing, including meeting logistics, scope, and format of the presentation no later than one week prior to the Applicant's oral presentation. The oral presentations will be conducted individually with each invited Applicant. ODM will limit the number of participants and expects participants to include members of the Applicant's proposed key staff. All participants must be employees of the Applicant; consultants may not participate in the oral presentation. ODM is not responsible for any costs incurred by the Applicant related to an oral presentation.

The Evaluation Committee will evaluate and score each oral presentation. An Applicant's oral presentation score will be added to the Applicant's Phase II score and will be considered during final selection.

4.5 Phase IV: Selection

The Applicants with the overall highest point totals will be recommended for selection to the Director of ODM for review, approval, and award. The maximum available points by phase is provided in the table below.

Phase	Maximum Available Points
Mandatory Qualifications	Not Applicable (pass/fail)
Response to Application Questions	1,000
Oral Presentation	100
Maximum Available Points	1,100

SECTION 5: CONDITIONS AND OTHER REQUIREMENTS

This section notifies potential Applicants seeking award of certain conditions and requirements that may affect their eligibility or willingness to participate in this procurement process or their eligibility to be awarded a provider agreement, and that would be in effect should they be awarded a provider agreement.

5.1 Communication Prohibitions

From the date this RFA is issued until a provider agreement is awarded, there may be no communications concerning the RFA between any Applicant and any employee, contractor, or subcontractor of ODM, who is in any way involved in the development of the RFA or the selection of an OhioRISE Plan.

The only exceptions to this prohibition are as follows:

1. Communications conducted pursuant to Section 2.5, Question and Answer Period;
2. Communications conducted as part of the conferences described in Section 2.3, Pre-Application Conference, and Section 2.4, Actuarial Conference for Potential Applicants;
3. Submission of the Applicant's notification of intent to apply pursuant to Section 2.7, Notification of Intent to Apply; and
4. As part of any oral presentation or Application clarification process initiated by ODM, which ODM deems necessary in order to make a final selection.

ODM is not responsible for the accuracy of any information regarding this RFA, which the Applicant obtains or gathers through a source other than the Q&A process described in this RFA. Any attempts at prohibited communications by Applicants may result in the disqualification of those Applicants' Application.

If interested Applicants need to communicate regarding this RFA, they must contact ODM using one of the permitted mechanisms above. Applicants are cautioned that communication attempts that do not comply with these instructions will not be answered, and ODM will not consider any Applications submitted to an address other than the one provided in this RFA. Prohibited communications and/or improperly addressed Applications may constitute grounds to disqualify an Applicant from participation in this RFA.

5.2 Sensitive Personal Information

It is the sole responsibility of the Applicant to remove all personal information (as defined by Ohio Revised Code (ORC) section 149.45) of Applicant staff and/or of any FDR and FDR staff from resumes or any other part of the Application package.

Following submission to ODM, all Applications may become part of the public record. ODM reserves the right to disqualify any Applicant whose Application is found to contain such prohibited personal information.

5.3 Cost of Application Preparation and Readiness Review

Any costs or expenses incurred by the Applicant in preparing, transmitting, or presenting any Application, including oral presentations, or other material submitted in response to this RFA shall be borne solely by the Applicant. Costs associated with the readiness review and preparation for go-live shall be borne solely by the selected Applicants.

5.4 Amended Applications

Applicants may amend their Applications prior to the Application submission deadline. The Applicant must resubmit the amended Application in its entirety. ODM will not review or score any previous submission; ODM will only evaluate the later submitted Application.

5.5 Application Offer Firm

All Applications submitted in response to this RFA will be considered firm for one hundred eighty (180) calendar days after the deadline for submission of Applications to ODM.

5.6 Review Process Exceptions

ODM reserves the right to negotiate with Applicants for adjustments to their Applications should ODM determine, for any reason, to adjust the scope of the project for which this RFA is released. Such negotiations are not violations of any communications prohibition, and are expressly permitted when initiated by ODM, but are at the sole discretion of ODM.

5.7 Start Work Date

ODM will notify the selected Applicant when work may begin. Any work begun by the Applicant prior to notification by ODM will NOT be compensated.

5.8 Trade Secrets Prohibition; Public Information Disclaimer

Applicants are prohibited from including any trade secret information, as defined in ORC section 1333.61, in their Applications. Any Applications that make claims of trade secret information may be disqualified from consideration immediately upon the discovery of such unallowable claim. ODM will consider all submissions to be free of trade secrets and will treat them accordingly. These Applications will become the property of ODM.

Submitted Applications are deemed to be public records pursuant to ORC section 149.43.

5.9 Model OhioRISE Plan Provider Agreement

If this RFA results in a contract award, the contract will consist of this RFA, including all attachments, written addenda to this RFA, the Offeror's accepted Proposal, the questions and answers posted during the inquiry period, and the duly authorized OhioRISE Provider Agreement.

Any provider agreement resulting from the issuance of this RFA is subject to the requirements as provided in the Model OhioRISE Plan Provider Agreement, which is included as Attachment A of this RFA. The Applicant must agree to the requirements of the Model OhioRISE Plan Provider Agreement as part of its Application submission (see Attachment B, Transmittal Letter Template).

The Applicant, and any FDR(s), will not use or disclose any information made available to them for any purpose other than to fulfill the contractual duties specified in the RFA. The Applicant, and any FDR(s), agrees to be bound by the same standards of confidentiality that apply to the employees of ODM and the State of Ohio. Any violation of confidentiality may result in an immediate termination of the provider agreement, and may result in legal action.

5.10 Public Release of Evaluations and/or Reports

Any release of data, evaluations and/or reports, or data sharing will be role-based and project specific, and in accordance with state and federal regulations. Any requests for access to data must be directed to ODM, and decisions about providing data to any parties will be at the sole discretion of ODM.

5.11 Ethical & Conflict of Interest Requirements

- 5.11.1** No Applicant, individual, company, or organization seeking a contract or provider agreement shall promise or give to any ODM employee anything of value of such character as to manifest a substantial and improper influence upon the employee with respect to their duties.
- 5.11.2** No Applicant or individual, company, or organization seeking a contract or provider agreement shall solicit any ODM employee to violate any of the conduct requirements for employees.
- 5.11.3** Any Applicant acting on behalf of ODM must refrain from activities that could result in violations of ethics and/or conflicts of interest. Any Applicant who violates the requirements and prohibitions defined here or in ORC section 102.04 is subject

to termination of the contract/provider agreement or refusal by ODM to enter into a contract/provider agreement.

5.11.4 ODM employees and contractors who violate ORC sections 102.03, 102.04, 2921.42, or 2921.43 may be prosecuted for criminal violations.

5.12 Mandatory Contract Performance Disclosure

Each Application must disclose whether the Applicant or any proposed FDR has received a formal claim for breach of contract. For purposes of this disclosure, “formal claims” means any claims for breach that have been filed as a lawsuit in any court, submitted for arbitration (whether voluntary or involuntary, binding or not), or assigned to mediation. If any such claims are disclosed, the Applicant must fully explain the details of those claims, including the allegations regarding all alleged breaches, any written or legal action resulting from those allegations, and the results of any litigation, arbitration, or mediation regarding those claims, including terms of any settlement. While disclosure of any formal claims in response to this section will not automatically disqualify an Applicant from consideration, at the sole discretion of ODM, such claims and a review of the background details may result in a rejection of the Applicant’s Application. ODM will make this decision based on its determination of the seriousness of the claims, the potential impact of the alleged behavior that led to the claims could have on the Applicant’s performance of the work, the outcome, judgment, or resolution of the claim, and the best interests of ODM.

5.13 Mandatory Disclosures of Governmental Investigations

Each Application must indicate whether the Applicant, or any of the Applicant’s proposed FDR(s), have been the subject of any adverse regulatory or administrative governmental action (federal, state, or local) with respect to Applicant’s performance of a government contract. If any such instances are disclosed, Applicant must fully explain, in detail, the nature of the governmental action, the allegations that led to the governmental action, and the results of the governmental action, including any legal action that was taken against Applicant by the governmental agency. While disclosure of any governmental action in response to this Section will not automatically disqualify an Applicant from consideration, such governmental action and a review of the background details and outcome, judgment, or resolution of the action may result in a rejection of the Applicant’s Application at the sole discretion of ODM.

5.14 No Obligation to Award

ODM, may, in its discretion, reject any or all responses to this RFA, in whole or in part, for any reason. Such action may occur when ODM determines that in any or all Applications, the response is not in compliance with the requirements or terms and conditions set forth in the RFA. ODM reserves the right to reject any or all Applications where the Applicant takes exception to the requirements or the terms and conditions of the RFA or fails to meet the requirements or terms and conditions specified in the RFA.

5.15 Request for Application Cancellation and Re-Procurement Authority

This RFA may be cancelled or terminated, and all Applications rejected, if ODM determines in its sole discretion such action to be in the best interest of the State or the Ohio Medicaid program.

During any period, either before provider agreement execution or thereafter, ODM reserves the right to issue procurements or offers to other potential contractors for performance of any portion of the services covered by this procurement or similar or comparable services.

SECTION 6: ATTACHMENTS

- Attachment A: Model OhioRISE Plan Provider Agreement.
- Attachment B: Letter of Transmittal Template.
- Attachment C: Application Checklist.
- Attachment D: Exceptions.
- Attachment E: Conflict of Interest.
- Attachment F: Location of Business and Offshore Declaration Form.
- Attachment G: Affidavit of Non-Collusion.
- Attachment H: Certification of Compliance with Special Conditions.
- Attachment I: Draft OhioRISE Rules and Managed Care Rules

Attachment A: Model OhioRISE Plan Provider Agreement

THE OHIO DEPARTMENT OF MEDICAID
OHIO RESILIENCE THROUGH INTEGRATED SYSTEM AND EXCELLENCE (OhioRISE)
PLAN PROVIDER AGREEMENT

Contents

Introduction	1
Definitions and acronyms	4
Baseline Provider Agreement	17
Appendix A – General Requirements	31
1. General Administrative Requirements	31
a. Inclusive Agreement.....	31
b. Certificate of Authority.....	31
c. National Committee for Quality Assurance Accreditation	31
d. Model Agreements with MCOs and SPBM	31
e. OhioRISE Plan Readiness Reviews.....	32
f. Local Presence	33
g. Contract Communications	34
h. Program Modifications.....	36
2. Eligibility, Enrollment, Transfers, and Enrollment Termination	36
a. Managed Care Eligibility and Enrollment	36
b. OhioRISE Membership.....	36
c. OhioRISE Plan Membership Acceptance, Documentation, and Reconciliation.....	37
3. Privacy Compliance Requirements	39
a. General	39
b. Data Security Agreement with Board of Pharmacy	40
c. Reporting of Disclosures.....	40
d. Mitigation Procedures.....	40
e. Incidental Costs.....	40
4. Member Requirements.....	40
a. Health Equity	40
b. Member Information	41
c. Member Services	43
d. Member Rights	47
e. Advance Directives.....	47
f. OhioRISE Program Member and Family Advisory Council	47
5. Grievance and Appeal System.....	49
a. General	49

b.	State Hearing Process.....	50
c.	Grievances, Appeals, and State Hearings Logs and Record-Keeping	50
d.	Grievance and Appeal System Reporting	51
6.	Provider Requirements	51
a.	Provider Services.....	51
b.	Provider Feedback.....	53
c.	Notification of OhioRISE Plan's Policy Changes	54
d.	Provider Manual	54
e.	Information for ODM-Designated Providers	54
f.	Provider Claim Dispute Resolution	55
g.	External Medical Review	57
h.	Provider Web Portal Complaints	58
i.	Provider Advisory Council.....	60
7.	OhioRISE Plan's Website Requirements.....	61
a.	General	61
b.	Online Member Website	62
c.	Online Provider Website	64
8.	Staffing Requirements	66
a.	General Requirements	66
b.	Key Staffing Requirements	67
c.	Key Staff.....	68
d.	OhioRISE Plan's Organizational Staff.....	84
e.	OhioRISE Plan's Staff Training Requirements	89
9.	Subcontractual Relationships and Delegation.....	90
a.	General Requirements	90
b.	First Tier, Downstream, and Related Entities Agreements	91
c.	Transparency Requirements.....	91
d.	FDR Agreement Provisions	92
e.	OhioRISE Plan's Accountability	94
10.	Comprehensive Disaster/Emergency Response Planning	95
a.	Comprehensive Disaster/Emergency Response Plan.....	95
b.	Primary Point of Contact	95
	Appendix B – Coverage and Services	97

1.	OhioRISE Basic Benefit Package.....	97
a.	Service Coverage Requirements	97
b.	Ohio Medicaid Services Not Covered by the OhioRISE Program	98
c.	Provider-Preventable Conditions.....	98
2.	Service Specific Clarifications	99
a.	Medication Therapy Management Program	99
b.	Moral or Religious Objections	99
c.	Behavioral Health Crisis Services	99
d.	Substance Use Disorder Treatment	100
e.	Coordinated Services Program	100
f.	Telehealth.....	100
g.	Non-Emergency Medical Transportation Services.....	100
3.	Additional Benefits	101
a.	Value-Added Services.....	101
b.	In Lieu of Services.....	102
4.	Member Cost-Sharing	102
5.	Utilization Management Program	103
a.	General Requirements	103
b.	Policies and Procedures.....	105
c.	Utilization Management Program Structure	105
d.	Authorization Data and Reporting	106
6.	Coverage Requirements.....	106
a.	Medical Necessity Criteria	106
b.	Child and Family-Centered Care Plan Review Criteria	107
c.	Inter-Rater Reliability	107
7.	Service Authorization.....	108
a.	General Requirements	108
b.	Behavioral Health Service Authorization.....	109
c.	Retroactive Coverage Requirements	110
d.	Notification of Authorization Decisions	110
e.	Peer-to-Peer Consultation.....	110
8.	Mental Health Parity and Addiction Equity Act Requirements	111
a.	General	111

b. Other Service Authorization Requirements	112
Appendix C – Population Health and Quality	113
1. Population Health Management	113
a. General	113
b. The OhioRISE Plan's Role in Support of MCO Population Health Management Strategies	113
2. Support for the Children with Behavioral Health Conditions Population Stream	114
a. Population Streams	114
3. Population Health Infrastructure	115
a. General	115
b. Senior Leadership Support	115
c. Staffing Resource Allocation	116
d. Population Health Information System	118
4. Population Health Improvement Strategies	121
a. General	121
b. Care Coordination	122
c. Health Equity	122
d. Optimal Delivery System	124
e. Coordination with MCO Specialized Services and Resources	126
f. Utilization Management	126
g. Community Reinvestment	126
h. Quality Improvement	127
i. Child and Family-Centered Care Plan Review	135
5. Cross System Collaboration	137
6. Evaluation	138
a. Support of MCOs' Population Health Management Strategy Evaluation	138
b. Quality Assessment and Performance Improvement Program and Evaluation	139
c. Monthly Quality Improvement Meeting Requirements	141
d. External Quality Review	142
Appendix D – Care coordination	144
1. OhioRISE Program Care Coordination	144
a. General Requirements	144
b. Guiding Principles	144
c. Care Coordination Tiers	145

d. OhioRISE Program Care Coordination Description	146
2. Care Coordination Requirements	148
a. OhioRISE Plan Care Coordination Staffing and Training.....	148
b. Assigning Care Coordination Tiers	149
c. Care Coordination Assignment	150
d. Care Coordination Activities	152
3. Transitions of Care Requirements	158
a. General	158
b. New OhioRISE Plan Enrollments	158
c. MCO Transitions.....	159
d. Care Management Entity Transitions.....	160
e. Transitions of Care from OhioRISE Plan to MCO Behavioral Health	160
f. Transitions of Care Between Health Care Settings	161
g. Continuity of Care	162
4. Care Coordination Information Systems and Data	163
a. OhioRISE Care Coordination Portal	163
b. OhioRISE Plan's Responsibilities for Care Coordination Portal Data.....	164
c. Member Access to the OhioRISE Care Coordination Portal	165
5. OhioRISE Care Coordination Portal Monitoring and Oversight	165
Appendix E – Marketing and Member Materials.....	167
1. Marketing	167
a. Marketing Activities	167
b. Alleged Marketing Violations.....	167
2. ODM-Requested Member Notifications	167
3. Member Materials.....	167
a. General	167
b. ODM Member Material Approval	168
c. New Member Materials	168
d. Issuance of New Member Materials	174
Appendix F – Provider Network	175
1. General.....	175
2. Documentation of Network Capacity	175
3. Provider Contracting	177

a.	Provider Selection	177
b.	Written Contracts and Medicaid Addendum	177
c.	Contracting with ODM-Enrolled Providers.....	177
d.	Centralized Credentialing	178
e.	OhioRISE Plan Provider Network Information.....	179
f.	Sole Source Contracting	179
4.	Provider Network Access Requirements.....	179
a.	General	179
b.	Behavioral Health Providers	180
5.	Exception Process for Provider Network Access Requirements.....	183
6.	Provider Network Changes.....	183
7.	Timely Access.....	184
8.	Appointment Availability.....	184
9.	Telehealth.....	186
10.	Network and Workforce Development	186
11.	Out-of-Network Requirements.....	187
12.	Provider Payment.....	187
a.	General	187
b.	Rate Changes	188
c.	Child and Adolescent Needs and Strengths Assessments	188
d.	Mobile Response and Stabilization Services.....	188
e.	Federally Qualified Health Centers/Rural Health Clinics.....	189
f.	Out-of-Network Emergency Services.....	189
g.	Out-of-Network Psychiatric Hospital Referrals.....	189
h.	Out-of-Network Providers During Transition	189
13.	Provider Directory.....	189
a.	General	189
b.	Content.....	190
c.	Printed Provider Directory.....	191
d.	Online Provider Directory.....	191
14.	Verification of Provider Network Information.....	191
a.	General	191
	Appendix G – Program Integrity.....	194

1. General.....	194
2. Compliance Program.....	194
3. Employee Education about False Claims Recovery	195
4. OhioRISE Plan Disclosures	195
5. ODM-Enrolled Providers	196
6. Data Certification.....	197
a. General	197
b. Submissions	197
c. Source, Content, and Timing of Certification	198
7. Explanation of Benefits Mailings	198
8. Special Investigative Unit	199
9. Fraud, Waste, and Abuse Plan.....	199
10. Reporting and Investigating Fraud, Waste, and Abuse	201
a. General	201
b. Reporting and Retention of Recovery	201
c. Reporting Provider Fraud, Waste, or Abuse	201
d. Reporting Member Fraud or Abuse	201
e. Coordination with Law Enforcement	202
f. Coordinating Provider On-site Audits	203
g. ODM Investigation and Recovery	203
11. Recovery of Provider Overpayments	203
a. Definition of Overpayment.....	203
b. General	203
c. Notice	204
d. Dispute Process.....	205
e. Extended Payment or Settlement.....	205
f. Accounting	206
g. Claims Adjustment	206
h. ODM Recovery of Provider Overpayments from the OhioRISE Plan	206
12. Recovery of OhioRISE Plan Overpayments.....	206
13. Cooperation with State and Federal Authorities	207
14. Additional Reporting Requirements	208
Appendix H – Value Based Payment	209

1. Value Based Payment	209
2. Alternative Payment Methodology Targets	211
3. Reporting	211
4. Value Based Initiatives	211
a. General	211
b. Care Coordination Payments	211
c. Mobile Response and Stabilization Services and Intensive Home Based Treatment	212
d. Episode Based Payments	212
Appendix I – Quality Measures	213
1. General	213
2. OhioRISE Plan Quality Measures (Table I.1)	214
3. Reporting on MCO Measures (Table I.2)	214
4. Collaborating on MCO Measure (Table I.3)	214
5. Data and Reporting	223
a. OhioRISE Plan Table I.1 Measures	223
b. OhioRISE Plan Table I.2 Measures	224
c. OhioRISE Plan Table I.3 Measures	224
d. Satisfaction Surveys of Families and Youth Receiving MRSS, ICC, and IHIT	224
e. Satisfaction Survey of Providers	224
f. HEDIS Data	225
g. Data Certification Requirements for HEDIS Interactive Data Storage System Data and HEDIS Final Audit Report	225
6. Additional Operational Considerations	226
a. Measures and Measurement Periods	226
b. Performance Standards – Compliance Determination	226
c. Performance Standards – Retrospective Adjustment	226
d. Standard Adjustment Methodology	226
Appendix J – Quality Withhold or incentive	227
7. Quality Withhold or Incentive Program	227
Appendix K – Information Systems, Claims, and Data	228
1. Health Information System Requirements	228
a. Federal Requirements	228
b. ODM Access to the OhioRISE Plan's Systems and Data	228

c.	Data and Systems Integration.....	229
d.	General	230
2.	Information Systems Review	231
3.	Business Continuity and Disaster Recovery	232
4.	Acceptance Testing	232
a.	General	232
b.	New or Modified Information System.....	232
5.	Claims Adjudication and Payment Processing Requirements	233
a.	Timely Filing	233
b.	Claims Adjudication.....	233
c.	Edits	234
d.	Grouping Methodology	234
e.	Systems Audit	234
f.	Claims Payment Systemic Errors.....	235
g.	Non-CPSE Errors.....	237
h.	Software Updates	237
i.	Implementing ODM Rate Changes.....	237
j.	Processing Delays.....	237
k.	Notice to Providers	237
6.	Electronic Data Interchange	237
7.	Encounter Data Submission Requirements.....	239
8.	Non-Claims Data Submission Requirements	240
9.	Electronic Health Records	240
10.	Health Information Exchanges.....	241
11.	Interoperability	241
	Appendix L – Payment and Financial Performance.....	243
1.	Monthly Premium Payment	243
2.	Submission of Financial Statements	243
a.	Quarterly and Annual NAIC Financial Statements	243
b.	Annual NAIC/Cost Report Reconciliation	243
c.	Health Insuring Corporation Tax.....	243
d.	Other Financial Reports and Information.....	243
3.	Financial Performance Measures and Standards	244

4.	Insurance Requirements	244
a.	General	244
b.	Minimum Scope and Limit of Insurance.....	244
c.	Required Provisions.....	246
d.	Notice of Cancellation	246
e.	Waiver of Subrogation	247
f.	Deductibles and Self-Insured Retentions	247
g.	Claims Made Policies.....	247
h.	Verification of Coverage.....	247
i.	Subcontractors.....	248
j.	Special Risks or Circumstances	248
5.	Reinsurance Requirements	248
a.	General	248
b.	Deductible and Coverage	248
c.	Reinsurance Documentation Requirements	249
d.	ODM Notification of Claims.....	249
e.	Submission of Reinsurance Agreements to ODM	249
6.	Prompt Pay Requirements	249
a.	Standard	249
b.	Separate Measurement.....	250
c.	Application.....	250
d.	Reporting	250
7.	Physician Incentive Plan Requirements	250
8.	Third Party Liability Requirements	251
9.	Submission of Cost Reports.....	251
10.	Sharing Data with ODM's Actuary.....	251
11.	Notification of Regulatory Action	252
	Appendix M – Rate Methodology	253
	Appendix N – Compliance Actions	254
1.	General Requirements	254
2.	Administrative Actions.....	254
a.	Notice of Noncompliance	254
b.	Corrective Action Plans	255

3. Sanctions	256
a. Pre-Determined Financial Sanctions	256
b. Pre-Determined Non-Financial Sanctions	263
c. Financial Sanctions.....	265
d. Compounded Financial Sanctions	267
e. Collection of Pre-Determined and Financial Sanctions	267
f. Temporary Management.....	268
g. Termination	268
4. Request for Reconsideration	268
Appendix O – Plan Termination and Non-Renewals	270
1. General Requirements	270
2. Transition Requirements.....	271
Appendix P — Chart of Deliverables	277
1. General.....	277
2. Ad Hoc Deliverables.....	278
3. Scheduled Deliverables	278
4. Chart of Scheduled Deliverables.....	278

List of Exhibits and Tables

Table F.1 Appointment Standards.....	185
Table F.2 Time and Distance Standards.....	192
Table F.3 Minimum Number of General Acute Care Hospital and Psychiatric Hospital Providers (includes Children, Adolescents, and Adults)	193
Table I.1. OhioRISE Plan Measures that the OhioRISE Plan will report to ODM. State Fiscal Years 2022, 2023, 2024, and 2025 Performance Measures, Measurements Sets, and Measurement Time Periods.	215
Table I.2. MCO Measures that the OhioRISE Plan will report to MCO. State Fiscal Years 2023, 2024, and 2025 Performance Measures, Measurements Sets, and Measurement Years	221
Table I.3. MCO Measures that the OhioRISE Plan must include in Contracts with CMEs. State Fiscal Years 2023, 2024, and 2025 Performance Measures, Measurements Sets, and Measurement Years.....	223
Table N.1. Pre-Determined Financial Sanctions.....	256
Table N.2. Pre-Determined Non-Financial Sanctions	263

INTRODUCTION

1. Ohio Department of Medicaid Mission and Goals

- a. Ohio Department of Medicaid's (ODM's) mission is to improve the health outcomes of the individuals we serve. Accordingly, ODM has designed the Ohio Medicaid managed care program to achieve the following goals:
 - i. Focus on the individual;
 - ii. Improve individual and population wellness and health outcomes;
 - iii. Create a personalized care experience;
 - iv. Support providers in continuously improving care;
 - v. Improve care for children and adults with complex needs; and
 - vi. Increase program transparency and accountability.
- b. The Ohio Resilience through Integrated Systems and Excellence (OhioRISE) vendor must perform its responsibilities and deliver services under this Agreement in a manner consistent with achieving these goals.

2. Ohio Medicaid Managed Care Program

- a. ODM envisions a Medicaid managed care program where ODM, the OhioRISE Plan, the MCOs, and the single pharmacy benefits manager (SPBM) coordinate and collaborate to achieve health care excellence through a seamless service delivery system for members, providers, and system partners.
- b. The Ohio Medicaid managed care program consists of the following three types of managed care entities that, under ODM's leadership, must collaborate closely to meet program goals:
 - i. The OhioRISE Plan is a single, statewide prepaid inpatient health plan responsible for providing, managing, and coordinating behavioral health care for children eligible for the OhioRISE Program. The OhioRISE Program is designed to provide comprehensive and highly coordinated behavioral health services for children with serious/complex behavioral health needs involved in, or at risk for involvement in, multiple child-serving systems; and
 - ii. MCOs are responsible for providing, managing, and coordinating:
 1. All covered services for adult members;
 2. Physical health services for child members; and
 3. Behavioral health services for child members not enrolled in the OhioRISE Plan.
 - iii. A statewide SPBM is responsible for providing and managing pharmacy benefits for all individuals.

- c. To reduce provider burden and promote consistency across the Ohio Medicaid managed care program, ODM has retained the administrative responsibilities for centralized claims submissions and for credentialing and re-credentialing.
 - i. ODM's fiscal intermediary will serve as a single clearinghouse for all medical (non-pharmacy) claims. All medical claims will be submitted to ODM's fiscal intermediary, and the fiscal intermediary will apply specified Strategic National Implementation Process (SNIP) level edits and send the claim to the OhioRISE Plan for claims processing and payment.
 - ii. ODM's fiscal intermediary will also serve as the single, centralized location for provider submissions of prior authorization requests. The fiscal intermediary 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 the OhioRISE Plan and multiple MCOs.

3. The OhioRISE Program

- a. As part of the Governor's overarching goal to improve care for children and adults with complex needs, Ohio is designing a reimagined Medicaid system and structure to serve multi-system youth and other children with complex behavioral health needs. Ohio's approach to achieve this goal is through implementation of the OhioRISE Program. OhioRISE will facilitate ODM and other state child serving agency goals by:
 - i. Creating a seamless delivery system for children, families, and system partners;
 - ii. Providing a "locus of accountability" by offering intensive care coordination; and
 - iii. Expanding access to critical services needed for this population and assisting families, state and local child serving agencies, and other health providers to locate and use necessary services.
- b. The OhioRISE Program has been jointly developed by ODM, the Governor's Office of Children's Initiatives, and other state child serving agencies. This multi-agency partnership will be responsible for the shared governance of the OhioRISE Program. The OhioRISE Plan will have a contractual relationship with ODM. This approach reflects the OhioRISE target population that includes children and youth with serious or complex behavioral health needs who are at risk of involvement or are involved in multiple child-serving systems. These child serving systems include the Department of Developmental Disabilities (DODD), Ohio Department of Education (ODE), Ohio Department of Health (ODH), Ohio Department of Job and Family Services (ODJFS), Ohio Department of Mental Health and Addiction Services (OMHAS), Ohio Department of Rehabilitation and Correction (ODRC), Ohio Department of Youth Services (DYS), and Ohio Family and Children First (OFCF).

- c. The OhioRISE Program will use intensive care coordination, through the creation of local care management entities (CMEs) to improve the timeliness and appropriateness of service delivery to its members. Through the use of enhanced care coordination offered by the CMEs, the OhioRISE Program seeks to:
 - i. Reduce unnecessary hospitalizations and emergency room visits;
 - ii. Decrease involvement with the juvenile justice and corrections systems;
 - iii. Reduce out-of-home and out-of-state placements (residential care and foster care);
 - iv. Increase school attendance and performance; and
 - v. Reduce custody relinquishment for children, youth and families.
 - d. The OhioRISE Plan will be responsible for ensuring the care coordination efforts support rather than supplant other child-serving systems case managers and providers, including County Boards of Developmental Disability, Regional Department of Youth Services, Public Child Serving Agencies, Family and Children First Councils, and providers certified by the Ohio Department of Mental Health and Addiction Services;
 - e. The OhioRISE Program will include new Medicaid services for its members. In addition to Intensive Care Coordination, the OhioRISE Program will develop new or enhance existing services such as:
 - i. Mobile Response and Stabilization Services (MRSS);
 - ii. Intensive Home Based Treatment, including evidenced based practices such as Multi-systemic Therapy and Functional Family Therapy;
 - iii. In-state Psychiatric Residential Treatment Facilities to reduce the need for out-of-state placement; and
 - iv. Respite Services.
 - f. In addition to these new services, the OhioRISE Program will include or enhance existing Medicaid services for its members including:
 - i. Outpatient mental health and substance use disorder (SUD) services;
 - ii. SUD Residential services; and
 - iii. Inpatient mental health and SUD services.
4. OhioRISE Service Area
- a. Under this Agreement, the OhioRISE vendor is responsible for providing covered services (see Appendix B, Coverage and Services) to all members statewide.

DEFINITIONS AND ACRONYMS

1. General

- a. Listed below are definitions of terms and acronyms used in this Agreement. Terms are consistent with federal and state requirements and must be construed and interpreted as follows for this Agreement.

2. Definitions

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

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

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

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

Adverse Benefit Determination – As defined in OAC rule 5160-26-08.4, the OhioRISE plan'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 OhioRISE Plan;
- c. Denial, in whole or part, of payment for a service;
- d. Failure to provide services in a timely manner as specified in OAC rule 5160-59-03.1;
- e. Failure to act within the resolution timeframes specified in this rule; or
- f. Denial of a member's request to dispute a financial liability, including cost sharing, co-payments, premiums, deductibles, coinsurance, and other member financial liabilities, if applicable.

Appeal – As defined in OAC rule 5160-26-08.4, a member's request for the OhioRISE Plan'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.

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 that will be deployed by OhioRISE Program to deliberately organize and support children, youth and their families by addressing needs to achieve better health outcomes.

Care Coordination Entity (CCE) – A local community agency (that is not a CME) that provides care coordination to specific populations in the Medicaid program.

Care Management Entity (CME) – A local community agency contracted with the OhioRISE Plan that provides behavioral health care coordination to OhioRISE Plan enrolled members.

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

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

Child and Adolescent Needs and Strengths (CANS) – A multiple purpose information integration tool developed for children's services to support decision-making, including level of care and service planning, facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. CANS is designed to be the output of a functional assessment process.

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.

Client Contact Record – As defined in OAC rule 5160-26-01, 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 – As defined in OAC rule 5160-26-01, the medical services set forth in OAC rule 5160-59-03 or a subset of those services.

Cultural Humility – An approach that incorporates a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician-patient dynamic, and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations.

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

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

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

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

Eligible Individual – Consistent with OAC rule 5160-26-01, any Medicaid recipient who is a legal resident of the state of Ohio and is in one of the categories eligible for OhioRISE Plan enrollment as provided in OAC rule 5160-59-02.

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

Emergency Services – As defined in OAC rule 5160-26-01, covered inpatient services, outpatient services, or medical transportation that are provided by a qualified provider and are needed to evaluate, treat, or stabilize an emergency medical condition.

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

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

Family – A child's family or caregiver may include biological, adoptive, or foster parents, as well as extended family or non-biological adults who have a role in the care for and support of a child or youth.

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

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

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

Health Care Effectiveness Data and Information Set (HEDIS) – Set of standardized performance measures developed, supported, and maintained by the National Committee for Quality Assurance (NCQA) designed to allow reliable comparison of health plan 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 challenges; sexual orientation; or geographic location).

Health Equity – Exists when everyone has a fair opportunity to attain their full health potential and that no one is disadvantaged from achieving this potential.

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

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

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

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

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

Incident – As defined in OAC 5160-44-05, an alleged, suspected, or actual event that is not consistent with the routine care of, and/or service delivery to a member.

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.

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

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

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

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

Medicaid Contracted Entities – Entities, such as the OhioRISE Plan, MCOs, the single pharmacy benefit manager (SPBM), and the Fiscal Intermediary that are under contract with ODM.

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

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

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

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

- b. Medical necessity for individuals not covered by EPSDT is defined as procedures, items, or services that prevent, diagnose, evaluate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability, and without which the person can be expected to suffer prolonged, increased, or new morbidity; impairment of function; dysfunction of a body organ or part; or significant pain and discomfort.
- c. Conditions of medical necessity are met if all the following apply:
 - i. Meets generally accepted standards of medical practice;
 - ii. Clinically appropriate in its type, frequency, extent, duration, and delivery setting;
 - iii. Appropriate to the adverse health condition for which it is provided and is expected to produce the desired outcome;
 - iv. Is the lowest cost alternative that effectively addresses and treats the medical problem;
 - v. Provides unique, essential, and appropriate information if it is used for diagnostic purposes; and
 - vi. Not provided primarily for the economic benefit of the provider nor for the convenience of the provider or anyone else other than the recipient.
- d. The fact that a physician, dentist, or other licensed practitioner renders, prescribes, orders, certifies, recommends, approves, or submits a claim for a procedure, item, or service does not, in and of itself, make the procedure, item, or service medically necessary and does not guarantee payment for it.
- e. The definition and conditions of medical necessity articulated in this rule apply throughout the entire Medicaid program. More specific criteria regarding the conditions of medical necessity for particular categories of service may be set forth within ODM coverage policies or rules.

Medicare – As defined in OAC rule 5160-26-01, the federally financed medical assistance program defined in 42 USC 1395.

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

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

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

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

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

Neglect – When there is a duty to do so, the failure to provide goods, services, and/or treatment necessary to assure the health 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 OhioRISE Plan and receives Medicaid funding directly or indirectly to order, refer, or render covered services as a result of ODM's provider agreement with the OhioRISE Plan. A network provider is not necessarily a subcontractor by virtue of the network provider contract.

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

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

ODM Approved Entity – For the purpose of this Agreement, an ODM Approved Entity is for Quality Improvement Training Requirements. Examples include the Institute for Healthcare Improvement, the Intermountain Healthcare Leadership Institute, the Cincinnati Children's Hospital, Anderson Center for Health System Excellence, the NC Center for Public Health Quality, the American Society for Quality's Learning Institute, the Deming Institute, and the National Association for Healthcare Quality.

Pending Member – As defined in OAC rule 5160-26-01, an eligible individual who will be enrolled in the OhioRISE Plan but whose OhioRISE Plan membership is not yet effective.

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

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

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

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

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

Prepaid Inpatient Health Plan (PIHP) – As defined in 42 CFR 438.2, a PIHP is an entity that 1) provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates; 2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and 3) does not have a comprehensive risk contract.

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

Protected Health Information (PHI) – Information received from or on behalf of ODM that meets the definition of PHI as defined by 45 CFR. 160.103.

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

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

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

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

Provider-Preventable Condition – As defined in 42 CFR 447.26, a condition that meets the definition of a "health care-acquired condition" (a condition occurring in any inpatient hospital setting, identified as a health care-acquired condition by the Secretary under section

1886(d)(4)(D)(iv) of the Act for purposes of the Medicare program identified in the Ohio Medicaid state plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Act; other than Deep Vein Thrombosis /Pulmonary Embolism as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients) or an "other provider-preventable condition" (a condition occurring in any health care setting) that meets the following criteria:

- a. Is identified in the Ohio Medicaid state plan;
- b. Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
- c. Has a negative consequence for the beneficiary;
- d. Is auditable;
- e. Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

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

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

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

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

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

managing employees, individuals with an ownership or controlling interest in the contractor and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or individuals.

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

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

Single Pharmacy Benefit Manager (SPBM) – The state pharmacy benefit manager selected under ORC section 5167.24 that is responsible for processing all pharmacy claims for OhioRISE Plan 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.

Subcontract – As defined in OAC rule 5160-26-01, a written contract between the OhioRISE Plan and a third party, including the OhioRISE Plan's parent company or any subsidiary corporation owned by the OhioRISE Plan'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 OhioRISE Plan's provider agreement with ODM.

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

System of Care – A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.

Telehealth – As defined in OAC rule 5160-1-18, is the direct delivery of health care services to a patient via secure, synchronous, interactive, real-time electronic communication comprised of both audio and video elements.

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 OhioRISE Plan 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 payment to the OhioRISE Plan.

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

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

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

3. Acronyms

ABD	Aged, Blind, and Disabled
ADAMH	Alcohol, Drug Addiction, and Mental Health or County Board of Alcohol, Drug Addiction, and Mental Health
AMA	American Medical Association
APM	Alternative Payment Model
APRN	Advanced Practice Registered Nurse
ASAM	American Society of Addiction Medicine
BDD	County Board of Developmental Disabilities
CAHP	Consumer Assessment of Healthcare Providers
CANS	Child and Adolescent Needs and Strengths
CCE	Care Coordination Entity
CDJFS	County Department of Job and Family Services
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CHW	Community Health Worker
CICIP	Care Innovation and Community Improvement Program
CIO	Chief Information Officer
CMHC	Community Mental Health Center
CME	Care Management Entity
CMO	Chief Medical Officer
COA	Certificate of Authority
COE	Center of Excellence
CPC	Comprehensive Primary Care

CPSE	Claims Payment Systemic Error
CSP	Coordinated Services Program
CY	Calendar Year
DME	Durable Medical Equipment
DODD	Department of Developmental Disabilities
DYS	Ohio Department of Youth Services
EAPG	Enhanced Ambulatory Patient Grouping
eCQM	Electronic Clinical Quality Measure
EDI	Electronic Data Interchange
EHR	Electronic Health Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQRO	External Quality Review Organization
ESC	Educational Service Center
EVV	Electronic Visit Verification
FCFC	Family and Children First Council
FDR	First Tier, Downstream, and Related Entities
FFS	Fee for Service
FQHC	Federally Qualified Health Center
FWA	Fraud, Waste, and Abuse
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HITECH	Health Information Technology for Economic and Clinical Health Act
IHBT	Intensive Home Based Treatment
IMD	Institution for Mental Disease
LISW	Licensed Independent Social Worker
LPCC	Licensed Professional Clinical Counselor
LSW	Licensed Social Worker
MAGI	Modified Adjusted Gross Income
MAT	Medication Assisted Treatment
MCO	Managed Care Organization
MFCU	Medicaid Fraud Control Unit
MHPAEA	Mental Health Parity and Addiction Equity Act
MISP	Maternal and Infant Support Program
MPS	Minimum Performance Standards
MRSS	Mobile Response and Stabilization Services
NAIC	National Association of Insurance Commissioners
NCQA	National Committee for Quality Assurance
NPI	National Provider Identifier
OAC	Ohio Administrative Code
ODE	Ohio Department of Education
ODH	Ohio Department of Health
ODJFS	Ohio Department of Job and Family Services
ODRC	Ohio Department of Rehabilitation and Correction
OFCF	Ohio Family and Children First
OMHAS	Ohio Department of Mental Health and Addiction Services
OMES	Ohio Medicaid Enterprise System
ORC	Ohio Revised Code
ORP	Ordering, Referring, and Prescribing

PCP	Primary Care Provider
PCSA	Public Children Services Agency
PHI	Protected Health Information
PIP	Performance Improvement Project
PMPM	Per Member Per Month
QAPI	Quality Assessment and Performance Improvement
QI	Quality Improvement
RHC	Rural Health Clinic
SDOH	Social Determinants of Health
SFTP	Secure File Transfer Protocol
SFY	State Fiscal Year
SIU	Special Investigative Unit
SPA	State Plan Amendment
SPBM	Single Pharmacy Benefit Manager
SSA	Social Security Act
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, 2022, 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 _____, OhioRISE Plan, an Ohio corporation, whose principal office is located in the city of _____, County of _____, state of Ohio.

The OhioRISE Plan is licensed as a Health Insuring Corporation by the state of Ohio, Department of Insurance (hereinafter 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 5160-59 and, when applicable, 5160-26 of the Ohio Administrative Code (OAC), and other applicable portions of the OAC as amended from time to time. Upon request, the OhioRISE Plan must submit to ODM any data submitted to ODI to establish that the OhioRISE Plan 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 OhioRISE Plan's debts, including those that remain in the event of OhioRISE Plan's insolvency or the insolvency of any subcontractors.

The OhioRISE Plan is an entity eligible to enter into this Agreement in accordance with 42 CFR 438.3 as a prepaid inpatient health plan as described in 42 CFR 438.2 for the provision of services described in OAC 516-59-03 for the Medicaid population described in OAC 5160-59-02 along with any other Medicaid eligible population authorized by the Centers for Medicare and Medicaid Services (CMS) and described in the Ohio Medicaid state plan.

ODM, as the single state agency designated to administer the Medicaid program under ORC section 5162.03 and Title XIX of the Social Security Act, desires to obtain the OhioRISE Plan's services for the benefit of certain Medicaid recipients. In doing so, the OhioRISE Plan has provided and must continue to provide proof of the OhioRISE Plan'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 OhioRISE Plan pursuant to the federal contracting provisions of 42 CFR 434.6 and 438.6 in which the OhioRISE Plan must provide or arrange for Medicaid services through the managed care program as provided in ORC Chapters 5164 and 5167 and OAC Chapter 5160-26 and 5160-59, 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 OhioRISE Plan's representations that it has the necessary expertise, resources, and experience to perform its obligations hereunder, and the

OhioRISE Plan represents and warrants that it does possess such necessary expertise and experience.

- B. The OhioRISE Plan must communicate with ODM as necessary in order for the OhioRISE Plan to ensure its understanding of the responsibilities and satisfactory compliance with this Agreement.
- C. The OhioRISE Plan 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 OhioRISE Plan concerning the performance of the services described in this Agreement. The OhioRISE Plan 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.

ARTICLE II – TIME OF PERFORMANCE

- A. Upon approval by the Director of ODM, this Agreement is in effect from the date executed through June 30, 2024, unless this Agreement is suspended or terminated pursuant to Article VIII of the Baseline Provider Agreement on or prior to the termination date, or otherwise renewed or amended pursuant to Article IX of the Baseline Provider Agreement.

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 OhioRISE Plan 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 OhioRISE Plan subject to any remittance as may be required by ODM in accordance with 42 CFR 438.8(j).
- C. Capitation rates for the OhioRISE Program are anticipated to include a risk corridor as a shared risk mitigation mechanism. The risk corridor is being considered in recognition of claims cost uncertainty during the initial years of the OhioRISE Program. Such a risk corridor may be a temporary arrangement to be reevaluated for future rating periods. The risk corridor parameters for each contract year will be included in capitation rate certification materials.
- D. In addition, ODM will consider implementing other risk mitigation techniques for the OhioRISE Program, including but not limited to risk pools for services or populations and Minimum Medical Loss Ratio (MLR) requirements.
- E. ODM may establish financial incentive programs for the OhioRISE Plan based on performance.

ARTICLE IV – RELATIONSHIP OF PARTIES

- A. ODM and the OhioRISE Plan agree that, during the term of this Agreement, the OhioRISE Plan must be engaged with ODM solely on an independent contractor basis, and neither the OhioRISE Plan 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 OhioRISE Plan is therefore responsible for all the OhioRISE Plan'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 that have fewer than five employees with the Independent Contractor Acknowledgment (Form PEDACKN). This form requires the OhioRISE Plan to acknowledge that ODM has notified the OhioRISE Plan that it has not been classified as a public employee and that no Ohio Public Employees Retirement System (OPERS) contributions will be made on behalf of the OhioRISE Plan, its employees, or its subcontractors for these services. If the OhioRISE Plan is a business entity with fewer than five employees, the OhioRISE Plan must ensure that each employee completes the PEDACKN form.
- B. The OhioRISE Plan must comply with all applicable federal, state, and local laws in the conduct of the work hereunder.
- C. ODM may take any action necessary to ensure that the OhioRISE Plan'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 OhioRISE Plan, 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 OhioRISE Plan is the receipt of services through a health care program offered by the OhioRISE Plan.
- B. The OhioRISE Plan represents, warrants, and certifies that the OhioRISE Plan 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 OhioRISE Plan further represents, warrants, and certifies that neither the OhioRISE Plan nor any of its employees will perform, cause, or omit any action in any way that is inconsistent with such laws and Executive Order. The Governor's Executive Orders may be found by accessing the following website:
<https://governor.ohio.gov/wps/portal/gov/governor/media/executive-orders>.

- C. The OhioRISE Plan hereby covenants that the OhioRISE Plan, its officers, members, and employees of the OhioRISE Plan 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 OhioRISE Plan must periodically inquire of its officers, members, and employees concerning such interests. The OhioRISE Plan must have a conflict of interest policy that ensures its corporate independence and objectivity.
- D. The OhioRISE Plan must ensure that any 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 OhioRISE Plan 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 OhioRISE Plan must provide written disclosure of such interest to ODM.
- E. The OhioRISE Plan must include language in all contracts and agreements that result from this Agreement to ensure the OhioRISE Plan 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 OhioRISE Plan 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 OhioRISE Plan 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 OhioRISE Plan is the receipt of services through a health care program offered by the OhioRISE Plan. The OhioRISE Plan, 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 OhioRISE Plan 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 OhioRISE Plan must not participate in, condone, or tolerate any form of sexual harassment against any employee, subcontractor, or other person or entity with which it is associated in performance of this Agreement that is considered a form of sex discrimination prohibited by Title VII

of the Civil Rights Act of 1964, ORC section 4112.02, OAC 123:1-49, the Anti-Discrimination Policy in State Government Executive Order 2019-05D, or state agency policy.

- D. In addition to requirements imposed upon subcontractors in accordance with OAC Chapter 5160-26, the OhioRISE Plan must hold all subcontractors and persons acting on behalf of the OhioRISE Plan in the performance of services under this Agreement responsible for adhering to the requirements of paragraphs (A) through (C) above. The OhioRISE Plan 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 OhioRISE Plan must ensure that all records, documents, data, or other information produced or used by the OhioRISE Plan or any subcontractor under this Agreement are treated in accordance with OAC rule 5160-26-06 and must be provided to ODM or its designee at no cost if requested. The records, documents, data, and information must be provided by the OhioRISE Plan in a format solely determined by ODM, which may include the analysis of any data and documentation the OhioRISE Plan is required to maintain. The OhioRISE Plan must maintain an appropriate record system for services provided to members. The OhioRISE Plan must retain all records in accordance with 42 CFR 438.3(u) and comply with the audit and inspection rights of those records in accordance with 42 CFR 438.3(h).

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

- B. Upon request by ODM, the OhioRISE Plan must submit information related to OhioRISE Plan's current performance or operations not specifically covered under this Agreement, unless otherwise excluded by law.
- C. The OhioRISE Plan must not withhold records, documents, data, or other information the OhioRISE Plan deems as proprietary from ODM. Proprietary information is information that: (a) if made public, would put the OhioRISE Plan at a disadvantage in the market place and trade of which the OhioRISE Plan is a part; and, (b) meets the definition of "trade secret" as defined in ORC section 1333.61(D). The OhioRISE Plan must prominently mark the top or bottom of each individual record containing information the OhioRISE Plan 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 OhioRISE Plan fails to mark a record as proprietary, the OhioRISE Plan waives any claim that the record is proprietary and ODM may not hold the record confidential. Upon request from ODM, the OhioRISE Plan 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 the disclosure.

Except as stated in this Agreement, ODM will not share or otherwise disclose proprietary information received from the OhioRISE Plan to any third party without the express written authorization of the OhioRISE Plan. Notwithstanding the foregoing, ODM is permitted to share or disclose (without a subpoena, grand jury subpoena, or court order) proprietary information to CMS, United States Department of Health and Human Services Office of Inspector General, the Ohio

Auditor of State, the Ohio Attorney General (or other legal counsel representing ODM through the Ohio Attorney General), 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.

When ODM determines that a court order, subpoena, or grand jury subpoena requires the disclosure of OhioRISE Plan proprietary information, ODM will promptly notify the OhioRISE Plan and will do so before any disclosure. If the OhioRISE Plan 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 OhioRISE Plan must provide for the legal defense of all such proprietary information. The OhioRISE Plan 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 OhioRISE Plan or by ODM. If the OhioRISE Plan fails to promptly notify ODM in writing that the OhioRISE Plan 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 OhioRISE Plan 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 OhioRISE Plan failed to make efforts that are reasonable under the circumstances to maintain the information's secrecy.

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

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

- E. The OhioRISE Plan 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 OhioRISE Plan 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 OhioRISE Plan must pay to ODM all damages, costs, and expenses incurred by ODM associated with any cause, action, or litigation arising from such destruction.

- F. The OhioRISE Plan 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 OhioRISE Plan to keep the records longer than the approved records retention schedule. ODM will notify the OhioRISE Plan when the litigation hold ends, and retention can resume based on the approved records retention schedule. If the OhioRISE Plan fails to retain the pertinent records after receiving a litigation hold from ODM, the OhioRISE Plan must pay to ODM all damages, costs, and expenses incurred by ODM associated with any cause, action, or litigation arising from such destruction.
- G. The OhioRISE Plan 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. OhioRISE Plan's notification to ODM must be made within five business days from the OhioRISE Plan'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 OhioRISE Plan possesses or has access to information or documentation needed by ODM with regard to the above, the OhioRISE Plan must cooperate with ODM in gathering and promptly providing such information and documentation to the extent permissible under applicable law.

ARTICLE VIII – NON-RENEWAL AND TERMINATION

- A. ODM may terminate this Agreement upon written notice pursuant to the applicable rules of the OAC. Any such termination will become effective at the end of the last calendar day of the month in which the termination is to take effect. The OhioRISE Plan must comply with the non-renewal and termination requirements as specified in Appendix O, Plan Termination and Non-Renewal.
- B. Subsequent to receiving a notice of termination or non-renewal from ODM, the OhioRISE Plan, 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, Plan Termination and Non-Renewal.
- C. In the event of termination or non-renewal under this article, the OhioRISE Plan is entitled to request reconciliation of reimbursements through the final month for which the OhioRISE Plan provided services under this Agreement, in accordance with the reimbursement provisions of this Agreement. The OhioRISE Plan 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.
- D. In the event of termination or non-renewal under this article, the OhioRISE Plan 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.
- E. ODM may, in its sole discretion, terminate this Agreement if the OhioRISE Plan or OhioRISE Plan's subcontractors violate or fail to comply with the provisions of this Agreement or other provisions of

law or regulation governing the Medicaid program. In the event ODM proposes to terminate 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 OhioRISE Plan's right to request an adjudication hearing under ORC Chapter 119.

- F. When initiated by the OhioRISE Plan, the OhioRISE Plan's written notice of termination 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 OhioRISE Plan, if the OhioRISE Plan 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.
- G. The OhioRISE Plan understands that availability of funds to fulfill the terms of this Agreement is contingent on appropriations made by the Ohio General Assembly and the United States government for funding the Medicaid program. If sufficient funds are not available from the Ohio General Assembly or the United States government to make payments on behalf of a specific population (e.g., Aged, Blind, Disabled, Modified Adjusted Gross Income, or Adult Extension Group VIII-Expansion) to fulfill the terms of this Agreement, the obligations, duties, and responsibilities of the parties with respect to that population will be terminated, except as specified in Appendix O, Plan Termination and Non-Renewal, as of the date funding expires. If the Ohio General Assembly or the United States government fails at any time to provide sufficient funding for ODM or the state of Ohio to make payments due under this Agreement, this Agreement will terminate as of the date funding expires without further obligation of ODM or the state of Ohio.

ARTICLE IX – AMENDMENT AND RENEWAL

- A. This Agreement, together with the Appendices and any other instruments to be executed and delivered pursuant to this Agreement, constitute 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.
- 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 OhioRISE Plan under this Agreement in accordance with 42 CFR 438.6, ODM shall notify the OhioRISE Plan regarding such changes and this Agreement shall be automatically amended to conform to such changes without the necessity for executing written amendments pursuant to this article of the Baseline Provider Agreement.
- C. This Agreement supersedes any and all previous agreements, whether written or oral, between the parties.

- D. A waiver by any party of any breach or default by the other party under this Agreement must not constitute a continuing waiver by such party of any subsequent act in breach of or in default hereunder.
- E. This Agreement may be renewed each fiscal year after June 30, 2024, 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 OhioRISE Plan if ODM decides to renew this Agreement. The OhioRISE Plan 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 OhioRISE Plan must (1) pay for the defense (if requested by ODM) of ODM and the state of Ohio and any of its agencies, and (2) indemnify and hold ODM, the state of Ohio, and any of its agencies harmless and immune from any and all claims for injury or damages resulting from the actions or omissions of the OhioRISE Plan in the fulfillment of this Agreement or arising from this Agreement that are attributable to the OhioRISE Plan's own actions or omissions, or of those of its trustees, officers, employees, members, agents, subcontractors, suppliers, third parties utilized by the OhioRISE Plan, or joint ventures. For purposes of this article, "members" does not include individuals whose sole connection with the MCO is the receipt of services through a health care program offered by the MCO. Such claims must include but are not limited to any claims by providers or Medicaid recipients, any claims made under the Fair Labor Standards Act or under any other federal or state law involving wages, overtime, or employment matters, and any claims involving patents, copyrights, trademarks, and applicable public records laws. The OhioRISE Plan is responsible for and must pay all legal fees, expert and consulting fees, expenses, and costs associated with defending ODM, the state of Ohio, and Ohio agencies against these claims, regardless whether those legal fees, costs or expenses are incurred by the MCO or the state of Ohio, ODM or other Ohio agencies. In any such litigation or claim, ODM, the state of Ohio, and its agencies have the right to choose their own legal counsel and any experts and consultants, subject only to the requirement that legal, expert, and consulting fees must be reasonable.
- B. The OhioRISE Plan is liable for any loss of federal funds suffered by ODM for members resulting from specific, negligent acts or omissions of the OhioRISE Plan 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 OhioRISE Plan or ODM, a major disaster, epidemic, complete or substantial destruction of facilities, war, riot, or civil insurrection occurs, neither ODM nor the OhioRISE Plan will have any liability or obligation on account of reasonable delay in the provision or the arrangement of covered services. So long as the OhioRISE Plan's Certificate of Authority remains in full force and effect, the OhioRISE Plan 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 OhioRISE Plan for indirect, consequential, incidental, special, or punitive damages, business interruption, or lost profits.

ARTICLE XI – CHANGE IN ORGANIZATIONAL STRUCTURE

- A. The OhioRISE Plan must notify and obtain written approval from ODM 180 calendar days prior to making any change in the OhioRISE Plan'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 OhioRISE Plan'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 OhioRISE Plan's operations to meet the requirements in this Agreement. The OhioRISE Plan must provide all information, data, and documents as directed by ODM to support a request to change the OhioRISE Plan's organizational structure.
- C. 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 OhioRISE Plan moves forward with the change in organizational structure, ODM may terminate this Agreement with the OhioRISE Plan pursuant to Article VIII of the Baseline Provider Agreement.

ARTICLE XII – ASSIGNMENT

- A. The OhioRISE Plan 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 OhioRISE Plan must submit any assignments of interest to ODM for ODM's approval 120 calendar days prior to the desired effective date. ODM must use reasonable efforts to respond to any such request for approval within the 120-calendar day period. Failure of ODM to act on the OhioRISE Plan's request for approval within the 120-calendar day period does not act as an approval of the request. ODM may require a receiving OhioRISE Plan to successfully complete a readiness review process before the transfer of obligations under this Agreement.
- B. The OhioRISE Plan 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 OhioRISE Plan must submit any such assignments of subcontracts to ODM for ODM's approval 30 calendar days prior to the desired effective date. No such approval by ODM of any assignment will be deemed in any event or in any manner to provide for the incurrence of any obligation by ODM in addition to the total agreed-upon reimbursement in accordance with this Agreement.

ARTICLE XIII – CERTIFICATION MADE BY THE OhioRISE Plan

- A. This Agreement is conditioned upon the full disclosure by the OhioRISE Plan to ODM of all information required for compliance with state and federal regulations.
- B. The OhioRISE Plan certifies that no federal funds paid to the OhioRISE Plan 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 OhioRISE Plan

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 OhioRISE Plan 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 OhioRISE Plan certifies that neither the OhioRISE Plan nor any principals of the OhioRISE Plan (e.g., a director, officer, partner, or person with beneficial ownership of more than 5% of the OhioRISE Plan's equity) is presently debarred, suspended, proposed for debarment, declared ineligible, or otherwise excluded from participation in transactions by any federal agency. The OhioRISE Plan 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 OhioRISE Plan also certifies that the OhioRISE Plan 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 OhioRISE Plan'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 OhioRISE Plan 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 OhioRISE Plan certifies that the OhioRISE Plan 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 OhioRISE Plan 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 OhioRISE Plan 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 OhioRISE Plan certifies and affirms that, as applicable to the OhioRISE Plan, 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 OhioRISE Plan's certification of this requirement is false or misleading, and notwithstanding any criminal or civil liabilities imposed by law, the OhioRISE Plan must return to ODM all monies paid to the OhioRISE Plan under this Agreement. The provisions of this section must survive the expiration or termination of this Agreement.
- G. The OhioRISE Plan 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 OhioRISE Plan 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 OhioRISE Plan must ensure that the OhioRISE Plan, 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 OhioRISE Plan will make a good faith effort to ensure that all OhioRISE Plan's 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 OhioRISE Plan 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 OhioRISE Plan 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 OhioRISE Plan must comply with the Federal Acquisition Regulation (FAR) 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 OhioRISE Plan must comply with Executive Order 2019-12D. A copy of Executive Order 2019-12D can be found at <https://governor.ohio.gov/wps/portal/gov/governor/media/executive-orders/2019-12d>. This Executive Order prohibits the use of public funds to purchase services provided outside of the United States except under certain circumstances. Such services include the use of offshore programming or call centers. Additionally, the OhioRISE Plan shall not transfer personal health information to any location outside the United States or its territories. Pursuant to 42 CFR 438.602(i), no OhioRISE Plan claim paid to any provider, out-of-network provider, subcontractor, or financial institution located outside of the United States is considered in capitation rates.
- N. The OhioRISE Plan certifies and confirms that the OhioRISE Plan must not boycott any jurisdiction with whom the state of Ohio can enjoy open trade and will not do so during the term of this Agreement. ODM reserves the right to terminate this Agreement immediately upon discovery of such a boycott.
- O. The OhioRISE Plan must cooperate with ODM and any child support enforcement agency in ensuring that the OhioRISE Plan and its employees meet child support obligations and requirements established by state and federal law, including present and future compliance with any court or valid administrative order for the withholding of support issued pursuant to the applicable sections of ORC Chapters 3119, 3121, 3123, and 3125.

ARTICLE XIV – CONSTRUCTION

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

ARTICLE XV – INCORPORATION BY REFERENCE

- A. The managed care and OhioRISE Program rules are located in OAC Chapter 5160-26 and OAC Chapter 5160-59 and are hereby incorporated by reference as part of this Agreement, having the full force and effect as if specifically restated herein. The OhioRISE Plan must subscribe to the appropriate distribution lists for notification of all OAC rule clearances, and final rules published with medical assistance letters (MALs), Medicaid handbook transmittal letters (MHTLs), and other transmittal letters affecting managed care program requirements. The OhioRISE Plan 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/home?1>; and ODM Rule Notification at <https://medicaid.ohio.gov/RESOURCES/Legal-and-Contracts/Rules>.
- B. Appendices A through P and any additional appendices are hereby incorporated by reference as part of this Agreement having the full force and effect as if specifically restated herein. Appendix O, Plan 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 OhioRISE Plan must comply with all requirements set forth in these sources, as well as any updates thereto. The OhioRISE Plan 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 Application (RFA) Number ODMR-2021-0025, the OhioRISE Plan is bound by the responses the OhioRISE Plan has submitted through that process. Accordingly, the OhioRISE Plan's responses to RFA Number ODMR-2021-0025 are incorporated by reference in this Agreement and have the full force and effect as if specifically restated herein.
- E. In the event of inconsistency or ambiguity between the provisions of OAC Chapter 5160-26 and this Agreement, the provisions of OAC Chapter 5160-59 will be determinative of the obligations of the parties unless such inconsistency or ambiguity is the result of changes in federal or state law, as provided in Article IX of the Baseline Provider Agreement, in which case such federal or state law will be determinative of the obligations of the parties. In the event OAC Chapter 5160-26 is silent with respect to any ambiguity or inconsistency, this Agreement (including Appendices) will be determinative of the obligations of the parties other than as specifically provided in federal or state law. In the event that a dispute arises that is not addressed in any of the aforementioned documents, the parties must make every reasonable effort to resolve the dispute, in keeping with the objectives of this Agreement and the budgetary and statutory constraints of ODM.

ARTICLE XVI – NOTICES

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

ARTICLE XVII – HEADINGS

- A. The headings in this Agreement have been inserted for convenient reference only and must not be considered in any questions of interpretation or construction of this Agreement.
- B. The parties have executed this Agreement the date first written above. This Agreement is hereby accepted and considered binding in accordance with the terms and conditions set forth in the preceding statements.

OhioRISE Plan NAME:

BY: _____ DATE: _____

PRESIDENT & CEO

ADDRESS:

THE OHIO DEPARTMENT OF MEDICAID:

BY: _____ DATE: _____

MAUREEN M. CORCORAN, DIRECTOR

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

APPENDIX A – GENERAL REQUIREMENTS

1. General Administrative Requirements

a. Inclusive Agreement

- i. The OhioRISE Plan acknowledges and agrees that the RFA Number ODMR-2021-0025, all attachments, written addenda to the RFA, the OhioRISE Plan's accepted proposal, the questions and answers posted during the inquiry period of the RFA Number ODMR-2021-0025 are hereby incorporated into this Agreement.

b. Certificate of Authority

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

c. National Committee for Quality Assurance Accreditation

- i. The OhioRISE Plan must hold and maintain, or must obtain National Committee for Quality Assurance (NCQA) accreditation from the date of the contract, for the OhioRISE Plan's Ohio Medicaid line of business.
- ii. The OhioRISE Plan must achieve and maintain a minimum status of "Accredited." If the OhioRISE Plan receives a "Provisional" or "Denied" status from NCQA, the OhioRISE Plan will be subject to sanctions as noted in Appendix N, Compliance Actions.
- iii. ODM will assess OhioRISE Plan compliance annually, based on the OhioRISE Plan'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 OhioRISE Plan 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 OhioRISE Plan must provide requested documents related to NCQA accreditation within the timeframe specified by ODM.

d. Model Agreements with MCOs and SPBM

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

1. The content of the written agreements must include:

- a. A primary point of contact to represent each entity in the cross-coordination, communication, and collaboration will be identified;
 - b. Operationalization detail of the respective roles and responsibilities of the parties, including processes to triage, track, and address shared grievances;
 - c. Collaborative communication and coordination protocols, including development and coordination across OhioRISE Plan, SPBM, and MCOs for shared stakeholder outreach and communication strategies, and streamlining/standardization of processes to minimize administrative burden for providers;
 - d. Data and information exchange requirements and timeframes;
 - e. Confidentiality and privacy requirements; and
 - f. Problem resolution protocols.
 - ii. The OhioRISE Plan, in collaboration with ODM, the MCOs, and SPBM, must renew and amend the model agreement on an annual basis or more frequently, as needed.
- e. OhioRISE Plan Readiness Reviews
- i. In accordance with 42 CFR 438.66(d), the OhioRISE Plan must participate in ODM-led readiness reviews for ODM to assess the OhioRISE Plan's readiness and ability to provide services consistent with the requirements in this Agreement.
 - ii. The OhioRISE Plan must demonstrate to ODM's satisfaction that it is able to meet the requirements in this Agreement prior to the effective date of this Agreement.
 - iii. Readiness review activities may include but are not limited to desk and on-site review of documents provided by the OhioRISE Plan, a walk-through of the OhioRISE Plan's operations, system demonstrations (including systems connectivity testing), and interviews with ODM-specified OhioRISE Plan staff. The scope of the review may include any of the requirements specified in this Agreement as determined by ODM.
 - i. Based on the results of the review activities, ODM shall issue a letter of findings and, if needed, will request a corrective action plan or issue a directed corrective action plan. The OhioRISE Plan must implement corrective action and demonstrate to ODM's satisfaction the OhioRISE Plan's ability to meet the requirements in this Agreement. The OhioRISE plan must complete the corrective action within the timeframes provided by ODM.
 - ii. ODM shall not assign members nor make payment to the OhioRISE Plan until ODM has determined that the OhioRISE Plan is able to meet the requirements of this Agreement.
 - iii. During the course of this Agreement, the OhioRISE Plan must participate in ODM-conducted readiness reviews prior to OhioRISE Plan implementation of significant

operational or program changes (e.g., service changes, IT system modifications), as determined by ODM. At ODM's sole discretion, ODM may retain expert consultants at the OhioRISE Plan's expense to verify readiness of significant OhioRISE Plan-initiated operational or program changes. The OhioRISE Plan must demonstrate to ODM's satisfaction that the OhioRISE Plan will continue to be able to meet the requirements in this Agreement prior to implementing the change.

f. Local Presence

i. Administrative Office

1. The OhioRISE Plan must maintain an administrative office located in Ohio at all times during the life of this Agreement.
2. Upon ODM's request, the OhioRISE Plan must provide ODM with private, on-site space to allow ODM to perform on-site reviews, audits, or other oversight activities.

ii. Utilization Management and Care Coordination

1. The OhioRISE Plan's Utilization Management (UM) and care coordination staff will need a thorough understanding of local communities as well as work collaboratively with members' Child and Family Teams (CFTs), therefore the following staff and functions must be located in Ohio:
 - a. All staff participating in UM functions, including care plan development and review, authorizations, discharge planning, CFT liaison, and medical/clinical staff peer-to-peer consultation.
 - b. All OhioRISE Plan and care management entity (CME) care coordination staff and functions, including for members assigned to Tiers 1, 2, and 3.

iii. Out-of-State Functions

1. For functions that the OhioRISE Plan is not required to perform in the state of Ohio (e.g., claims processing), the OhioRISE Plan must maintain a list of the functions and where they are located. The OhioRISE Plan must notify and obtain ODM's approval prior to moving those functions, whether they are performed inside or outside of the state. The OhioRISE Plan notification must occur prior to implementation and include a transition and implementation plan.
2. OhioRISE Plan must bear any ODM costs (including travel and subcontractor cost) associated with ODM conducted on-site audits, readiness review, or other oversight activities for out-of-state OhioRISE Plan functions.

g. Contract Communicationsi. Key Contacts

1. The OhioRISE Plan must designate a primary contact person for this Agreement, the OhioRISE Plan Contract Administrator, as described below in this appendix, who must dedicate a majority of their time to the OhioRISE product line and coordinate overall communication between ODM and the OhioRISE Plan. The OhioRISE Plan Contract Administrator must ensure the timeliness, accuracy, completeness, and responsiveness of all OhioRISE Plan communications and submissions to ODM.
2. The OhioRISE Plan must designate and identify contact staff for specific program areas upon ODM request.
3. ODM will identify contact staff for the OhioRISE Plan, including an ODM Contract Administrator.

ii. Communication Process

1. The OhioRISE Plan must take all necessary and appropriate steps to ensure all OhioRISE Plan staff are aware of, and follow, the following communication process:
 - a. Unless otherwise directed by ODM, the OhioRISE Plan must copy the ODM-provided regulatory email address on all submissions and communications to ODM.
 - b. The OhioRISE Plan is prohibited from contacting entities that contract or subcontract with ODM, unless necessary to fulfill the requirements under this Agreement or when specifically instructed by ODM. However, ODM reserves the right to contact the subcontractor directly at its discretion.
 - c. Under the terms of this Agreement, the OhioRISE Plan must meet all program requirements, regardless of delegation of functions.
 - d. The OhioRISE Plan must escalate requests from state or federal legislators, the Governor, the Lieutenant Governor, news media, or inquiries of a potentially controversial nature to the ODM Contract Administrator within one business hour of receipt and prior to responding to such requests.

iii. Timeframes for Responding to Requests for Information

1. Unless otherwise stated in this Agreement or in the request for information from ODM, the OhioRISE Plan must respond to requests for information within the following timeframes:
 - a. Within 24 hours for requests for information regarding OhioRISE Program eligibility, assessment, and enrollment processes;

- b. Within 24 hours for youth referred from mobile crisis and stabilization services providers and requests regarding member health, safety, and welfare;
 - c. Within 24 hours for requests regarding member access to services;
 - d. Within five business days for requests regarding members received through Healthtrack, including provider or member billing inquiries, or constituent inquiries received through external business relations; and
 - e. Ten business days for requests regarding policy research queries, coding, rate change inquiries, and all other requests for information unless otherwise stated in the request.
 2. Prior to the expiration of the allotted timeframe, the OhioRISE Plan 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. The OhioRISE Plan must use Transport Layer Security for all email communication between ODM and the OhioRISE Plan. The OhioRISE Plan's email gateway must be able to support the sending and receiving of large email files using Transport Layer Security, and the OhioRISE Plan's gateway must be able to enforce the sending and receiving of email via Transport Layer Security.
- v. Meeting Attendance
 1. The OhioRISE Plan must prepare for and send appropriate staff representatives to participate in all meetings and events when ODM requires OhioRISE Plan 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 OhioRISE Plan must send staff who are appropriately qualified and authorized to take actions or make decisions in the topic area. It is insufficient to send solely the OhioRISE Plan's Contract Administrator to meetings and events that require specific subject matter expertise and authority (e.g., discussion of clinical topics, quality topics, program integrity, or claims).
- vi. Program Input from the OhioRISE Plan
 1. The OhioRISE Plan must respond on a timely basis to Ohio Medicaid managed care program input opportunities, including but not limited to:

- a. Review and comment on the capitation rate-setting timeline, proposed rates, proposed changes to the OAC program rules, and proposed amendments to this Agreement;
- b. Commenting on Ohio Medicaid program policy and procedural changes and, whenever possible, offer sufficient time for comment and implementation; and
- c. Revising OhioRISE Plan's program updates and discuss program issues with ODM staff.

vii. Performance and Compliance Feedback

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

h. Program Modifications

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

2. Eligibility, Enrollment, Transfers, and Enrollment Termination

a. Managed Care Eligibility and Enrollment

- i. Pursuant to OAC rule 5160-59-02, the OhioRISE Plan must comply with eligibility and enrollment requirements.
- ii. The OhioRISE Plan must pay for all medically necessary services covered under this Agreement provided to members starting on the date of enrollment into the OhioRISE Plan and while the member is enrolled in the OhioRISE Plan.
- iii. The OhioRISE Plan, in cooperation with and approval from ODM and other state child-serving agencies, will develop an implementation strategy and transition plan for members that will be enrolled on first day of the effective date of the Agreement and in the 90 calendar days following the effective date of the Agreement.

b. OhioRISE Membership

- i. ODM will enroll individuals who meet the eligibility criteria in OAC rule 5160-59-02 into the OhioRISE Program. Such individuals may include, but are not limited to:
 1. Individuals in custody of the child welfare system;
 2. Individuals receiving services from child welfare but not in custody;
 3. Individuals receiving adoptive assistance;

4. Individuals who are served by juvenile courts pre-adjudication through post-adjudication;
 5. Individuals transitioning out of Ohio Department of Youth Services (DYS) facilities through post-release;
 6. Individuals transitioning out of Ohio Department of Rehabilitation and Correction facilities through post-release;
 7. Individuals who have intellectual/developmental disabilities and mental health and/or SUD needs;
 8. Individuals who have SUD, including those with opioid use disorder; and
 9. Individuals who have serious emotional disturbances.
- ii. ODM, at its discretion, may include additional children and youth in the OhioRISE Plan membership.
- c. OhioRISE Plan Membership Acceptance, Documentation, and Reconciliation
- i. Medicaid Consumer Hotline Contractor
 1. The OhioRISE Plan must provide ODM prior-approved OhioRISE Plan's materials and must provide directories to the Medicaid Consumer Hotline contractor for distribution to eligible individuals.
 - ii. Monthly Remittance Advice
 1. The HIPAA 820 monthly remittance advice contains the following: a capitation payment for each member listed on the HIPAA 834F monthly enrollment file, a capitation payment/recoupment for changes listed in the HIPAA 834C daily enrollment file, any other capitation payment/recoupment, and delivery payment/recoupment from the previous calendar month.
 - iii. Enrollment and Monthly Capitation Reconciliation
 1. The OhioRISE Plan must maintain the integrity of its membership data through processing and loading of data contained for each member in the daily HIPAA 834C enrollment files and reconciling the daily changes with the HIPAA 834F monthly enrollment file.
 2. The OhioRISE Plan 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 OhioRISE Plan must submit reconciliation for any discrepancies of enrollment(s)/disenrollment(s) 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 OhioRISE Plan must report discrepancies and reconciliation requests.

3. The OhioRISE Plan must submit all reconciliation requests in the format specified by ODM.
4. ODM, at its discretion, may process or reject reconciliation requests submitted by the OhioRISE Plan after the initial 60 calendar day due date.
5. ODM will not accept OhioRISE Plan's reconciliation requests for enrollment or payment beyond the last day of the 18th month after the capitation/enrollment month.
6. ODM will process reconciliations for ODM recoupment of capitation payments.

iv. *Change in Member Circumstance*

1. In accordance with 42 CFR 438.608, the OhioRISE Plan must notify ODM no later than 30 calendar days after being notified of the date of death of a member.
2. The OhioRISE Plan 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.
3. The OhioRISE Plan's notifications must follow ODM prescribed submission guidelines, and be provided in the format prescribed by ODM.

v. *Enrollment into the OhioRISE Plan due to an Inpatient Behavioral Health Stay*

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

vi. *Termination of Enrollment*

1. Pursuant to OAC rule OAC 5160-59-02, the OhioRISE Plan must comply with Ohio Medicaid OhioRISE Plan's termination of enrollment requirements.

vii. *OhioRISE Plan-Initiated Disenrollment Requests*

1. The OhioRISE Plan may make a disenrollment request only if there is evidence to support that the member no longer meets the threshold score on the CANS assessment (or other assessment) as established by ODM. Disenrollment requests must be submitted in the format specified by ODM and must include a request for reassessment of the member. Upon verification by ODM that the member no longer meets the threshold score, the member will be disenrolled on the last day of the month that the determination was made.

viii. Member Initiated Disenrollments

1. The OhioRISE Plan must assist any member requesting disenrollment from the OhioRISE Plan by initiating a referral to the CANS assessment (or other assessment) as established by ODM to determine if they no longer meet the threshold score.

ix. Pending Member

1. If a pending member (i.e., a member who meets the CANS threshold score prior to their membership effective date) contacts the OhioRISE Plan, the OhioRISE Plan must provide any membership information requested, including how to access services as an OhioRISE Plan's member and assistance in determining whether the eligible individual's current services require prior authorization.
2. The OhioRISE Plan must ensure any care coordination (e.g., prescheduled services, transition of care) information provided by the pending member is logged in the OhioRISE Plan's system and forwarded to the appropriate OhioRISE Plan's staff for processing as required.
3. The OhioRISE Plan may confirm any information provided on the Client Contact Record at the time the pending member contacts the OhioRISE Plan. Such communication does not constitute confirmation of membership. Upon receipt of the Client Contact Record or the HIPAA 834, the OhioRISE Plan may contact a pending member to confirm information provided on the Client Contact Record, the CANS assessment, or the HIPAA 834, assist with care coordination and transition of care, and inquire if the pending member has any membership questions.

3. Privacy Compliance Requirements

a. General

- i. The OhioRISE Plan must safeguard confidential information in accordance with state and federal requirements, including but not limited to: the HIPAA 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 OhioRISE Plan acknowledges that ODM is a Covered Entity under HIPAA.
- iii. The OhioRISE Plan 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 OhioRISE Plan 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 OhioRISE Plan must enter into a data security agreement with the state of Ohio's Board of Pharmacy that governs the OhioRISE Plan's use of the Board's drug database established and maintained under ORC section 4729.75.

c. Reporting of Disclosures

- i. The OhioRISE Plan 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 of which the OhioRISE Plan has knowledge or reasonably should have knowledge under the circumstances. If the OhioRISE Plan determines, pursuant to 45 CFR 164.402, that any inappropriate use or disclosure of PHI does not require breach notification, then the OhioRISE Plan shall make any documentation related to such determination available to ODM upon request. In addition, as specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must submit an annual report (Protected Health Information Breach Report) to ODM regarding the number of breaches of PHI and specify how many breaches were reported to U.S. Department of Health and Human Services as required by 45 CFR 164.408(b) and (c).

d. Mitigation Procedures

- i. The OhioRISE Plan must coordinate with ODM to determine specific actions that will be required of the OhioRISE Plan 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 OhioRISE Plan must report all of its mitigation activity to ODM and must preserve all relevant records and evidence.

e. Incidental Costs

- i. The OhioRISE Plan must bear the sole expense of all costs to mitigate any harmful effect of any breaches or security incidents that were caused by the OhioRISE Plan, 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.

4. Member Requirements

a. Health Equity

- i. In accordance with 42 CFR 438.206(c), the OhioRISE Plan must address health care disparities and ensure equitable access to and the delivery of services to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, 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://www.thinkculturalhealth.hhs.gov/clas>).
- iii. In accordance with 42 CFR 438.206(c)(3), the OhioRISE Plan must ensure that the OhioRISE Plan, its subcontractors, and network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities.
- iv. The OhioRISE Plan's health equity, including racial equity efforts must align with the requirements in Appendix C, Population Health and Quality.
- v. The OhioRISE Plan must participate in ODM's health equity initiatives as requested by ODM.

b. Member Information

- i. The OhioRISE Plan must comply with the following information requirements for eligible individuals and members, in accordance with 42 CFR §438.10 and OAC rules 5160-59-01.1, 5160-59-03.1, 5160-26-05, and 5160-26-05.1:

1. Oral Interpretation

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

2. Written Materials

- a. The OhioRISE Plan must make written materials critical to obtaining services available in English and in the prevalent non-English languages identified by ODM. 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, and denial and termination notices.
- b. The OhioRISE Plan's written materials must include taglines to the extent required by federal law in the prevalent non-English languages, as well as large print (no smaller than 18-point font) explaining the availability of written translations or oral interpretation free of charge to understand the information provided.
- c. The OhioRISE Plan must make all written member materials available in alternative formats and provide auxiliary aids and services when requested at no expense to eligible individuals and members.

- i. Alternative formats must include but are not limited to Braille, large print, and audio, as determined by the need of the individual member.
 - ii. The OhioRISE Plan'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 OhioRISE Plan's written materials must include the toll-free and TeleTYpe/ Telecommunications Device for the Deaf (TTY/TDD) telephone number of the OhioRISE Plan'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 OhioRISE Plan 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 OhioRISE Plan must ensure that all member materials are clearly legible, and use person-centered, trauma-informed, and easily understood language and format.
 - i. The OhioRISE Plan must write member materials at or below a sixth grade reading level, unless otherwise approved by ODM.
 - ii. If the OhioRISE Plan must include medical terminology that is not understandable from a layperson perspective, the OhioRISE Plan must offer the member an opportunity to speak to an OhioRISE Plan's representative to explain the information.
 - iii. The determination of whether the OhioRISE Plan's materials comply with member material requirements is in the sole discretion of ODM.
3. Contracting for Translation, Oral Interpretation, and Sign Language
- a. If, in accordance with OAC rule 5160-26-05.01, the OhioRISE Plan is required to develop mutual policies between OhioRISE Plan and a network provider regarding obligations to provide oral translation, oral interpretation, and sign language services, including whether or not the OhioRISE Plan or the provider will be financially responsible for those services. If the OhioRISE Plan and provider agree that the OhioRISE Plan will be responsible for these services, then in accordance with this appendix, the OhioRISE Plan must use a local agency to provide the services.

- b. The OhioRISE Plan must receive ODM's approval prior to executing a sole source contract with an entity to provide oral translation, oral interpretation, or sign language services.

4. Centralized Communication Database

- a. The OhioRISE Plan must develop a centralized database to record:
 - i. The special communication needs of all OhioRISE Plan's 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., OhioRISE Program materials in alternate format, oral interpretation, oral translation services, written translations of OhioRISE Program materials, and sign language services).
- b. The OhioRISE Plan's centralized database must include all OhioRISE Plan's member primary language information, as well as all other special communication needs information for OhioRISE Plan's members, as indicated above, when identified by any source, including ODM, the SPBM, the MCOs, the Automated Health Systems Consumer Hotline, OhioRISE Plan's staff, providers, and members.
- c. This centralized database must be readily available to OhioRISE Plan's staff and must be used in coordinating communication and services to members.
- d. The OhioRISE Plan must share information on member-specific communication needs with its providers, including CMEs, subcontractors, and Third Party Administrators as applicable.
- e. Upon ODM's request, the OhioRISE Plan must submit information regarding the OhioRISE Plan'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 OhioRISE Plan as well as those services reported to the OhioRISE Plan that were arranged by the provider, including the CMEs).

c. Member Services

i. Member Services Telephone System

- 1. The OhioRISE Plan must develop and implement member services call center policies and procedures that address staffing, training, hours of

operation, access and response standards, transfers/referrals, including referrals from all sources, monitoring of calls via recording or other means, translation/interpretation, and compliance with standards.

2. The OhioRISE Plan must provide member services to members through a toll-free telephone system.
3. The OhioRISE Plan's member services telephone system must have services available to assist:
 - a. Members who are hard of hearing (i.e., TTY/TDY); and
 - b. Members with limited English proficiency in the primary language of the member.
4. The OhioRISE Plan must have the capability for ODM or its designee to monitor calls remotely.
5. The OhioRISE Plan must have the capability to capture "audio signatures" for any required forms or requests that require a member's signature.
6. The OhioRISE Plan must measure and monitor the accuracy of responses provided by OhioRISE Plan's call center staff and take corrective action as necessary to ensure the accuracy of responses by staff.

ii. Member Services Responsibilities

1. The OhioRISE Plan's member services program must assist members, and as applicable, eligible individuals seeking information about OhioRISE Program's membership, with the following:
 - a. The services and supports available through the OhioRISE Program;
 - b. Eligibility requirements and processes for the OhioRISE Program;
 - c. Methods of accessing the CANS;
 - d. Accessing Medicaid-covered services;
 - e. Obtaining or understanding information on the OhioRISE Plan's policies and procedures;
 - f. Understanding the scope of the role of the OhioRISE Plan compared to the role of the MCO;
 - g. Understanding the requirements and benefits of the OhioRISE Program;
 - h. Resolving of concerns, questions, and problems;
 - i. Filing of grievances and appeals as specified in OAC rule 5160-26-08.4;

- j. Obtaining information on state hearing rights;
 - k. 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;
 - l. Appealing to or filing directly with the ODM Office of Civil Rights any complaints of discrimination on the basis of race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, health status, or need for health services in the receipt of health services; and
 - m. Accessing sign language, oral interpretation, and auxiliary aids and services.
 - i. The OhioRISE Plan must ensure these services are provided at no cost to the eligible individual or member.
 - ii. The OhioRISE Plan must designate a staff person to coordinate and document the provision of these services.
2. In the event the OhioRISE Plan's member services center receives a call during normal business hours about a matter that is the responsibility of the SPBM or an MCO, the OhioRISE Plan must directly transfer the call to the member services center of the SPBM or the MCO, which has enrolled the member. If the call is received after hours or the contact is made other than by phone (e.g., email or fax), the OhioRISE Plan must provide the relevant information to the SPBM or the MCO as expeditiously as possible, but no more than one business day from receipt of the contact.
- iii. Member Services Hours of Operation
- 1. The OhioRISE Plan must ensure member services staff are available nationwide to provide assistance to members through the toll-free call-in system at all times during the hours of 7:00 am to 8:00 pm Eastern Time, Monday through Friday, except on the following major holidays: New Year's Day, Martin Luther King Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day.
 - 2. The OhioRISE Plan may select two additional optional closure days, which may be used separately or in combination with any of the major holiday closures, but may not both be used within the same closure period. Before announcing any optional closure dates to members or staff, the OhioRISE Plan must receive ODM prior approval that verifies that the optional closure days meet the specified criteria.
 - 3. If a major holiday falls on a Saturday, the OhioRISE Plan may close its member services line on the immediately preceding Friday.

4. If a major holiday falls on a Sunday, the OhioRISE Plan may close its member services line on the immediately following Monday.
 5. The OhioRISE Plan must specify member services closure days in the OhioRISE Plan's member handbook, member newsletter, or other written communication to the OhioRISE Plan's members at least 30 calendar days in advance of the closure.
 6. The OhioRISE Plan 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 outside of the OhioRISE Plan's member services hours of operation. The OhioRISE Plan must collaborate with ODM and OMHAS to ensure OMHAS' statewide crisis line will have access to deploy MRSS providers when necessary.
- iv. Medical Advice Line
1. The OhioRISE Plan is not required to operate its own Medical Advice Line.
 2. The OhioRISE Plan must be able to refer and provide a direct transfer for a member to the member's MCO's Medical Advice Line or to their MCO's customer service office.
- v. Member Call Center Performance Standards
1. The OhioRISE Plan must meet or exceed the following call center standards:
 - a. 90% of calls answered within 30 seconds;
 - b. Capture rate of 95%;
 - c. Hold time not to exceed 30 seconds;
 - d. All inquiries that require a call back must be returned within 1 business day of receipt; and
 - e. A minimum 70% of all calls to the customer service center are resolved during the first call.
 2. The OhioRISE Plan must self-report its monthly and semi-annual performance on these five standards for its member services and 24/7 hour toll-free call-in systems to ODM (Member Services Call Center Report) as specified in Appendix P, Chart of Deliverables.
 3. The OhioRISE Plan must have a separate telephone line and phone number for this Agreement.
 4. The OhioRISE Plan must report performance standards more frequently, if required by ODM.
 5. The OhioRISE Plan must comply with any changes or updates to Utilization Review Accreditation Commission call center standards.

d. Member Rights

- i. In accordance with 42 CFR 438.100 and OAC rule 5160-26-08.3, the OhioRISE Plan must comply with all federal and state laws that pertain to member rights and ensure that its employees and contractors adhere to such laws when furnishing services to its members under this Agreement.
- ii. The OhioRISE Plan must include language in its contracts requiring subcontractors and network providers to adhere to federal and state laws pertaining to member rights when providing services to members.

e. Advance Directives

- i. The OhioRISE Plan must maintain written policies and procedures that meet the requirements for advance directives, as set forth in 42 CFR Part 489 Subpart I.

f. OhioRISE Program Member and Family Advisory Council

- i. The OhioRISE Plan must convene an OhioRISE Program Member and Family Advisory Council (council) at least quarterly. The OhioRISE Plan must offer meeting attendance in person, by phone, or virtually.
- ii. The OhioRISE Plan, through council support and activities, must engage members and their families or caregivers in such a way as to elicit meaningful input into the OhioRISE Plan's population health and quality improvement strategies, and address strengths and challenges of these strategies with serving members.
- iii. The Member and Family Advisory Council must serve in an advisory capacity to ODM, and other child-serving agencies.
- iv. The OhioRISE Program Member and Family Advisory Council must participate in OhioRISE Plan and ODM quality assurance processes, including:
 - 1. Providing input and recommendations to the quality improvement activities of the OhioRISE Plan;
 - 2. Receiving and reviewing quality assurance reports from the OhioRISE Plan on a regular basis and make recommendations to improve service quality and outcomes;
 - 3. Participating in cross-system planning at the state level;
 - 4. Participating in state and regional coordination activities;
 - 5. Identifying training and technical assistance needs in coordination with the Centers of Excellence (COEs) and ODM;
 - 6. Proposing quality improvement issues and projects to the OhioRISE Plan resulting from the efforts of the OhioRISE Program council, as applicable (The OhioRISE Plan's quality team will receive and evaluate the proposed projects, and if indicated, incorporate any resulting action into the OhioRISE Plan's quality plan);

7. Reviewing quality performance and improvement analyses from the OhioRISE Plan, and provide input on high priority issues for OhioRISE Plan and ODM consideration to improve the system serving OhioRISE Plan's members and their families. These will include but not be limited to the following:
 - a. Reviewing reports on quality of care elements (e.g., youth and family satisfaction with services, providers and quality of life improvement measures) gathered from members of the OhioRISE Plan;
 - b. Reviewing reports related to CME performance, quality and outcomes; and
 - c. Reviewing reports related to System of Care interface between MCOs, CMEs, OhioRISE Plan, community providers, and social determinants of health (SDOH) resources.
 8. Providing input to the OhioRISE Plan regarding the development, implementation, and outcomes of a publicly available report card for providers serving members, grading them in areas such as ongoing engagement with youth and families, quality of service, overall progress experienced by members, and quality of life improvements;
 9. Providing specific input to improve and enhance outreach to members and their families to educate them with regard to available services, in particular care coordination; mobile response; and how youth and families can access and advocate for services, support, guidance, and connection to other supportive family resources, as needed.
- v. The OhioRISE Plan, with council input and recommendations, must develop policies and procedures for the inclusion of family voice that demonstrate at least quarterly accommodation to working families and schooling children, youth, and young adults.
 - vi. The OhioRISE Plan must ensure that the composition of the council is diverse and representative of the OhioRISE Plan's current membership throughout the state with respect to the members' race, ethnic background, primary language, age, Medicaid eligibility category (e.g., Medicaid Adjusted Gross Income [MAGI]; Aged, Blind, and Disabled; Adoption Assistance; Foster Care; Supplemental Security Income), and health status.
 - vii. As new populations are enrolled in managed care, the OhioRISE Plan must actively ensure the council's membership reflects the diversity of its enrolled population.
 - viii. The OhioRISE Plan must report the following to ODM as specified in Appendix P, Chart of Deliverables:
 1. A list of attending members during the prior quarter for the council;

2. Meeting dates, agenda, and the minutes from each regional council meeting that occurred during the prior quarter;
 3. Improvement recommendations developed by each regional council; and
 4. The OhioRISE Plan's response to or implementation of the council's improvement recommendations.
 - ix. The OhioRISE Plan is encouraged to establish other processes, in addition to the Member and Family Advisory Council, to seek input on priorities and improvement opportunities, share findings and lessons learned from members and their families, child-serving state and local entities, Medicaid contracted entities, and others as directed by ODM consistent with expectations for cross-system collaboration.
5. Grievance and Appeal System
 - a. General
 - i. The OhioRISE Plan must develop and implement written policies and procedures for a grievance and appeal system for members in compliance with the requirements of OAC rule 5160-26-08.4 and 42 CFR 438 Subpart F.
 - ii. The OhioRISE Plan must use the ODM standardized appeal form to document member appeals. While the OhioRISE Plan may offer the ODM standardized appeal form for member use (e.g., as an attachment to a notice of appeal or as a form available on the OhioRISE Plan's website), the OhioRISE Plan 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 OhioRISE Plan's policies and procedures must include the process by which members may file grievances and appeals with the OhioRISE Plan, and a process by which members may access the state's fair hearing system through the Ohio Department of Job and Family Services Bureau of State Hearings.
 - iv. The OhioRISE Plan must include the participation of individuals authorized by the OhioRISE Plan to require corrective action in the OhioRISE Plan's grievance and appeal processes.
 - v. The OhioRISE Plan must use information from grievances, appeals, and state hearings to inform improvements to the OhioRISE Plan's operations and service delivery system.
 - vi. In the event the OhioRISE Plan receives a grievance, appeal, or state hearing request related to a decision or matter that is the responsibility of the SPBM or MCO, the OhioRISE Plan must forward the grievance, appeal, or state hearing request to the appropriate entity:
 1. Immediately, for grievances that involve a member's emergent or urgent need to access health care, or for expedited appeals; and

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

b. State Hearing Process

- i. The OhioRISE Plan must develop and implement written policies and procedures that ensure the OhioRISE Plan's compliance with the state hearing provisions pursuant to division 5101:6 of the Administrative Code.
- ii. The OhioRISE Plan must submit its state hearing policies and procedures for review and approval by ODM upon ODM's request.
- iii. When the OhioRISE Plan is notified by the Bureau of State Hearings that a member has requested a state hearing, the OhioRISE Plan 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 OhioRISE Plan has no record that the member has requested an OhioRISE Plan appeal pertaining to the state hearing request.
 - a. In this event, the OhioRISE Plan must attempt to contact the member to initiate the OhioRISE Plan's appeal process unless the timeframe for a member to file an appeal with the OhioRISE Plan is exhausted in accordance with OAC rule 5160-26-08.4.
 2. The OhioRISE Plan 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 OhioRISE Plan 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 OhioRISE Plan has not yet made a decision on the appeal request pertaining to the state hearing request, identify the date the OhioRISE Plan received the appeal request, and identify the date the OhioRISE Plan must currently issue a timely appeal resolution.

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

- i. The OhioRISE Plan must log and keep records of grievances, appeals, and state hearings documenting OhioRISE Plan's performance of all state and federal requirements (e.g., timely acknowledgement, continuation of benefits when applicable) that in accordance with 42 CFR 438.416 must include:
 1. The name of the member for whom the appeal, grievance, or state hearing was filed;
 2. The date the appeal, grievance, or state hearing was received;

3. A general description of the reason for the appeal, grievance, or state hearing;
4. The date of each review or, if applicable, review of meeting;
5. If applicable, the resolution of the appeal, grievance, or state hearing; and
6. If applicable, the date of the resolution.

d. Grievance and Appeal System Reporting

- i. The OhioRISE Plan must submit the Grievance and Appeal Activity Report to ODM as specified in Appendix P, Chart of Deliverables. The OhioRISE Plan 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 OhioRISE Plan must submit the Monthly Grievance and Appeal System Report to ODM as specified in Appendix P, Chart of Deliverables. The OhioRISE Plan must submit grievance, appeal, and state hearing information as required in *ODM's Grievance, Appeal, and Service Authorization Reporting Specifications Manual*. As part of the OhioRISE Plan's report submission, the OhioRISE Plan must include the analysis of individual and aggregate outliers and trends and identify the OhioRISE Plan's actions taken in response.

6. Provider Requirements

a. Provider Services

i. General

1. The OhioRISE Plan must comply with provider services requirements pursuant to OAC rule 5160-26-05.1.
2. The OhioRISE Plan must provide assistance to providers through a toll-free call-in system.
3. The OhioRISE Plan must have the capability to capture "audio signatures" for any required forms or requests that require the provider's signature.
4. The OhioRISE Plan must use information from provider services interactions to inform improvements to the OhioRISE Plan's operations and service delivery system.
5. In the event the OhioRISE Plan's provider services center receives a call during normal business hours about a matter that is the responsibility of the SPBM or MCO, the OhioRISE Plan must provide the caller the appropriate contact information and transfer the caller to the SPBM's or MCO's provider services center. If the call is received after hours or the contact is made other than by phone (e.g., email or fax), the OhioRISE Plan must provide the

relevant information to the SPBM or MCO as expeditiously as possible, but no more than one business day from receipt of the contact.

ii. Provider Services Hours of Operation

1. The OhioRISE Plan must ensure provider services staff are available nationwide to provide assistance to providers through the toll-free call-in system at all times during the hours of 7:00 am to 8:00 pm Eastern Time, Monday through Friday, except on the following major holidays: New Year's Day, Martin Luther King Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day.
2. The OhioRISE Plan may select two additional optional closure days, which may be used separately or in combination with any of the major holiday closures, but may not both be used within the same closure period. Before announcing any optional closure dates to providers or staff, the OhioRISE Plan must receive ODM's prior approval that verifies that the optional closure days meet the specified criteria.
3. If a major holiday falls on a Saturday, the OhioRISE Plan may close its provider services line on the immediately preceding Friday.
4. If a major holiday falls on a Sunday, the OhioRISE Plan may close its provider services line on the immediately following Monday.
5. The OhioRISE Plan must specify provider services closure days in the OhioRISE Plan's provider manual, provider portal, and website at least 30 calendar days in advance of the closure.
6. The OhioRISE Plan must request and obtain prior approval from ODM of any extended hours of operation of the provider services line outside the required days and time specified above.
7. The OhioRISE Plan must have the capability to transfer providers directly to the respective MCO for questions tied to MCO covered benefits, contracting, etc.

iii. Provider Call Center Performance Standards

1. The OhioRISE Plan must meet or exceed the following provider call center standards:
 - a. 90% of calls answered within 30 seconds;
 - b. Capture rate of 95%;
 - c. Hold time not to exceed 30 seconds;
 - d. All inquiries that require a call back must be returned within 1 business day of receipt; and

- e. A minimum 70% of all calls to the customer service center are resolved during the first call.
 2. The OhioRISE Plan must self-report provider call center performance (Provider Call Center Report) as specified in Appendix P, Chart of Deliverables, in the standards identified above for its Provider Call Center.
 3. The OhioRISE Plan must have a separate telephone line and phone number for its provider call center under this Agreement. The OhioRISE Plan must separately report call center performance for member services and provider services.
 4. The OhioRISE Plan must report performance standards more frequently by provider type, if required by ODM.
- iv. Provider Representatives
 1. The OhioRISE Plan must designate and make available provider representatives across all areas of the state with the training and knowledge to promptly and accurately respond to inquiries and resolve problems raised by providers of all types.
- v. Provider Training
 1. The OhioRISE Plan must ensure providers and subcontractors receive training on applicable program requirements and all necessary OhioRISE Plan's operational requirements.
 2. The OhioRISE Plan must submit its calendar of provider and subcontractor required training (Calendar of Provider and Subcontractor Required Training) for ODM review as specified in Appendix P, Chart of Deliverables.
 3. The OhioRISE Plan must ensure that individuals who oversee and deliver training must have demonstrable experience and expertise in the topic for which they are providing training.
 4. The OhioRISE Plan must represent, warrant, and certify to ODM that such training has occurred. Upon ODM request, the OhioRISE Plan must provide evidence of provider and subcontractor completion of OhioRISE Plan-required training.
 5. The OhioRISE Plan must require providers to attend ODM-delivered provider training, as mandated by ODM.
- b. Provider Feedback
 - i. The OhioRISE Plan must have the administrative capacity to monitor individual providers on its adherence to evidence-based practice guidelines, positive and negative care variances from standard clinical pathways, and the direct impact on treatment outcomes and costs of care.

- ii. The OhioRISE Plan must use this information to guide OhioRISE Plan's activities, such as performance improvement projects for providers that include incentive programs, or the development of quality improvement programs.
 - iii. The OhioRISE Plan must collaborate with ODM and the MCOs on prescriber engagement strategies to educate and monitor the OhioRISE Plan's network providers regarding compliance with the State's preferred drug list, prior authorization requirements, billing requirements, and appropriate prescribing practices.
- c. Notification of OhioRISE Plan's Policy Changes
 - i. In instances when the OhioRISE Plan must provide notice to a provider regarding a change in policy as specified in this Agreement, the OhioRISE Plan must provide direct communication (e.g., email, letter, in-person meeting) to any applicable provider association(s) at least 30 calendar days prior to implementation.
- d. Provider Manual
 - i. The OhioRISE Plan must customize, distribute, and maintain a provider manual, using ODM-provided template and required model provider manual language.
 - ii. The OhioRISE Plan must submit the provider manual to ODM for review and approval prior to distribution.
 - iii. The OhioRISE Plan 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 OhioRISE Plan must post the provider manual on its website.
- e. Information for ODM-Designated Providers
 - i. The OhioRISE Plan must share specific information with CMEs, MRSS (including referrals from MRSS for children who may be eligible for the OhioRISE Program due to a crisis), Intensive Home Based Treatment and other behavioral health providers identified in Appendix B, Coverage and Services.
 - ii. The information must be shared within the timeframe established by ODM after the OhioRISE Plan 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 OhioRISE Plan's Medicaid provider number (this information must only be provided to non-panel federally qualified health centers [FOHCs]). 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 processing;

- c. The OhioRISE Plan's prior authorization and referral procedures;
- d. A picture of the ODM-issued OhioRISE Plan's member ID card (front and back);
- e. Contact numbers for obtaining information for eligibility verification, claims processing, referrals, prior authorization, post-stabilization care services, and if applicable, information regarding the OhioRISE Plan's behavioral health administrator; and
- f. A listing of the OhioRISE Plan's providers.

f. 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 call center, provider advocates, OhioRISE Plan's provider portal), they do not include inquiries that come through ODM's Provider Web portal (Healthtrack). Provider claims disputes do not include provider disagreements with the OhioRISE Plan's decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity that are subject to external medical review (EMR) as described in this appendix.
2. The OhioRISE Plan 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 OhioRISE Plan.
3. The OhioRISE Plan 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 OhioRISE Plan must:
 - a. Allow providers to file a written claim dispute no later than 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 and 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 OhioRISE Plan's written policies and procedures;
 - f. Resolve and provide written notice to the provider of the disposition of all claim disputes 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. 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.
 - g. If additional time to resolve a dispute is needed past 15 business days then the OhioRISE Plan must provide a status update to the provider every five business days beginning on the 15th business day until the dispute is resolved;
 - h. 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
 - i. 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 OhioRISE Plan must develop and use a system to capture, track, and report the status and resolution of all provider claim disputes, including all associated documentation.
 - 2. The OhioRISE Plan must evaluate the effectiveness of the claim dispute resolution system and identify opportunities to improve the provider experience.

3. The OhioRISE Plan 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 OhioRISE Plan 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, time to resolution, identified trends, and program improvements.

g. External Medical Review

- i. The OhioRISE Plan must offer an external medical review to a provider who is unsatisfied with the OhioRISE Plan'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. Services that are denied for reasons other than lack of medical necessity (e.g., the service is not covered by Medicaid) are not subject to external medical review.
- ii. The OhioRISE Plan must use the individual or 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.
- iii. The OhioRISE Plan must ensure that the external medical review process does not interfere with the provider's right to request a peer-to-peer review, or a member's right to request an appeal or state hearing, or the timeliness of appeal and/or state hearing resolutions.
- iv. The OhioRISE Plan must include the following information to providers for decisions subject to external medical review:
 1. The provider's right to request an external medical review within 30 calendar days after the provider's receipt of the OhioRISE Plan's decision and how to do so; and
 2. That the external medical review is available at no cost to the provider.
- v. The OhioRISE Plan must transmit all relevant information to the external medical review request to the ODM-identified external medical review entity within 5 business days of the receipt of the provider's request for an external medical review. 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 OhioRISE Plan in connection with the medical necessity determination.
- vi. If the decision from the external medical review entity reverses the OhioRISE Plan's coverage decision in part or in whole, the external medical review decision is final and binding on the OhioRISE Plan.
- vii. The OhioRISE Plan must issue a written decision to the provider within the following timeframes:

1. For external medical record requests that are associated with expedited service authorization decisions, within 24 hours from the OhioRISE Plan's receipt of the external medical review. The OhioRISE Plan must also notify the provider verbally of the decision within that timeframe;
 2. For external medical review requests that are associated with standard service authorization decisions, within 30 calendar days from the OhioRISE Plan's receipt of the request for an external medical review; and
 3. For external medical review requests that are associated solely with provider payment (i.e., the service was already provided to the member), within 60 calendar days from the OhioRISE Plan's receipt of the request for external medical review.
- viii. For reversed service authorization decisions, the OhioRISE Plan must authorize the services promptly and as expeditiously as the member's behavioral health condition requires, but no later than 72 hours from when the OhioRISE Plan receives the external medical review decision.
- ix. For reversed payment decisions, the OhioRISE Plan must pay for the disputed services within the timeframes established for claims payment in Appendix L, Payment and Financial Performance.
- x. The OhioRISE Plan must develop and use a system to capture, track, and report the status and resolution of all external medical review, including external medical review volume and trends. The OhioRISE Plan must provide external medical review reports as specified by ODM.
- xi. The OhioRISE Plan must evaluate the effectiveness of the external medical review process and identify opportunities to improve the provider experience.
- xii. The OhioRISE Plan must use information collected from the external medical review process to improve service authorization decision-making.
- h. Provider Web Portal Complaints
- i. The OhioRISE Plan must check ODM's Provider Web portal (hereinafter referred to as Healthtrack) complaint inbox daily for updates and new complaints assigned to it.
 1. The OhioRISE Plan 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 OhioRISE Plan must leave a voicemail. Outreach must include that the complaint was received and that the OhioRISE Plan will respond by the assigned due date; and

- b. Documenting the OhioRISE Plan'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 dates 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 methods of contact;
 - iv. The person that made the contact; and
 - v. The name of the individuals contacted.
- 2. The OhioRISE Plan 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 OhioRISE Plan's provider representative's contact information;
 - iii. The Healthtrack complaint number or call reference number; and
 - iv. The OhioRISE Plan'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 OhioRISE Plan must make a minimum of three outreach attempts to the provider by the OhioRISE Plan.
 - c. The OhioRISE Plan must document the following in Healthtrack by the assigned due date:
 - i. The date or dates that the OhioRISE Plan 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 OhioRISE Plan must include the report month and row number.
 - d. If the OhioRISE Plan requires additional time to research a provider complaint, the OhioRISE Plan must:
 - i. Contact the provider, advise the provider of the delay in response, and indicate that the OhioRISE Plan will ask ODM to grant an extension. ODM will not grant the OhioRISE Plan an extension if the request does not include evidence that the OhioRISE Plan contacted the provider; and
 - ii. Document the OhioRISE Plan'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 OhioRISE Plan to address a complaint. If ODM shortens the timeframe, ODM will advise the OhioRISE Plan by entering a comment in Healthtrack.
- i. Provider Advisory Council
- i. The OhioRISE Plan must establish a provider advisory council.
 - ii. The OhioRISE Plan must hold provider advisory council meetings no less than on a quarterly basis. The OhioRISE Plan must offer meeting attendance in person, by phone, or virtually.
 - iii. The OhioRISE Plan must ensure that the provider advisory council is composed of a wide array of provider types, including CMEs, behavioral health providers, and SUD providers, as well as those predominantly serving minorities, LGBTQ youth, people with disabilities, or other populations disadvantaged by social determinants of health (SDOH).
 - iv. The purpose of the provider advisory council is for the OhioRISE Plan 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 OhioRISE Plan's provider advisory council must be chaired by the OhioRISE Plan's Administrator/Chief Executive Officer (CEO)/Chief Operating Officer (COO) or designee.
 - vi. The OhioRISE Plan must invite ODM to attend provider advisory council meetings and provide an agenda to ODM in advance of the meetings.

- vii. The OhioRISE Plan must invite other child serving system agency representatives to the advisory council meetings to ensure representation for multi-system youth.
- viii. The OhioRISE Plan 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 OhioRISE Plan's responses or follow-up activities to provider advisory council recommendations.

7. OhioRISE Plan's Website Requirements

a. General

- i. The OhioRISE Plan 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 OhioRISE Plan 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 OhioRISE Plan must have a mobile version of OhioRISE Plan's website content.
- iv. The OhioRISE Plan must ensure that all information is located on the OhioRISE Plan's website in a manner that allows members and providers to navigate to it easily from the OhioRISE Plan's home page.
- v. The OhioRISE Plan 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 OhioRISE Plan must indicate it serves the entire state.
- vii. As specified in Appendix F, Provider Network, the OhioRISE Plan's website must have a link to ODM's online provider directory and may have its own internet-based, mobile enabled internet-based provider directory that allows members to electronically search for providers.
- viii. The OhioRISE Plan's website must have a link to the ODM's Preferred Drug List and a link to the SPBM's website, and provide information about how members can access pharmacy services, including how to request prior authorization, how to access the pharmacy provider directory (via link to ODM's provider directory), and the SPBM's toll-free call member services call center.
- ix. The OhioRISE Plan's website must have links to all MCO websites operating in the State and a description of the OhioRISE Plan and MCOs' responsibilities.
- x. The OhioRISE Plan's website must have links to the ODM webpage.

- xi. The OhioRISE Plan website must have links regarding eligibility criteria for OhioRISE enrollment, process for requesting enrollment into the OhioRISE Program, including information on obtaining a CANS assessment.
- xii. The OhioRISE Plan must post on its website the OhioRISE Plan's criteria for medical necessity determinations for services requiring authorization. In accordance with 42 CFR 438.915(a), the OhioRISE Plan must provide a hard copy of the OhioRISE Plan's medical necessity criteria to providers and members upon request.
- xiii. The OhioRISE Plan must post information on its website to support members and their families/caregivers to understand and access behavioral health services, including:
 - 1. Systems of Care values and goals;
 - 2. The roles of the OhioRISE Plan, CMEs, and care coordinators;
 - 3. Where and how to access services, including emergency and crisis services, and a description of covered services;
 - 4. The family's/caregiver's role in the assessment, treatment, and support for members with mental health or substance use disorders, with a focus on member goals and strengths-based approaches; and
 - 5. General information on the managing mental and substance use disorders; family- and person-centered and youth- and young adult-driven approaches; types of providers and services; and evidence-based and promising practices managed under the OhioRISE Plan.
- xiv. The OhioRISE Plan 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).
- xv. The OhioRISE Plan must include additional information on its website as determined necessary by ODM.

b. Online Member Website

i. Member Information

- 1. The OhioRISE Plan must update the member website regularly to include the most current ODM-approved materials.
- 2. The OhioRISE Plan member website must also include the following information that must be accessible to members and the general public without any log-in restriction:
 - a. OhioRISE Plan contact information, including the OhioRISE Plan's toll-free member services phone number, service hours, and closure dates;

- b. General information about how to request interpreter, translation, or auxiliary aids and services;
 - c. The ODM-approved OhioRISE Plan member handbook, Quick Guide, SPBM information, recent newsletters, and announcements. The OhioRISE Plan's online version of its member handbook must offer hyperlinks from the table of contents to applicable section or topic;
 - d. A link to ODM's online provider directory;
 - e. The OhioRISE Plan's own internet-based, mobile enabled provider directory, if the OhioRISE Plan has opted to provide one as referenced in this appendix;
 - f. A section for member forms, including the following:
 - i. Change of address (County);
 - ii. Grievance and appeal form;
 - iii. Authorized representative;
 - iv. Advanced Directive; and
 - v. Any other forms the OhioRISE Plan requires the member to complete.
 - g. A list of services requiring prior authorization;
 - h. A 30-calendar days' advance notice of changes to the list of all services requiring prior authorization. The OhioRISE Plan must provide a hard copy of the notification of any Prior Authorization changes upon request;
 - i. The toll-free telephone statewide number for crisis behavioral health calls; and
 - j. Contact information for the MCOs and links to the MCO's websites to schedule non-emergency transportation assistance, including an explanation of the available services and to contact MCO member services for transportation services complaints, or OhioRISE Plan/CME care coordination for assistance with any transportation barriers.
3. The OhioRISE Plan must ensure that toll-free member services, 24/7 call-in systems, statewide and local behavioral health crisis response, and the MCO's transportation scheduling telephone numbers are easily identified on either the OhioRISE Plan'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 OhioRISE Plan 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 OhioRISE Plan to provide that information to the County; and
 - c. Request a change in behavioral health provider, including the member's CME.
2. The OhioRISE Plan must respond to questions or comments received from members within one business day from receipt.
3. The OhioRISE Plan must offer members the option to "opt in" to receive information from the OhioRISE Plan via email or text message.
4. The OhioRISE Plan must develop a secure member portal that allows members to access the following information:
 - a. The member's Medicaid redetermination date;
 - b. Authorized services;
 - c. The member's current care coordinator;
 - d. Explanation of benefits;
 - e. Community resources; and
 - f. Other Information that the OhioRISE Plan determines would be helpful to encourage the member to engage in their own health care.

c. Online Provider Websitei. Secure Provider Portal

1. The OhioRISE Plan 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. Confirm member primary language information and any other special communication needs;

- iii. Access to child- and family-centered care plans for OhioRISE Plan's members; and
 - iv. Access claims and utilization history.
 - b. File and track the status of pending provider claim disputes and EMRs.
 - c. Update their address and contact information.
 - 2. The OhioRISE Plan's secure provider portal must be accessible by Public Children's Service Agencies (PCSAs) and IV-E Courts for children and youth in their custody who are enrolled in the OhioRISE Program.
 - a. The provider portal must allow each PCSA and IV-E court to access information about all children and youth in their custody through a single login.
 - b. The OhioRISE Plan must work with PCSAs and IV-E Courts to determine the information about each child and youth that will be made available through their login. At a minimum, information about each child or youth must include:
 - i. CME responsible for care coordination, or designation that care coordination is the responsibility of the OhioRISE Plan;
 - ii. Contact information for the child or youth's assigned care coordinator at the CME or OhioRISE Plan; and
 - iii. The Child and Family Centered Plan.
 - 3. The OhioRISE Plan'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.
 - 4. The OhioRISE Plan 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 OhioRISE Plan 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 OhioRISE Plan must ensure that its provider page includes, at a minimum, the following information that the OhioRISE Plan must make accessible to providers and the general public without any log-in restrictions:
 - a. OhioRISE Plan's provider services contact information for provider issues;

- b. The OhioRISE Plan's provider manual as described in this appendix;
- c. Links to policies and prominent alerts that notify providers of changes to OhioRISE Plan's coverage processes and policies:
 - i. The OhioRISE Plan must provide notice of changes to OhioRISE Plan's 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 OhioRISE Plan 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 OhioRISE Plan'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 OhioRISE Plan;
- e. ODM-provided provider instruction regarding the need to submit claims and prior authorization requests through the Fiscal Intermediary Portal;
- f. New edits or system changes related to claims adjudication or payment processing;
- g. The OhioRISE Plan's documentation requirements for prior authorization and details about Medicaid programs and the OhioRISE Plan's services requiring prior authorization pursuant to ORC section 5160.34;
- h. A sample network provider agreement by provider type; and
- i. Links to Medicaid managed care and OhioRISE requirements in the Ohio Administrative Code and Ohio Revised Code.

8. Staffing Requirements

a. General Requirements

- i. The OhioRISE Plan must employ the identified qualified key and organizational staff, sufficient in number, to meet performance and compliance expectations as set forth in this Agreement.
- ii. The OhioRISE Plan must provide ODM with an OhioRISE Plan's Organizational and Functional Chart that identifies key staff, organizational staff, and reporting lines as specified in Appendix P, Chart of Deliverables.

- iii. Prior to the implementation of this Agreement, the OhioRISE Plan 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 OhioRISE Plan must have Ohio-based staff available 24/7 to work with ODM and other entities as identified by ODM on urgent issue resolutions. The OhioRISE Plan must have sufficient staff to meet the needs of ODM and its members. Urgent issues resolutions include but are not limited to immediate health and safety concerns for members and public emergency events.
 - 1. The OhioRISE Plan 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 OhioRISE Plan must notify ODM of the names and contact information, as well as any changes thereto, for these staff.

b. Key Staffing Requirements

- i. All OhioRISE Plan's key staff must be full time and based (working) in the state of Ohio, unless otherwise indicated in this Agreement. OhioRISE Plan's key staff, including staff performing key staff functions on an interim basis, must be approved by ODM.
- ii. An OhioRISE Plan's key staff member must only occupy one of the key positions listed below unless the OhioRISE Plan receives prior written approval from ODM allowing the key staff to occupy more than one key position.
- iii. Key staff must be dedicated to the OhioRISE Plan and may not share roles or responsibilities with an Ohio Medicaid MCO and/or MyCare Ohio Plan unless specifically indicated in the position requirements in this Agreement.
 - 1. Any position that may be shared between the OhioRISE Plan and an affiliated Ohio Medicaid and/or MyCare Ohio Plan may be a part time position if the selected OhioRISE Plan is unaffiliated with an Ohio Medicaid MCO and/or MyCare Ohio Plan, subject to ODM's review and approval.
 - 2. The OhioRISE Plan's Organization and Functional Chart must indicate any shared or part-time positions and must be reviewed and approved by ODM.
- iv. The OhioRISE Plan must notify ODM in writing of interim and permanent replacements for key staff.
 - 1. OhioRISE Plan's 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 OhioRISE Plan is prohibited from using interim staff to fill a key position for longer than six months, unless approved in writing by ODM.

c. Key Staffi. 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 OhioRISE Plan and have clear local authority over the general administration and implementation of all requirements set forth in this Agreement. The Administrator/CEO/COO must have at least five years of experience with children's behavioral health services and devote full time/40 hours per week to the OhioRISE Plan's operations to ensure adherence to program requirements and timely responses to ODM.
2. The Administrator/CEO/COO may not be shared with or report to the CEO of an Ohio Medicaid MCO and/or MyCare vendor and must be authorized and empowered to represent the OhioRISE Plan in all matters pertaining to this Agreement.

ii. Chief Medical Officer

1. The Chief Medical Officer (CMO) must be a physician with a current, unencumbered license through the Ohio State Medical Board and have at least five years of experience with children's behavioral health services. A physician who is a Board-Certified Child and Adolescent Psychiatrist is preferred. The CMO shall devote a minimum of 32 hours per week to the OhioRISE Plan's operations to ensure clinical oversight and consultation and shall be a member of the OhioRISE Plan's executive team.
2. The responsibilities of the Medical Director/CMO include but are not limited to:
 - a. Ensuring that the OhioRISE Plan makes timely medical decisions, including after-hours consultation as needed;
 - b. Leading all major clinical, population health management, and quality improvement components of the OhioRISE Plan;
 - c. Developing, implementing, and interpreting medical policies and procedures, including service authorization, claims review, discharge planning, and medical reviews performed through the OhioRISE Plan's grievance and appeal system;
 - d. Leading the administration of all medical management activities of the OhioRISE Plan;
 - e. Serving as the chair or co-chair of the Utilization Management committee and of the OhioRISE Plan's internal quality improvement committee;
 - f. Play a lead role in monitoring the overall safety of members with complex and or comorbid medical conditions;

- g. Coordinating with the MCOs' care management staff and providers on medical services not included in the OhioRISE Plan's service array, early and periodic screening, diagnostic and treatment (EPSDT), receipt of maternal and postpartum care, family planning, and preventative health strategies;
- h. Serving as a key clinical lead in developing and implementing evidence-based clinical policies and practices;
- i. Participating in regulatory/accreditation reviews;
- j. Working with MCO's clinical leadership as needed for integration of all health care needs and services for OhioRISE Plan's members; and
- k. Assuming key role in quality improvement initiatives, care coordination activities, and member safety activities (i.e., incident management).

iii. Behavioral Health Clinical Director

1. The Behavioral Health (BH) Clinical Director who possesses an independent, current, and unrestricted Ohio license to provide behavioral health services in the state of Ohio (MD, DO, RN with Advance Practice Registered Nurse [APRN] licensure, psychologist, licensed independent social worker [LISW], professional clinical counselor [PCC], independent marriage and family therapist [IMFY]) with a minimum of five years of experience in the provision and supervision of treatment service for mental illness and substance use disorders for children and adolescents. The BH Clinical Director must have specialty experience with children and adolescents with complex behavioral health needs, multi-system experience, and understanding of managed care.
2. The BH Clinical Director shall demonstrate knowledge and understanding of Ohio's overall behavioral health system that includes mental health, alcohol and drug addiction; developmental disabilities services; child welfare system; juvenile justice system; as well as Family and Children First Councils. The responsibilities of the BH Clinical Director include but are not limited to:
 - a. Providing daily operational activities of BH 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. Serve as a key clinical lead in developing and implementing evidence-based clinical policies and practices at both the OhioRISE Plan and the clinical practice levels. This will necessarily require the integration of relevant pharmacy and social data to inform clinical policies and practices;
 - d. Promoting preventive BH strategies;

- e. Identifying and coordinating assistance for member needs specific to BH;
 - f. Participating in management and program improvement activities with other key staff for enhanced integration with primary care and coordination of BH services and achievement of outcomes; and
 - g. Working with MCO clinical leadership as needed for integration of all health care needs and services for OhioRISE Plan's members.
 - 3. Other duties and responsibilities of the BH Clinical Director staff must include:
 - a. Engaging in oversight and quality improvement activities associated with case management activities;
 - b. Providing guidance to BH network development recruitment, and value-based contracting, including CMEs in conjunction with OhioRISE Plan's provider relations, COE(s), and ODM;
 - c. Assisting in the review of utilization data to identify variances in patterns, and providing feedback and education to OhioRISE Plan's staff and providers as appropriate;
 - d. Representing the OhioRISE Plan as the BH clinical liaison to members, providers, and ODM; and
 - e. Ensuring whole person care by fully integrating physical and behavioral health throughout the care continuum and actively managing transitions of care.
- iv. Chief Financial Officer
 - 1. The Chief Financial Officer (CFO) must oversee the OhioRISE Plan's budget and accounting systems and operations. The CFO must have access to an actuary and is responsible for ensuring that the OhioRISE Plan meets ODM requirements for financial performance and reporting. The CFO may be a shared position with an Ohio Medicaid MCO and/or MyCare Ohio Plan.
- v. Pharmacy Director
 - 1. The OhioRISE Plan 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. This may be a part-time position. The Pharmacy Director may be a shared position with an Ohio Medicaid MCO and/or MyCare Ohio Plan.
 - 2. The primary roles and responsibilities of the Pharmacy Director include:

- a. Overseeing the OhioRISE Plan's responsibilities related to pharmacy benefits;
- b. Coordinating with the SPBM;
- c. Coordinating with ODM to provide input in the review of new drugs to market, changes to ODM's Preferred Drug List and ODM's/SPBM's prior authorization criteria for pharmacy benefits;
- d. Consultation, coordination, and training for medication issues relevant to children for CMEs and prescribers in the OhioRISE Plan or MCO provider networks;
- e. Monitoring, managing, and coordinating the care of the OhioRISE Plan's members as it relates to utilization of prescription drugs (e.g., Coordinated Services Program, use of antipsychotics in children); and
- f. Participating in the Pharmacy and Therapeutics Committee, the Drug Utilization Review Committee, the Drug Utilization Review Board, and any other committee or board as requested by ODM.

vi. 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;
 - c. Have specialty experience with children and adolescents with complex behavioral health needs, experience with multi-system involved children and youth, experience with addressing health equity and race equity issues, and understanding of the different systems that serve children and youth; and
 - d. Report directly to the OhioRISE Plan's Medical Director/CMO or Administrator/CEO/COO.
2. The primary roles and responsibilities of the Population Health Director are to:
 - a. Oversee OhioRISE Plan support of system-wide and MCO population health initiatives based on a deep understanding of scientific population health principles;

- b. Coordinate with ODM, MCOs, and other state child-serving agencies to design, implement, coordinate, and evaluate population health initiatives focused on the behavioral health of high-risk children and youth;
- c. Sponsor and champion OhioRISE Plan and system-wide initiatives, including cultivating the support necessary to achieve the desired operational objectives for each initiative;
- d. Liaison with ODM, MCOs, the SPBM, and other ODM contracted MCOs on population health activities;
- e. Develop and implement operational plans that address the market opportunities/challenges and align with the established population health goals; and
- f. Provide leadership for programmatic initiatives to reduce health disparities and address SDOH.

vii. Quality Improvement Director

1. The Quality Improvement (QI) Director must:

- a. Be an Ohio-licensed registered nurse, physician, or physician's assistant, or be certified as a Certified Professional in Health Care Quality by the National Association for Healthcare Quality (NAHQ), Certified Quality Improvement Associate by the American Society for Quality, 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. A minimum of two years' experience in a senior QI role in child/adolescent behavioral health managed care is required;
- c. Have experience in quality management and quality improvement as specified in 42 CFR 438.206 through 438.370; and
- d. Report directly to the Medical Director/CMO.

2. The primary functions of the QI Director are to:

- a. Develop and manage the OhioRISE Plan'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 OhioRISE Plan's improvement teams and coordinate QI training for OhioRISE Plan's staff;

- c. Reinforce the application of QI tools and methods within OhioRISE Plan's improvement projects and initiatives;
- d. Ensure that learning from all improvement projects and initiatives are shared with ODM and ODM's contracted managed care entities; and
- e. Coordinate with MCOs on Healthcare Effectiveness Data and Information Set (HEDIS) measures, including ensuring timely and accurate collection and exchange of data and collaboration on HEDIS outcome improvement initiatives.

viii. Care Coordination Director

1. The Care Coordination Director must be Ohio-licensed as a registered nurse, independent social worker, psychologist, professional clinical counselor, independent marriage and family therapist, independent chemical dependency counselor, or school psychologist 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 have at least three years' experience providing direct behavioral health care coordination or oversight for children and adolescents with complex behavioral health needs, and must report through the Medical Director/CMO or BH Clinical Director. Additionally, the Care Coordination Director must have specialty experience with children and adolescents with complex behavioral health needs, and understanding of managed care and other child-serving systems, including child welfare, juvenile justice, and developmental disabilities.
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 and as set forth in the Care Coordination Plan described in Appendix D, Care Coordination. 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. Ensure access to primary care, behavioral health, and coordination of health care services for all members;
 - c. Serve as the OhioRISE Plan's primary point of contact for the MCOs on care coordination;
 - d. Develop and support the care coordination roles and responsibilities of the CMEs, in conjunction with OhioRISE Plan's clinical and provider leadership, COE(s) and ODM guidance;

- e. Provide clinical leadership, in conjunction with the CMO, BH Clinical Director and Utilization Management Director, for assisting OhioRISE Plan and CME care coordinators with responsibilities to support and develop CFT members' understanding of service and placement recommendations based on member need;
- f. Develop and implement processes and resources for providing support to members who opt out of care coordination;
- g. Coordinate services furnished to the member with the services the member receives from any other health care entity; and
- h. Ensure care coordination and disease management is part of population health and quality improvement activities, when appropriate.

ix. Utilization Management Director

1. The Utilization Management Director must:

- a. Be an Ohio-licensed registered nurse, APRN, 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. The Utilization Management Director must have at least three years' experience providing direct behavioral health care coordination or oversight for children and adolescents with complex behavioral health needs;
- b. Preferably be certified as a Certified Professional in Health Care Quality by the NAHQ 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. Collaborate with OhioRISE Plan's clinical leadership to implement the Utilization Management Program in a manner reflective of the roles and responsibilities of the CFT;

- e. 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;
 - f. Ensure OhioRISE Plan's Notices of Adverse Action are provided in accordance with 42 CFR 438.404;
 - g. Ensure that all authorization decisions are made within the specified allowable timeframes; and
 - h. Evaluate under and over utilization information for impact on member quality of care and outcomes, including access to care.
- x. Provider Network Director
 - 1. The Provider Network Director acts as the primary point of accountability to ODM to address escalated provider issues and is responsible for network development, network sufficiency, and network reporting functions.
 - 2. The primary functions of the Provider Network Director are to:
 - a. Meet provider services requirements under this Agreement;
 - b. Provide provider education and develop and deliver provider training;
 - c. Ensure network adequacy and appointment access, including development of network resources for identified unmet needs;
 - d. Ensure that contracted providers impacted by population health initiatives, such as quality improvement projects, are included on project teams to identify provider perceived barriers and provide input on design and intervention test that may impact providers;
 - e. Ensure that contracted provider perspectives and feedback are included in evaluations of improvement initiative successes;
 - f. Collaborate with other ODM-contracted managed care entities to simplify provider requirements and remove administrative barriers;
 - g. Serve as the point of communication and coordination with the COE(s); and
 - h. Develop and implement the OhioRISE Plan's provider claim dispute resolution process as described in this appendix.
- xi. Claims and Encounter Administrator
 - 1. The Claims and Encounter Administrator is responsible for ensuring prompt and accurate provider claims processing and accurate and timely encounter reporting to ODM. Sufficient staffing under this position must be in place to ensure all claims and encounter contract requirements are met.

- a. The Claims and Encounter Administrator responsibilities may be shared with an Ohio Medicaid MCO and/or MyCare Ohio Plan, and the OhioRISE Plan's Organization and Functional Chart must indicate how claims and encounter responsibilities will be shared across organizations.
 - b. If the OhioRISE Plan is not affiliated with an Ohio Medicaid MCO and/or MyCare Ohio Plan, the Claims and Encounter Administrator must be a full-time position.
2. 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, including resubmissions and overall adjudication of claims;
 - b. Develop processes for cost avoidance;
 - c. Ensure minimization of claims recoupments;
 - d. Ensure claims processing timelines are met; and
 - e. Ensure ODM encounter reporting requirements are met, including sufficient staff to ensure the submission of timely, accurate, and complete encounter data to ODM.

xii. 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. The CIO may be a shared position with an Ohio Medicaid MCO and/or MyCare Ohio Plan.
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 OhioRISE Plan's 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 OhioRISE Plan's 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 OhioRISE Plan's 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, providers, and other authorized participants in the CFT process 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 MCOs, SPBM, 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;
- g. Responsible for working with providers, particularly CMEs, to connect with and exchange information from OhioRISE systems to facilitate care coordination and efficient use of resources; and
- h. Support program areas to integrate information contained within multiple data systems for use in improvement activities.

xiii. Grievance and Appeal Director

- 1. The Grievance and Appeal Director may be a shared position with an Ohio Medicaid MCO and/or MyCare Ohio Plan.
- 2. The primary functions of the Grievance and Appeal Director are to:
 - a. Establish and implement a grievance and appeals system pursuant to OAC rule 5160-26-08.4 and in accordance with 42 CFR Part 438, Subpart F;
 - b. Ensure the OhioRISE Plan'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.

xiv. 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 may be a shared position with an Ohio Medicaid MCO and/or MyCare Ohio Plan. The Member Services Director must also:
 - a. Ensure that members impacted by population health initiatives, such as quality improvement 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 OhioRISE Plan's population health improvement initiatives is incorporated into member services.

xv. Family Engagement Director

1. The Family Engagement Director is a member of the Senior Management team and is involved across OhioRISE Plan's functions, principally, utilization management, care coordination, quality monitoring, population health, and outreach/enrollment.
2. The Family Engagement Director must have personal experience parenting a child or youth with significant behavioral health challenges or co-occurring disorders.
3. The primary functions of the Family Engagement Director are to:
 - a. Work with OhioRISE Plan's senior management team members, ODM, CMEs, providers, other child-serving systems, the Member and Family Advisory Council, family-run organizations, and a diverse group of stakeholders to support the design, implementation, evaluation, and expansion of culturally competent, family-driven and youth-guided practice and principles that support families, children, and youth who are being served through the OhioRISE Plan;
 - b. Keep informed of national, regional, and local trends and developments and supports the OhioRISE Plan to be a leader in implementation of culturally competent, family-driven public sector behavioral health care, through participation in strategic planning sessions and networking with experts in these fields, internal and external;
 - c. Draw on their own personal experience of:

- i. Parenting a child or youth with significant behavioral health challenges or co-occurring disorders;
 - ii. Negotiating services and supports for their child and family; and
 - iii. Being knowledgeable in key resources for children, youth, and families in the State.
- d. Assist with new member outreach and orientation, including, assisting:
 - i. Members to learn to navigate the behavioral health care delivery system, community resources, transportation, and effectively use behavioral health plan benefits;
 - ii. Families to understand the treatment process and service choices for their children and providing education to families who have questions, concerns, or specific needs related to behavioral health; and
 - iii. Families to understand the roles of the OhioRISE Plan, CMEs, and providers, as well as their relationship to Ohio Department of Job and Family Services (ODJFS), OMHAS, DYS, and the MCOs.
- e. Ensure culturally competent, family-driven principles are woven throughout all communications and outreach approaches and materials;
- f. Work with OhioRISE Plan's senior management staff in the development of training curricula, educational materials, program standards, program descriptions, and expected outcomes for OhioRISE Plan-funded services;
- g. Conduct member and family focus groups to determine strengths and opportunities for improvement in OhioRISE Plan, CME, and provider functions;
- h. Lead roundtables, forums, and other meetings, as assigned;
- i. Ensure input into quality improvement from the OhioRISE Program Member and Family Advisory Council;
- j. Work with Provider Network Development staff to support the alignment of the provider network with culturally competent, family-driven principles, including:
 - i. Ensuring input from the Family and Youth Council into Provider Development issues; and

- ii. Assisting with developing ongoing training programs for OhioRISE Plan's staff, as well as for staff at network provider agencies, including online training modules, conferences, etc.
- k. Provide input into UM policies and practices from the perspective of culturally competent, family-driven care;
- l. Serve as a resource for families to help explain UM policies and practices;
- m. Make UM staff aware of UM related issues identified through focus groups and other input from families and work with UM staff to resolve these issues;
- n. Develop and maintain strategies to garner stakeholder, community, member, and family feedback to identify key issues and inform/refine overall population health strategy;
- o. Disseminate information at conferences and other meetings of professional communities to family-run organizations and other stakeholders through exhibits and presentations;
- p. Develop strong relationships with stakeholders and act as spokesperson for families, parents, and youth as needed;
- q. Support population health objectives by assisting with outreach to and obtaining input from populations experiencing disparities in access to care or disproportional service use;
- r. Speak at local and regional conferences showcasing the OhioRISE Plan's work to promote culturally competent, family-driven care, and population health objectives and support OhioRISE Plan's major campaigns such as children's mental health awareness;
- s. Assist families with understanding care coordination tiers and provide assistance, as needed, for families transitioning from or between tiers, including conducting member and family focus groups to determine strengths and opportunities for improvements at CMEs and with tiers;
- t. Work with OhioRISE Plan's staff care coordinators to perform data collection and analysis of trends;
- u. Provide support to family peer specialists working for agencies in the OhioRISE Plan's network;
- v. Sponsor periodic conference calls for peer specialists, for training, support, and peer exchange;

- w. Serve as liaison with parent-run and consumer organizations and provider agencies regarding efforts to expand the use of peer specialists, achieve family-driven and youth-guided care, and support resiliency-oriented programs; and
 - x. Act as liaison with advocacy organizations regarding peer support training and implementation initiatives.
- xvi. Youth Engagement Director
- 1. The Youth Engagement Director is responsible for facilitating and coordinating a robust youth engagement strategy for the OhioRISE Plan, with a particular focus on young people who are experiencing or have experienced behavioral health challenges as well as those who have been impacted by foster care, juvenile justice, or homelessness. The Youth Engagement Specialist should have direct lived experience with behavioral health challenges.
 - 2. The primary functions of the Youth Engagement Director are to:
 - a. Work closely with OhioRISE Plan's senior management and staff and the OhioRISE Program Member and Family Advisory Council to assist in the development, evaluation, and improvement of services to ensure adherence to the OhioRISE Program's mission and values of authentic youth engagement, building community, equitable practices that promote race equity, diversity and inclusion, and strengths-based, youth-guided practice;
 - b. Develop and provide support to a Youth subgroup of the OhioRISE Program Member and Family Advisory Council, including outreach to recruit young people to the subgroup with lived experience in behavioral health, foster care, juvenile justice, or who are experiencing homelessness to participate in opportunities to inform OhioRISE Plan's operations, population health strategies, and quality improvement;
 - c. Conduct orientation, as well as initial and ongoing training for young people on various topics;
 - d. Provide ongoing support, guidance, and coaching to young people engaged in opportunities and programming, including life domain development, conflict resolution, emotional and moral support, and providing transportation as needed;
 - e. Provide ongoing input, information, and materials (as requested) that support internal and external communication efforts about youth-guided care;

- f. Support young people as they advocate to ensure that the unique needs of young people are a priority for the systems designed to support them and in the broader community;
- g. Participate in the continuous quality improvement and data-driven decision-making processes to assess efficacy of programming and drive programmatic refinements;
- h. Ensure adherence to data collection requirements relevant to youth; and
- i. Provide ancillary support for other OhioRISE Plan's projects by coordinating with and supporting colleagues as needed or requested.

xvii. 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. The Chief Compliance Officer may be a shared position with an Ohio Medicaid MCO and/or MyCare Ohio Plan.
- 2. The Chief Compliance Officer must report to the Administrator/CEO/COO and the OhioRISE Plan's Board of Directors, and must be solely dedicated to ensuring OhioRISE Plan compliance with this Agreement.

xviii. 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 health care 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 Lead Investigator may be a shared position with an Ohio Medicaid MCO and/or MyCare Ohio Plan.
- 4. The primary responsibilities of the Lead Investigator are to:
 - a. Identify risk, and guard against, fraud, waste, and abuse throughout the OhioRISE Plan's service delivery system;

- b. Actively monitor for aberrant providers;
- c. Refer potential fraud, waste, and abuse to ODM as required in Appendix G, Program Integrity, in a timely manner; 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.

xix. OhioRISE Plan's Contract Administrator

1. The OhioRISE Plan Contract Administrator must serve as the primary point-of-contact for all OhioRISE Plan's operational issues.
2. The primary functions of the OhioRISE Plan's Contract Administrator include but are not limited to:
 - a. Coordinating the tracking and submission of all contract deliverables;
 - b. Fielding and coordinating responses to ODM inquiries;
 - c. Coordinating, preparing for, and facilitating random and periodic audits and site visits; and
 - d. Serving as the OhioRISE Plan's contract transition coordinator for transitions resulting from OhioRISE Plan's termination or non-renewal, as identified in Appendix O, OhioRISE Plan's Terminations and Non-Renewals, that includes:
 - i. Coordinating the development and submission of the OhioRISE Plan's transition plan to ODM;
 - ii. Coordinating the tracking and submission of all transition-related reports and deliverables;
 - iii. Coordinating OhioRISE Plan's representation and attendance for ODM-identified transition meetings;
 - iv. Coordination and overseeing all member transition activities to ensure the safe, timely, and orderly transition of members and their care; and
 - v. Coordinating the development and submission of OhioRISE Plan's transition plan updates and the final report to ODM.

xx. Transition of Care Coordinator

1. The Transition of Care Coordinator is a full-time position and will serve as the primary point of contact with MCOs and with state agency staff for

planning, managing, and troubleshooting transition issues as members' transition from MCOs into the OhioRISE Plan or back to the MCOs. The position reports to the Director of Care Coordination and must serve as the OhioRISE Plan's primary point of contact for planning and managing all member transitions of care as identified in Appendix D, Care Coordination, and transitions resulting from OhioRISE Plan's enrollments and disenrollments. The Transition of Care Coordinator must meet the following minimum qualifications:

- a. Have a minimum of two years' experience managing or coordinating children's mental health, child welfare, developmental disabilities, juvenile justice, or a related public sector human services or behavioral health care field, providing community-based services to children and youth and their family/caregivers;
 - b. Have background and experience in one or more of the following areas of expertise: family systems; community systems, and resources; case management; child and family counseling/therapy; child protection; or child development;
 - c. Be clinically and culturally competent/responsive with training and experience necessary to manage complex cases in the community across child-serving systems.
2. The primary functions of the OhioRISE Plan's Transition of Care Coordinator include but are not limited to:
- a. Development of OhioRISE Plan's policies and procedures for successful transition of members to and from MCOs in alignment with state requirements;
 - b. Primary point of contact for OhioRISE Plan's staff, ODM, MCO representatives, and other state agency staff for transition of care issues; and
 - c. Interface with Regional Coordinators to ensure member transitions of care include local resources and input as needed.

d. OhioRISE Plan's Organizational Staff

i. Provider Services Representatives

1. The OhioRISE Plan must have Provider Services Representatives sufficient in number to meet the standards set forth in this Agreement.
 - a. Provider Services Representatives are responsible for ensuring providers receive prompt resolution to provider issues, including problems with claims payments, prior authorizations, and referrals.
 - b. Provider Services Representatives must be regionally based and familiar with the communities and providers serving that region.

- c. Provider Services Representatives may be shared positions with an Ohio Medicaid MCO and/or MyCare vendor.
- d. At least one full time Provider Services Representative must be dedicated to OhioRISE Plan's functions, if the OhioRISE Plan is affiliated with an Ohio Medicaid MCO and/or MyCare Ohio Plan.

ii. Regional Coordinators

1. The OhioRISE Plan must have Regional Coordinators who develop and execute OhioRISE Plan's engagement activities in priority communities. Regional coordinators must have at least two years' experience in a setting that includes services or management of multi-system youth, work with local/community systems of care, and knowledge of Ohio's child-serving systems.
2. The primary responsibilities of Regional Coordinators are to:
 - a. Serve as the OhioRISE Plan's primary points of contact for ODM-approved improvement efforts involving community-based organizations and requiring community outreach and active involvement in priority communities (e.g., juvenile detention diversion initiatives or reduction in efforts to reduce out-of-home placements);
 - b. Serve as the OhioRISE Plan's dedicated contact for county or local child serving agencies. Attend or oversee OhioRISE Plan attendance at community events in priority communities (e.g., trainings; County Alcohol Drug and Mental Health Boards [ADAMH], Boards of Developmental Disability, PCSA, Family and Children First Councils, Juvenile Courts, and School District meetings; and racism dialogues);
 - c. Provide in-person communication with ODM or other state agency funded community-based organizations in order to bolster the presence of the OhioRISE Plan itself as a collaborative and trusted partner of the community-based organization and as a supporter of the ODM initiative;
 - d. Coordinate training for county or local child-serving entities regarding the roles and responsibilities of the OhioRISE Plan and the CMEs;
 - e. Collaborate with the CMEs to identify service and resource gaps in local communities and assist state and local child-serving agencies in addressing those gaps;
 - f. Collaborate with MCO's Regional Coordinators to collectively strategize and address community concerns;

- g. Coordinate the tracking and submission of process measures, as needed, related to OhioRISE Plan's improvement efforts in communities (e.g., reductions in out-of-home placements);
- h. Promote the referral of members to community-based organizations when services are provided that will promote better outcomes;
- i. Respond to ODM inquiries related to OhioRISE Plan's community engagement activities; and
- j. Build alliances with family- and youth-run organizations to strengthen family and youth voice in OhioRISE Plan's operations.

iii. Special Investigative Unit Staff

- 1. The OhioRISE Plan must maintain adequate staffing and resources for its Special Investigative Unit (SIU) that includes, at a minimum, one SIU staff person per 60,000 members.
- 2. The OhioRISE Plan's proposed SIU staffing must be included in the OhioRISE Plan's fraud, waste, and abuse plan described in Appendix G, Program Integrity.
 - a. The Lead Investigator may also serve the Special Investigation Unit staff resources on a full or part-time basis depending on OhioRISE Plan's membership levels and required time to fulfill leadership responsibilities.
 - b. Proposed SIU staffing, including total full-time equivalents, are subject to ODM review and approval annually based on the OhioRISE Plan's fraud, waste, and abuse plan.
- 3. The OhioRISE Plan must ensure that all SIU staff investigators meet the following qualifications:
 - a. A minimum of two years in a health care field working on fraud, waste, and abuse investigations and audits;
 - b. A bachelor's degree, or an associate's degree with an additional two years working on health care fraud, waste, and abuse investigations and audits;
 - c. The ability to understand and analyze health care claims and coding.

iv. Population Health Staffing

- 1. In addition to senior clinical leadership, the OhioRISE Plan must employ sufficient population health staffing to improve population health outcomes, including the creation of new processes and procedures through

iterative testing and evaluation that, at a minimum, incorporates insights from data, research, members, and providers.

- a. Population Health staff may be shared positions with an Ohio Medicaid MCO and/or MyCare Ohio Plan.
 - b. At least one full time Population Health staff must be dedicated to OhioRISE Plan's functions, if the OhioRISE Plan is affiliated with an Ohio Medicaid MCO and/or MyCare Ohio Plan.
2. The OhioRISE Plan's population health staff must understand and execute their role in responding quickly and agilely to the needs of internal (i.e., OhioRISE Plan's staff) and external stakeholders (e.g., ODM).
 3. The OhioRISE Plan's population health staffing must include health equity staff, and staff in the fields of analytics, statistics, and informatics.

v. Member Services Staffing

1. OhioRISE Plan's member services staffing must be sufficient to designate at least one full-time member relations staff position to serve as the contact to address barriers identified by members during quality improvement projects aimed at improving member outcomes.
2. Member services staff may be shared positions with an Ohio Medicaid MCO and/or MyCare Ohio Plan.
3. At least one full time member services staff must be dedicated to OhioRISE Plan's functions, if the OhioRISE Plan is affiliated with an Ohio Medicaid MCO and/or MyCare Ohio Plan.

vi. Utilization Management Staff

1. The OhioRISE Plan must ensure that all staff involved in reviewing, evaluating information for service planning, authorization, or other UM functions meets the following minimum qualifications:
 - a. Be clinically licensed with a specialty in mental health, SUD, or child or youth services;
 - b. Have a minimum of two years' experience in children's behavioral health, child welfare, developmental disabilities, juvenile justice, or a related public sector human services or behavioral health care field, providing community-based services to children and youth, and their family/caregivers;
 - c. Have background and experience in one or more of the following areas of expertise: family systems, community systems and resources, case management, child and family counseling/therapy, child protection, or child development;

- d. Be clinically and culturally competent/responsive with training and experience necessary to manage complex cases in the community across child-serving systems; and
 - e. Be trained to screen and assess crisis or emergency calls and assess the caller's degree of acuity/severity and clinical necessity for treatment based on ODM approved criteria.
 - 2. The OhioRISE Plan must not use generalists to review and make prior authorization decisions for specialty services (e.g., child behavioral health services or services for substance use disorders).
 - a. UM staff may be shared positions with an Ohio Medicaid MCO and/or MyCare Ohio Plan.
 - b. At least one full time UM staff must be dedicated to OhioRISE Plan's functions, if the OhioRISE Plan is affiliated with an Ohio Medicaid MCO and/or MyCare Ohio Plan.
- vii. Care Coordination Staff
 - 1. The OhioRISE Plan must employ a sufficient number of care coordination staff to support the care coordination and population health needs of its members as specified in Appendix D, Care Coordination.
 - 2. The OhioRISE Plan shall ensure that OhioRISE Plan's care coordinators meet the following minimum qualifications:
 - a. Have a minimum of two years' experience in children's mental health, child welfare, developmental disabilities, juvenile justice, or a related public sector human services or behavioral health care field, providing community-based services to children and youth, and their family/caregivers;
 - b. Have background and experience in one or more of the following areas of expertise: family systems, community systems and resources, case management, child and family counseling/therapy, child protection, or child development; and
 - c. Be clinically and culturally competent/responsive with training and experience necessary to manage complex cases in the community across child-serving systems.
- viii. Other Organizational Staff
 - 1. The OhioRISE Plan must employ sufficient organizational staff and appropriately utilize staffing resources to comply with this Agreement. ODM will evaluate staffing adequacy based on the OhioRISE Plan's ability to achieve compliance with this Agreement.

e. OhioRISE Plan's Staff Training Requirements

- i. The OhioRISE Plan 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 OhioRISE Plan must ensure staff receive training on applicable program requirements commensurate with position responsibilities.
- iii. The OhioRISE Plan must ensure staff receive training on characteristics of their members (multi-system youth) and best practices (including strategies to address trauma) for addressing the behavioral health needs of this population.
- iv. The OhioRISE Plan must ensure staff receive training on the role of child welfare caseworkers, legal mandates, especially for youth in custody, and training on courts and juvenile corrections system.
- v. The OhioRISE Plan must use the most appropriate training methods, which may include instructor-lead and web-based trainings.
- vi. The OhioRISE Plan must submit an OhioRISE Plan's 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 OhioRISE Plan's training must include:
 1. Orientation to Ohio Medicaid managed care program, including roles and responsibilities of the MCOs, CCEs, the OhioRISE Program, SPBM, COE(s) and CMEs;
 2. Training on health and race 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 management staff;
 5. Training on trauma-informed approaches, and
 6. Any additional training topics as directed by ODM.
- vii. The OhioRISE Plan must ensure that individuals who develop and deliver training have demonstrable experience and expertise in the topic for which they are providing training.
- viii. 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 OhioRISE Plan must include:
 1. An inter-rater reliability component to the training;
 2. 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.

9. Subcontractual Relationships and Delegation

a. General Requirements

- i. The OhioRISE Plan may delegate administrative responsibilities subject to the requirements in this section.
- ii. Unless otherwise specified by ODM, administrative services of a first tier, downstream, or related (FDR) entity include care coordination, marketing, utilization management, quality improvement, enrollment, disenrollment, membership functions, claims administration, provider network management, and coordination of benefits.
- iii. For any other administrative functions not listed above that could impact a member's health, safety, welfare, or access to covered services, the OhioRISE Plan 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. The OhioRISE Plan 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 OhioRISE Plan to provide administrative services for Ohio Medicaid-eligible individuals.
 2. "Downstream entity" means any party that enters into a written arrangement, acceptable to ODM, with a first tier or related entity or below the level of a first tier or related entity to provide administrative services for Ohio Medicaid-eligible individuals. These arrangements continue down to the level of the ultimate provider of the administrative services.
 3. "Related entity" means any related party to the OhioRISE Plan by common ownership or control under an oral or written arrangement to perform some of the administrative services under the OhioRISE Plan's contract with ODM. A related party includes but is not limited to agents, managing employees, individuals with an ownership or controlling interest in the OhioRISE Plan and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or individuals.
 4. "FDR" is the collective term for first tier, downstream, and related entities.
 5. "FDR agreement" is the written agreement between the OhioRISE Plan and an FDR to delegate administrative responsibilities or service.

b. First Tier, Downstream, and Related Entities Agreements

- i. If the OhioRISE Plan delegates administrative responsibilities or services under this Agreement to any first tier, downstream, and related entities (FDR), the OhioRISE Plan must ensure it has an FDR agreement with the FDR to perform administrative services on the OhioRISE Plan's behalf.
- ii. The following requirements apply to all FDR agreements.
 1. The OhioRISE Plan must evaluate the FDR's ability to perform the administrative services before the OhioRISE Plan executes or renews any FDR agreement.
 2. The OhioRISE Plan must notify ODM of a proposed FDR agreement at least 30 calendar days prior to the OhioRISE Plan executing the FDR agreement. ODM, in its sole discretion, may require the OhioRISE Plan to submit the complete and exact text of the proposed FDR agreement for ODM review and approval prior to execution.
 3. The OhioRISE Plan must allow ODM to review the terms of any FDR arrangement upon ODM's request.
 4. The OhioRISE Plan must completely and accurately respond to ODM's questions and requests for information about the FDR and any provisions in the proposed 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 ODM Medicaid state plan amendment (SPA) 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 proposed FDR agreement is unacceptable or incompatible as stated above, the OhioRISE Plan 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 OhioRISE Plan 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 OhioRISE Plan must include a term in all FDR agreements to require 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 OhioRISE Plan must disclose to ODM all financial terms and arrangements for payment of any kind that apply between the OhioRISE Plan, or the OhioRISE Plan'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 OhioRISE Plan and FDR must narrowly designate as proprietary portions of any FDR agreement that it deems to contain 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.C of the Baseline Provider Agreement; and
 - b. Portions of the FDR agreement that consist of unique business or pricing structures that a competitor may use to gain an unfair market advantage over the FDR.
 - 2. Proprietary designations in every FDR agreement must be limited consistent with the foregoing.
 - 3. Every portion of an FDR agreement that is not designated as proprietary may be deemed by ODM to be a public record as defined in ORC 149.43.
- d. FDR Agreement Provisions
 - i. The OhioRISE Plan 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 OhioRISE Plan;
 - 2. The beginning date and expiration date or automatic renewal clause for the arrangement, as well as applicable methods of extension, renegotiation, and termination;
 - 3. Identification of the service area and Medicaid population, either "non-dual" or "non-dual and dual" the FDR will serve;
 - 4. A provision stating that the FDR must release to the OhioRISE Plan and ODM any information necessary for the OhioRISE Plan to perform any of its obligations under the OhioRISE Plan'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 OhioRISE Plan, ODM, ODM's designee, or other entities as specified under the OhioRISE Plan's provider agreement with ODM;
 - 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 OhioRISE Plan; and that the agreement is automatically

amended to conform to any changes in laws, regulations, and OhioRISE Plan contractual obligations to ODM without the necessity for written amendment;

7. A provision that Medicaid-eligible members and ODM are not liable for any cost, payment, co-payment, cost-sharing, down payment, or similar charge, refundable or otherwise for services performed, including in the event the FDR or the OhioRISE Plan cannot or will not pay for the administrative services. This provision does not prohibit waiver entities from collecting patient liability payments from OhioRISE Plan 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 arrangement, 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 OhioRISE Plan's written policies regarding the False Claims Act and the detection and prevention of fraud, waste, and abuse;
10. A provision that requires the FDR to adhere to all screening and disclosure requirements as described in Appendix G, Program Integrity;
11. A provision that the FDR, and all employees of the FDR, are subject to the applicable provider qualifications in OAC rule 5160-26-05;
12. For an FDR providing administrative services that result in direct contact with a Medicaid-eligible member, a provision that the FDR must meet the member information requirements as stated in this appendix and identify, and where indicated, arrange pursuant to the mutually agreed upon policies and procedures between the OhioRISE Plan 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 OhioRISE Plan retains the right to approve, suspend, or terminate any such selection;
14. A provision that permits ODM or the OhioRISE Plan to seek revocation of the OhioRISE Plan's contractor with the FDR or other remedies, as applicable, if ODM or the OhioRISE Plan determines that the FDR has not performed satisfactorily, or the arrangement is not in the best interest of the OhioRISE Plan'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 OhioRISE Plan's provider agreement with ODM;
16. A provision that all of the provisions applicable to the FDR of under the OhioRISE Plan's provider agreement with ODM supersede all applicable provisions in an FDR agreement. If a provision in an FDR agreement contradicts or is incompatible with any applicable provision in the OhioRISE Plan'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 OhioRISE Plan in fulfilling the OhioRISE Plan's obligations under the OhioRISE Plan's provider agreement with ODM; and
18. A provision that allows the OhioRISE Plan, 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, 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.

e. OhioRISE Plan's Accountability

- i. The OhioRISE Plan is ultimately responsible for meeting all contractual obligations under the OhioRISE Plan's provider agreement with ODM, regardless of delegation.
- ii. For all OhioRISE Plan delegated responsibilities under this Agreement, the OhioRISE Plan must:
 1. Monitor FDR performance on an ongoing basis and conduct a formal review at least annually to identify any deficiencies or areas for improvement;
 2. Communicate the results of the performance review to the FDR and impose corrective action on the FDR as necessary;
 3. Notify ODM and submit a corrective action plan to ODM if at any time the FDR is found to be in non-compliance with OhioRISE Plan delegated contractual obligations;
 4. Report the results of the annual performance review and any corrective action plan (FDR Oversight Report) to ODM as specified in Appendix P, Chart of Deliverables; and
 5. Ensure there is no disruption in meeting the OhioRISE Plan's contractual obligations to ODM, if the FDR or the OhioRISE Plan terminates the arrangement between the FDR and the OhioRISE Plan.

- iii. Unless otherwise specified by ODM, all information must be submitted to ODM directly by the OhioRISE Plan.
- iv. The OhioRISE Plan must report changes to or termination of FDR arrangements to ODM no less than 15 calendar days prior to the effective date.
- v. In accordance with 42 CFR 438.602, the OhioRISE Plan 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 OhioRISE Plan that relates directly or indirectly to the performance of the OhioRISE Plan's obligations under this Agreement, not including a network provider.

10. Comprehensive Disaster/Emergency Response Planning

a. Comprehensive Disaster/Emergency Response Plan

- i. As directed by ODM, the OhioRISE Plan 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 OhioRISE Plan, 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 OhioRISE Plan must make the ODM-approved Comprehensive Disaster/Emergency Response Plan available to all staff.

b. Primary Point of Contact

- i. As identified in the OhioRISE Plan staffing requirements in this appendix, the OhioRISE Plan must designate both a primary and alternate point of contact who will perform the following functions with respect to the OhioRISE Plan'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 OhioRISE Plan;
 - 4. Respond to directives and emergent requests for information issued by ODM; and
 - 5. Cooperate with the local- and state-level Emergency Management Agencies.
- c. The OhioRISE Plan must participate in workgroups and processes as required by ODM to establish a state-level emergency response plan that will include a provision for Medicaid recipients, and must comply with the resulting procedures.

- d. During the time of an emergency or a natural, technological, or man-made disaster, the OhioRISE Plan must:
 - i. Generate a current list of members for whom an individual disaster plan, according to the specifications below, has been developed, including the risk and the individual-level plan; and
 - ii. Distribute the list to local and state emergency management authorities according to the protocol established by ODM.
- e. The OhioRISE Plan must identify members who are at risk for harm, loss, or injury during any emergency or potential natural, technological, or man-made disaster. OhioRISE Plan identification of vulnerable members must include populations as identified by ODM.
 - i. For these members, the OhioRISE Plan must develop an individual-level plan with the member when appropriate.
 - ii. The OhioRISE Plan must ensure staff, including care coordination staff, are prepared to respond to and implement the plans in the event of an emergency or disaster.
 - iii. The member-level plan must:
 - 1. Include a provision for the continuation of critical services appropriate for the member's needs in the event of a disaster, including but not limited to access to medication/prescriptions;
 - 2. Identify how and when the plan will be activated;
 - 3. Be documented in the member record maintained by the OhioRISE Plan; and
 - 4. Be provided to the member.

APPENDIX B – COVERAGE AND SERVICES

1. OhioRISE Basic Benefit Package

a. Service Coverage Requirements

- i. Pursuant to OAC rule 5160-59-03, included within Attachment I to this RFA, the OhioRISE Plan must cover and ensure members have timely access to all medically necessary services listed below, in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to members under fee-for-service (FFS) Medicaid:
 1. Intensive care coordination using High Fidelity Wraparound;
 2. Moderate care coordination using a Wraparound-informed approach;
 3. Mobile Response and Stabilization Services (MRSS);
 4. Intensive Home Based Treatment (IHBT) Services;
 5. Respite services for members under the age of 21 with behavioral health needs in accordance with OAC rule 5160-26-03;
 6. Inpatient psychiatric hospital services, including services in accordance with Chapter 5160-2 of the Administrative Code provided in a free-standing psychiatric hospital or a general acute care hospital that provide:
 - a. Inpatient psychiatric services; or
 - b. Inpatient substance use disorder (SUD) services (including withdrawal management) provided in accordance with the American Society of Addiction Medicine Level of Care 4.
 7. Psychiatric residential treatment facilities (PRTFs);
 8. Opioid Treatment Programs (OTP) services delivered by community SUD programs licensed by Ohio Department of Mental Health and Addiction Services (OMHAS) as a methadone administration program and/or certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) as an OTP;
 9. Behavioral health services provided in accordance with OAC Chapter 5160-27;
 10. Behavioral health services rendered by other licensed practitioners in accordance with OAC Chapter 5160-8-05;
 11. Behavioral health services rendered by psychiatrists in accordance with OAC Chapter 5160-4 and Advanced practice registered nurses in accordance with OAC Chapter 5160-4-04;

12. Behavioral health services rendered by outpatient hospital providers in accordance with ODM guidance;
 13. Behavioral health services rendered by federally qualified health centers (FQHCs) and rural health centers (RHCs) in accordance with OAC Chapter 5160-28-01;
 14. Physician administered drugs for the treatment of mental health and SUD conditions. All other pharmacy services and benefits are covered by ODM's contracted single pharmacy benefit manager (SPBM). The OhioRISE Plan must coordinate and collaborate with the SPBM as necessary to ensure that members receive medically necessary pharmacy services for the treatment of mental health and SUD conditions;
 15. Limited customized goods and services included in a Wraparound plan using flexible funding consistent with ODM guidance.
 16. Other services identified by ODM during the period of this Agreement.
- ii. In accordance with 42 CFR 438.210, the OhioRISE Plan may place appropriate limits on service coverage, as specified in this appendix, with the exception of emergency and post-stabilization services, including MRSS. The OhioRISE Plan must provide coverage and payment for these services, in accordance with 42 CFR 438.114 and OAC 5160-59-03.
 - iii. The OhioRISE Plan is not required to pay for services not covered by Ohio Medicaid, except as specified in this Agreement. Coverage exceptions can be found in OAC rules 5160-1-61.
- b. Ohio Medicaid Services Not Covered by the OhioRISE Program
- i. The OhioRISE Plan is not required to cover pharmacy services for members other than the limited pharmacy services described in this appendix. All other pharmacy benefits are covered by ODM's contracted SPBM. The OhioRISE Plan must coordinate and collaborate with the SPBM as necessary to ensure that members receive medically necessary pharmacy services.
 - ii. The OhioRISE Plan is not required to cover behavioral health services for members enrolled in ODM's contracted MCOs when the member is not also enrolled in the OhioRISE Plan.
 - iii. The OhioRISE Plan is not required to cover any medical services for members that are not listed in Section 1.a. of this appendix as covered OhioRISE Program's services.
- c. Provider-Preventable Conditions
- i. The OhioRISE Plan must not use Medicaid funding to pay for a service resulting from a provider-preventable condition (PPC) as defined in 42 CFR 447.26.

- ii. In accordance with 42 CFR 438.3(g), the OhioRISE Plan must identify and report all PPCs, regardless of the provider's intention to bill for that event, to ODM in the manner specified by ODM.
- iii. The OhioRISE Plan must ensure that the prohibition on payment for PPCs does not result in a loss of access to care or services for members.

2. Service Specific Clarifications

a. Medication Therapy Management Program

- i. As requested by ODM, the OhioRISE Plan shall work with other MCOs, the SPBM, ODM, and other stakeholders to develop medication therapy management (MTM) services, including the trigger events and MTM activities. These include but are not limited to initiatives focused on polypharmacy and the use of antipsychotic medications in pediatric populations served by the OhioRISE Plan and MCOs.

b. Moral or Religious Objections

- i. If the OhioRISE Plan determines that it will no longer provide, reimburse, or cover a counseling service or referral service due to an objection to the service on moral or religious grounds, the OhioRISE Plan 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 OhioRISE Plan must notify its members of this change at least 30 calendar days prior to the effective date. The OhioRISE Plan must include in its member handbook and provider directory any such services that the OhioRISE Plan will not cover.

c. Behavioral Health Crisis Services

- i. The OhioRISE Plan must ensure that OhioRISE Plan's staff who have direct member contact know the continuum of community resources for behavioral health crisis services, including the statewide behavioral health crisis line and the appropriate MRSS within each region.
- ii. The OhioRISE Plan must train OhioRISE Plan's staff who interface with the public or have direct member contact how to connect (through direct linkages) members in need of behavioral health crisis services to the statewide behavioral health crisis line and the appropriate MRSS.
- iii. The OhioRISE Plan 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 OhioRISE Plan or care management entity (CME) for appropriate follow-up.

- iv. The OhioRISE Plan must work with ODM, the OMHAS, and other entities as identified by ODM to develop a robust continuum of behavioral health crisis services.

d. Substance Use Disorder Treatment

- i. The OhioRISE Plan must continue to work with ODM to implement Ohio's 1115 SUD demonstration waiver to provide services to members under the age of 21 who have an SUD diagnosis. Additional work will include developing utilization management strategies, increasing care coordination efforts, and monitoring network adequacy. The OhioRISE Plan shall assist with the development and integration of these activities in alignment with System of Care Principles and child and family-centered practice.

e. Coordinated Services Program

- i. The OhioRISE Plan must actively participate and coordinate with ODM and the MCOs for lock-in member monitoring, as described in OAC rule 5160-20-1, as well as Coordinated Services Program (CSP) performance measurement and program evaluation.
- ii. The OhioRISE Plan's solution must include functionality to support ODM's prescriber and pharmacy lock-in programs, including but not limited to the following:
 - 1. Ensure the provision of care coordination services to any member who is enrolled in the CSP, including coordination with any care management activities at the applicable MCO;
 - 2. Support member lock-in for a specific drug, drug class, Drug Enforcement Administration (DEA) schedule, and other parameters as defined by ODM;
 - 3. Support the capability to lock members into one or more specific providers (pharmacies or prescribers); and
 - 4. Implement provider training and transmission messages to make clear to providers that the member is locked into a specific prescriber or pharmacy, and the grievance procedure.

f. Telehealth

- i. Services set forth in 1.a.i of this Appendix that are provided through telehealth must be consistent with the requirements set forth in Appendix F.9 of this Agreement.

g. Non-Emergency Medical Transportation Services

- i. The member, their family, or their caregiver may contact the MCO using processes in the OhioRISE Plan's member handbook to arrange for transportation to receive a medically necessary Medicaid-covered service. If the member, their family, or their caregiver requests or requires assistance, the member's care coordinator (whether provided by a CME or the OhioRISE Plan) must work with the identified MCO representative (e.g., MCO Care Guide Plus) to arrange for transportation.

- ii. Should a member, their family, or their caregiver experience problems related to non-emergency transportation services, the OhioRISE Plan shall develop a procedure for contacting and working with an MCO at an organizational level to address and resolve these problems.
- iii. The OhioRISE Plan must collaborate with ODM, ODM contracted MCOs, and the counties within the regions served to improve member experience and access to transportation services.
- iv. The OhioRISE Plan will assist ODM and MCOs in the development of criteria to identify when it is necessary and appropriate for family members to be transported with the member for OhioRISE Plan-related services.

3. Additional Benefits

a. Value-Added Services

- i. In accordance with 42 CFR 438.3(e)(1)(i), the OhioRISE Plan may elect to provide services in addition to those covered under the Ohio Medicaid FFS program. Before the OhioRISE Plan notifies potential or current members of the availability of those services, the OhioRISE Plan must first notify ODM of its plans to make such services available through the process determined by ODM.
- ii. The OhioRISE Plan must demonstrate to the satisfaction of ODM 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.
- iii. When determining the types of value-added services the OhioRISE Plan elects to provide, the OhioRISE Plan should consider the population health needs of the members.
- iv. The OhioRISE Plan must give advance notice of at least 90 calendar days to ODM and members when decreasing or ceasing any additional benefits. When the OhioRISE Plan finds that it is impossible to provide 90 calendar days prior notice for reasons beyond its control, as demonstrated to ODM's satisfaction, the OhioRISE Plan must notify ODM within at least one business day of discovery.
- v. The OhioRISE Plan may include, at its option, activities or other benefits to members, or their families, to facilitate accessing care according to child and family-centered care plans. These activities should be tailored to the needs of the individual family, but could include:
 - 1. Offering child care for any other children in the same family during in-home appointments for the member;
 - 2. Reimbursing for lodging or extended lodging for caregivers visiting children in inpatient/residential treatment facilities including out-of-state facilities; or

3. Providing access to a phone or phone application to the enrolled members or caregivers to help facilitate virtual visits with their providers or care coordinators.
- vi. To the extent that the OhioRISE Plan provides these type of value-added services, it should report the use of these to ODM on a quarterly basis (Value-Added Services Report) consistent with Appendix P, Schedule of Deliverables.

b. In Lieu of Services

- i. In accordance with 42 CFR 438.3(e)(2) the OhioRISE Plan may propose to ODM coverage for services that are in lieu of those covered under the Ohio Medicaid state plan (in lieu of services).
 1. The OhioRISE Plan's proposal must demonstrate that any in lieu of service is a medically appropriate and cost-effective substitute for a service covered under the Ohio Medicaid state plan.
 2. The OhioRISE Plan's proposal must include a cost-benefit analysis for any in lieu of service it proposes to provide, including how the proposed service would be a medically appropriate and cost-effective substitute for a service covered under the Ohio Medicaid state plan.
- ii. In lieu of services must be approved by ODM in writing prior to being delivered.
- iii. The OhioRISE Plan must not require a member to use an in lieu of service as an alternative to a service covered under the Ohio Medicaid state plan.

4. Member Cost-Sharing

- a. Pursuant to OAC rules 5160-26-05 and 5160-26-12 and 42 CFR 438.108, the OhioRISE Plan may not impose any member co-payment on any services covered under this Agreement.
- b. The OhioRISE Plan's payment for any covered services constitutes payment in full and the OhioRISE Plan must ensure its subcontractors do not charge members, their custodians, or ODM any additional co-payment, cost sharing, down payment, or similar charge, refundable or otherwise.
- c. In accordance with 42 CFR 438.106(b), the OhioRISE Plan 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 OhioRISE Plan.
- d. Pursuant to OAC rule 5160-26-05, the OhioRISE Plan must ensure that OhioRISE Plan's subcontractors and providers do not bill members or their custodians any amount greater than would be owed if the entity provided the services directly (i.e., no balance billing by providers).

5. Utilization Management Program

a. General Requirements

- i. The OhioRISE Plan must establish a Utilization Management (UM) program to ensure access to care and utilization of services for children and youth who are its members. The UM program must be developed and implemented consistent with Systems of Care Principles and include the review of the OhioRISE Plan member's child and family-centered care plan. All UM staff and peer advisors must be specially trained in Ohio's child and youth family System of Care guiding principles in order to facilitate the child and family-centered model. The UM program must be responsible for determining adequacy and appropriateness of the child and family-centered plan, consistent with Fidelity Wraparound and Systems of Care Principles, clinical need for included services, authorizing specific services appropriate to the child or youth's needs where indicated, and reviewing member utilization to ensure services are adequate given their level of need.
- ii. The OhioRISE Plan must develop, implement, and maintain a 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 OhioRISE Plan's UM program must be used to inform the OhioRISE Plan's population health and quality improvement strategies as outlined in Appendix C, Population Health and Quality.
- iii. The OhioRISE Plan must monitor its UM program on an ongoing basis, and evaluate and update UM program requirements at least annually as a component of the OhioRISE Plan's quality improvement plan and assessment. This monitoring, evaluation, and update requirement shall include and consider the Child and Family Care Plan Review process as described in this agreement. Based upon the evaluation and assessment, the OhioRISE Plan must update the UM program policies, structures, and processes as necessary. The OhioRISE Plan's monitoring and evaluation of its UM program shall include:
 1. Monitoring the timeliness of service authorization as stipulated in this Agreement;
 2. Monitoring the consistency and inter-rater reliability of the OhioRISE Plan's application of service authorization criteria;
 3. Assessing to determine whether the OhioRISE Plan's prior authorization procedures unreasonably limit member access to Medicaid-covered services;
 4. Assessing the UM program's adherence and support of a child and family-centered care planning process consistent with High Fidelity Wraparound practice and System of Care Principles, including:
 - a. Monitoring the comprehensiveness of the child and family-centered plan needs and goals to ensure that all necessary CME and other provider services and supports are incorporated into the child and family-centered plan of care;

- b. Monitoring alignment between child and family-centered care plan needs and goals, and OhioRISE Plan's service authorizations;
 - c. Training needs for OhioRISE Plan's staff involved with the UM process; and
 - d. Training needs related to medical necessity, child and family-centered plans, and appropriate levels of services.
 - 5. Reviewing the OhioRISE Plan'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;
 - 6. Using provider advisory feedback to identify opportunities to standardize and streamline service authorization processes to reduce administrative burden for providers; and
 - 7. Monitoring for updates to ODM clinical coverage criteria, evidence-based nationally recognized medical necessity guidelines, and other professional literature to inform and update the OhioRISE Plan's clinical coverage policies and criteria. This shall also include ensuring alignment between OhioRISE Plan and MCO criteria for the same services.
- iv. While the OhioRISE Plan must have mechanisms in place to ensure that its UM program interfaces with and informs the OhioRISE Plan's program integrity responsibilities under Appendix G, Program Integrity, the OhioRISE Plan must demonstrate that the primary function of its UM program is to:
- 1. Meet the clinical needs of the member consistent with the child and family-centered care planning process and Systems of Care principles;
 - 2. Meet all state and federal requirements, including early and periodic screening, diagnostic and treatment (EPSDT);
 - 3. Ensure continuity for members when transitioning between the OhioRISE Plan, the MCOs, or between CMEs; and
 - 4. Deliver efficient and appropriate services.
- v. In accordance with 42 CFR 438.210(e), the OhioRISE Plan 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.
- vi. In accordance with 42 CFR 438.210, the OhioRISE Plan 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.
- vii. The OhioRISE Plan must use UM data (including data from the SPBM) and other quality information to identify and appropriately address providers who appear to be operating outside peer norms with respect to service utilization, prescribing

patterns, and quality of care concerns. The OhioRISE Plan must report providers who are operating outside of such peer norms, including practices that impact member safety, to ODM consistent with the requirements of Appendix G, Program Integrity.

b. Policies and Procedures

- i. The OhioRISE Plan must develop and implement clearly defined UM policies, structures, and processes pursuant to OAC rule 5160-59-03.1 to maximize the effectiveness of care provided to members.
- ii. The OhioRISE Plan must implement UM requirements for SUD services as necessary to support Ohio's SUD 1115 demonstration waiver implementation plan.
- iii. The OhioRISE Plan must submit clinical coverage policies and any subsequent proposed changes to ODM for review and approval prior to implementation. The OhioRISE Plan's submission must include a proposed list of the services and items subject to UM clinical coverage reviews. The OhioRISE Plan must submit the proposed list and changes.
 1. As part of the OhioRISE Plan's submission of clinical coverage policies or changes thereto, the OhioRISE Plan must include a summary of the OhioRISE Plan's analysis that demonstrates that the policy or changes comport with the parity requirements in 42 CFR 438.910(d).
 2. The OhioRISE Plan's parity analysis must demonstrate that the non-quantitative treatment limits resulting from the OhioRISE Plan'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. More information can be found in Section 8, Mental Health Parity and Addiction Equity Act (MHPAEA) requirements.
- iv. The OhioRISE Plan must notify network and out-of-network providers of clinical coverage policies. The communication must include an outline or summary specifying the changes and their impact on specific providers receiving these policy changes. Changes to policies require 30 calendar days' advance notice. Provider notifications must meet the requirements in Appendix A, General Requirements.

c. Utilization Management Program Structure

- i. The OhioRISE Plan must structure the OhioRISE Plan's Utilization Management (UM) program to meet requirements in OAC rule 5160-59-03.1.
- ii. The OhioRISE Plan must ensure that the administrative and organizational staff of the OhioRISE Plan's UM program reports to the Chief Medical Officer (CMO).
- iii. The OhioRISE Plan must employ at least one child-trained Medical Director (i.e., either pediatrician or child board certified psychiatrist) who participates in the UM program.

- iv. The OhioRISE Plan's UM structure must include a UM Committee, chaired or co-chaired by the OhioRISE Plan's CMO, to review and approve the OhioRISE Plan's UM program, plan, and annual evaluations, as well as UM policies and procedures. The OhioRISE Plan must include the Behavioral Health Clinical Director as a member of the UM Committee.
- v. The OhioRISE Plan's clinical leadership must ensure the UM program is implemented in a manner reflective of System of Care Principles and a High Fidelity Wraparound practice.
- vi. The OhioRISE Plan must have appropriately qualified UM review staff who are available by telephone from 8 am to 5 pm Eastern Time Monday through Friday (except for the major holidays and two optional closure days as described in Appendix A, General Requirements) to render UM decisions for providers. UM review staff must be based in and operate from Ohio. They must be available by telephone 24/7 to respond to authorization requests for inpatient admissions and other urgent services requiring prior authorization as specified by ODM. With ODM's prior approval, the OhioRISE Plan may have policies and procedures that allow for admissions to inpatient or other urgent services with authorization the next business day.

d. Authorization Data and Reporting

- i. The OhioRISE Plan must provide ODM with 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.
- ii. The OhioRISE Plan 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 on a quarterly basis. This must include analysis of discrepancies between authorizations and recommendations on the child and family-centered care plan. The results of this analysis shall be reviewed in the quality and UM committee structure.

6. Coverage Requirements

a. Medical Necessity Criteria

- i. Pursuant to OAC rule 5160-59-03, the OhioRISE Plan's coverage requirements and decisions must be based on the coverage and medical necessity criteria published in OAC Chapter 5160 and practice guidelines as specified in OAC rule 5160-26-05.1.
- ii. The OhioRISE Plan must have objective, written criteria based on sound clinical evidence to make medical necessity and utilization decisions. The OhioRISE Plan must involve appropriate providers as well as the Child and Family Advisory Council input in the development, adoption, and review of medical necessity criteria. The OhioRISE Plan's written criteria must meet NCOA standards and must specify procedures for appropriately applying the criteria.

- iii. In the absence of ODM-developed medical necessity criteria or ODM-approved, clinically accepted, evidence-informed medical necessity criteria, the OhioRISE Plan'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 well-designed 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 a rationale that is based upon well-designed research and endorsements by national medical bodies or panels regarding scientific efficacy and rationale.
 - iv. When applying coverage policies and medical necessity criteria, the OhioRISE Plan must consider individual member needs as demonstrated through the child and family-centered care planning process, an assessment of the local delivery system, and continuity of care for the same or similar services available and accessed through the MCOs.
- b. Child and Family-Centered Care Plan Review Criteria
- i. The OhioRISE Plan must have and use objective written criteria to evaluate and provide feedback on child and family-centered care plans to the CMEs.
 - ii. The OhioRISE Plan shall incorporate and use the specifications for child and family-centered care plans as specified by ODM in the OhioRISE Plan and/or CME program guidance manuals.
- c. Inter-Rater Reliability
- i. The OhioRISE Plan must perform inter-rater reliability testing to ensure consistent application of the OhioRISE Plan's medical necessity criteria when making coverage decisions and comprehensive understanding and consistent application of the child and family-centered care planning process.
 - ii. At least annually, the OhioRISE Plan must ensure that all staff performing initial and continuing stay authorizations, denial reviews, and child and family-centered plan reviews participate in inter-rater reliability testing to assess consistency in the application of practice guidelines and access to care criteria.
 - iii. The OhioRISE Plan must meet ODM set thresholds for inter-rater reliability. Where thresholds are not directed by ODM, the OhioRISE Plan must establish specific inter-rater reliability thresholds by service or category of service.
 - iv. The OhioRISE Plan must not permit staff performing below acceptable thresholds for inter-rater reliability to make independent review or authorization decisions until such time that staff member has been retrained and monitored and demonstrates performance that exceeds the acceptable threshold.

- v. The OhioRISE Plan must continually monitor performance and implement corrective measures if the OhioRISE Plan does not meet internal inter-rate reliability benchmarks.

7. Service Authorization

a. General Requirements

- i. The OhioRISE Plan must cooperate with ODM to develop processes and systems necessary to allow providers to submit requests for service authorization, and for the OhioRISE Plan to accept and respond to authorization requests from providers through secure electronic transmission and exchanges with ODM's fiscal intermediary. The OhioRISE Plan must require its providers to comply with service authorization submission requirements through ODM's fiscal intermediary as determined by ODM.
- ii. The OhioRISE Plan must comply with requirements in OAC rule 5160-59-03.1 for responding to provider requests for initial and continuing authorization of services.
- iii. For any designated service or prior authorization request or decision, ODM may require an additional clinical review or a different clinical review process. The OhioRISE Plan must cooperate with and assist, as needed, with this additional or different review. ODM retains authority to ultimately decide whether a service should be approved.
- iv. Upon medical necessity review and in accordance with approved medical necessity criteria, if a needed level of care for treatment is not available, the OhioRISE Plan must authorize at the next highest available level of care for treatment.
- v. The OhioRISE Plan must comply with service authorization requirements to meet the member transition of care requirements in Appendix D, Care Coordination, and within this Agreement.
- vi. The OhioRISE Plan must permit and facilitate ODM real time, read-only access to the OhioRISE Plan's child and family-centered care plan review and service authorization systems, including all approval and denial documentation.
- vii. The OhioRISE Plan must ensure coordination between the service authorization process and the Child and Family-Centered Care Plan review process.
- viii. The OhioRISE Plan must implement ODM expectations to standardize and streamline requirements to reduce administrative burden for providers that deliver services to MCO and OhioRISE members, including:
 - 1. Standardizing some aspects of approved lengths of stay for certain services requiring prior authorization (e.g., 30 days for SUD Level 3 residential services);
 - 2. Standardizing prior authorization requirements for SUD residential services;

3. Standardizing expectations for OhioRISE Plan's notification of providers for submission of authorization requests to continue services that require prior authorization; and
4. Standardizing and specifying the type of clinical documentation required for child and family-centered care plan review and prior authorization decision making.

b. Behavioral Health Service Authorization

i. Prohibition of Prior Authorization and Concurrent Review

1. The OhioRISE Plan is prohibited from requiring prior authorization for the following behavioral health services:
 - a. A Child and Adolescent Needs and Strengths (CANS) assessment; and
 - b. Up to 72 hours of MRSS.

ii. Utilization Management Decisions

1. All UM decisions shall be made in the context of the member's child and family-centered care plan (when one exists and is current). When a member is receiving care coordination services through a CME, the OhioRISE Plan's UM clinical staff shall coordinate and collaborate with the CME care coordinator or their supervisor.

iii. Substance Use Disorder Services

1. The OhioRISE Plan must make medical necessity determinations for inpatient and outpatient SUD treatment authorizations in accordance with the ASAM Criteria for Adolescents and Adults. When making medical necessity determinations for inpatient services for individuals with co-occurring SUD and physical health diagnoses, the OhioRISE Plan must also use other clinical criteria (i.e., MCG® or InterQual®) in addition to ASAM criteria, and must authorize services when either ASAM or MCG®/InterQual® indicates the need for inpatient services.
2. The OhioRISE Plan must ensure that all OhioRISE Plan's 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 adolescent and adult criteria and complete competency and inter-rater reliability testing to ensure consistent application of criteria.
3. All OhioRISE Plan's medical directors, peer advisors, clinical directors, and clinicians that have a role in the denial or reconsideration of SUD treatment must have documented SUD and ASAM experience. At least one OhioRISE Plan-employed or contracted board-certified addiction medicine physician must be available for consultation with OhioRISE Plan's staff.

4. Upon medical necessity review and in accordance with ASAM adolescent and adult criteria, if a needed level of care for SUD treatment is not available, the OhioRISE Plan must authorize at the next highest available level of care for SUD treatment. For example, if an authorization request for ASAM 4.0 does not meet clinical criteria for inpatient hospitalization, but the member needs medically monitored withdrawal management at ASAM level 3.7, the OhioRISE Plan must authorize level 4.0 until access to level 3.7 withdrawal management.
 5. OhioRISE Plans must have processes in place, including the use of quality improvement methods, provider development assistance, and corrective action plans, to address providers not complying with ASAM adolescent and adult criteria or otherwise evidencing patterns of high denial or other authorization process issues for SUD treatment services.
- c. Retroactive Coverage Requirements
- i. Pursuant to the criteria in ORC section 5160.34(C), the OhioRISE Plan is prohibited from retroactively denying a prior authorization request as a utilization management strategy. In addition, the OhioRISE Plan 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).
- d. Notification of Authorization Decisions
- i. The OhioRISE Plan must meet Notice of Action requirements pursuant to OAC rule 5160-26-08.4.
 1. The OhioRISE Plan must use the ODM-developed Notice of Action template, and all information included by the OhioRISE Plan must meet the member information requirements as described in Appendix A, General Requirements.
- e. Peer-to-Peer Consultation
- i. When the OhioRISE Plan denies a service authorization request from a provider, the OhioRISE Plan must notify the provider and offer them the option to request a peer-to-peer consultation. When the denial of authorization is for a service on a member's established child and family-centered care plan, the peer-to-peer consultation must be offered to the appropriate clinical representative at the assigned CME who shall serve as the liaison to the member's Child and Family Team if one has been established. If the requesting provider for the service is not the CME, peer-to-peer consultation shall be offered to the provider and to the CME who is responsible for the comprehensive child and family-centered plan of care developed by the care plan team in addition to the CME.
 - ii. The OhioRISE Plan must use accepted clinical guidelines under this Agreement when conducting peer-to-peer consultations.

- iii. The OhioRISE Plan must ensure that OhioRISE Plan's staff conducting peer-to-peer consultations are behavioral health care professionals who have clinical expertise in treating the member's condition, with the equivalent or higher credentials as the requesting/ordering provider. All OhioRISE Plan's staff conducting peer-to-peer consultations must be trained in the Ohio Child and Family Team approach using high Fidelity Wraparound and Systems of Care Principles to serving multi-system children and youth and must be based in Ohio.
- iv. The OhioRISE Plan's staff conducting the peer-to-peer consultation must clearly identify what documentation the provider must provide in order to obtain approval of the specific item, procedure, or service; or of a more appropriate course of action based upon accepted clinical guidelines.
- v. The OhioRISE Plan must offer a peer-to-peer consultation within a mutually agreed-upon time within 24 hours of a provider and/or CME's request for a peer-to-peer consultation.

8. Mental Health Parity and Addiction Equity Act Requirements

a. General

- i. The OhioRISE Plan must comply with Mental Health Parity and Addiction Equity Act (MHPAEA) requirements outlined in 42 CFR Part 438 Subpart K. The requirements apply to the provision of all covered benefits and additional services (i.e., value-added and in lieu of services) to all populations included under the terms of this Agreement.
- ii. The OhioRISE Plan must participate in ODM-requested meetings, respond to ODM information requests, work with ODM and MCOs to resolve compliance risks, and notify ODM of any changes to benefits or limitations that may impact compliance with MHPAEA.
- iii. The OhioRISE Plan must conduct ongoing monitoring to determine compliance with MHPAEA for benefits provided by the OhioRISE Plan and provide a MHPAEA Compliance Analysis/Attestation of Compliance report annually to ODM as specified in Appendix P, Chart of Deliverables. The OhioRISE Plan's report must describe:
 - 1. Changes to financial requirements and quantitative treatment limits;
 - 2. Changes to benefit packages, covered services, or service delivery structures (e.g., change in subcontractors performing administrative functions);
 - 3. Changes to policies or procedures of the OhioRISE Plan or subcontractors performing administrative functions on the OhioRISE Plan's behalf that impact benefit coverage, access to care, or provider contracting;
 - 4. OhioRISE Plan self-monitoring activities and analysis conducted to ensure that quantitative and non-quantitative treatment limitations are, in writing and operation, applied no more stringently to mental health/SUD benefits than to medical/surgical benefits; and

5. A summary of:
 - a. Parity compliance concern identified;
 - b. The financial requirement, quantitative treatment limit, or non-quantitative treatment limit associated with the parity compliance concern;
 - c. The applicable benefit package and classifications impacted;
 - d. The nature of the parity compliance concern; and
 - e. The actions taken by the OhioRISE Plan to remedy the parity compliance concern.
 - iv. Based on ODM's overall review of MCOs' and OhioRISE Plan's MHPAEA compliance analysis, the OhioRISE Plan may be requested to make the necessary changes identified in Section 8.a.iii of this appendix.
- b. Other Service Authorization Requirements
- i. With ODM's prior written approval, the OhioRISE Plan may waive prior authorization requirements for specific services that are delivered by providers who are participating in an established and validated OhioRISE Plan program and demonstrating their consistent adherence to approved medical necessity criteria and protocols.

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, child- and family-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 approach and will identify the respective roles and responsibilities of ODM, the MCOs, OhioRISE Program, and SPBM for population health. The OhioRISE Plan must participate in ODM-led meetings and activities, and fulfill ODM-established population health roles and responsibilities as directed by ODM.
- iii. Consistent with the construct of ODM's population health management approach, the OhioRISE Plan must support the population health management strategies developed by each of the MCOs, recognizing each MCO must lead population health efforts across the MCO, OhioRISE Program, and SPBM for the members of that MCO.
 1. The requirements and components of the MCO Population Health Management Strategy are detailed in the MCO Provider Agreement, Appendix C.
- iv. The OhioRISE Plan must continuously coordinate with the ODM and the MCOs to ensure that the OhioRISE Plan is appropriately participating in and supporting the population health management strategies across the MCOs.

b. The OhioRISE Plan's Role in Support of MCO Population Health Management Strategies

- i. The OhioRISE Plan will support its members, by:
 1. Coordinating with ODM, the MCOs, and other ODM-contracted managed care entities to support the ODM population health approach;
 2. Coordinating with each MCO on population health efforts at the leadership/organizational level;
 3. Sharing available individual and aggregate data with MCOs in support of their population health management strategies and strategic initiatives;
 4. Providing consultation related to the behavioral health care needs of children and youth and the Children with Behavioral Health Conditions Population Stream;
 5. Supporting alignment across MCO care coordination efforts, care coordination provided by the OhioRISE Plan, and care coordination

managed by the care management entities (CMEs) in support of population health management strategies and strategic initiatives.

- ii. The specific role and activities of the OhioRISE Plan within each MCO's Population Health Management Strategy shall be described in the MCO/OhioRISE Plan's Model Agreement (described in Appendix A, General Requirements) executed between the OhioRISE Plan and each MCO.

2. Support for the Children with Behavioral Health Conditions Population Stream

a. Population Streams

- i. To organize its population health work, ODM has identified six population streams for the Ohio Medicaid system: women (mothers and infants), children with behavioral health conditions, adults with behavioral health conditions, healthy children, healthy adults, and individuals with chronic conditions. Each MCO must stratify populations within its membership to drive the MCO population health management approach, prioritization of initiatives, and resource allocation and to optimize health outcomes.
- ii. The OhioRISE Plan must, at the direction of ODM, play a primary role in driving population health efforts for high-risk children and youth in the population stream focused on children with behavioral health conditions, including:
 - 1. Work with ODM and the MCOs to develop cross-cutting population health and quality improvement initiatives for high-risk children and youth within this population stream;
 - 2. Providing consultation, upon ODM request, to ODM, the MCOs, the SPBM, and other ODM-contracted managed care entities in the following areas related to this population stream:
 - a. The development and implementation of population health strategies;
 - b. The collection, analysis, and reporting of quality measures;
 - c. Service system and clinical issues;
 - d. Health and race equity issues; and
 - e. Strategic initiatives and other quality improvement activities.
 - 3. Monitoring and evaluating population health and quality improvement activities under this population stream.

3. Population Health Infrastructure

a. General

- i. The OhioRISE Plan must provide the infrastructure necessary to support ODM's population health management approach and each MCO's population health management strategy, including but not limited to:
 1. The support of senior leadership;
 2. A robust information system and the related analytics; and
 3. Adequate staffing and resources to support the MCOs' strategic initiatives to improve population health and to evaluate and integrate the results of population health improvement strategies into MCO and OhioRISE Plan practices.

b. Senior Leadership Support

- i. The OhioRISE Plan's senior leadership must foster and create an ongoing dynamic culture of innovation and health care excellence in support of Ohio's Medicaid population health management approach. The lead member of the senior quality improvement (QI) leadership team must report directly to the OhioRISE Plan's Chief Executive Officer (CEO).
- ii. The OhioRISE Plan must ensure that the Chief Medical Officer (CMO) is involved with and provides oversight for all clinically related population health and quality improvement initiatives.
- iii. The OhioRISE Plan, through its senior leadership, must:
 1. Provide direction and oversight of OhioRISE Plan's activities related to population health improvement efforts under the ODM Population Health Approach, including OhioRISE Plan's activities related to MCO population health management strategies;
 2. Promote an OhioRISE Plan 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 systemic levels of improving quality of care and reducing health disparities;
 4. Ensure that gaps in behavioral health care are remedied at both the individual and systemic levels and ensure that any physical health gaps identified at either level are reported to the MCOs of the impacted members;
 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 OhioRISE Plan's business processes;

6. Ensure that the OhioRISE Plan works collaboratively with the MCOs, other ODM-contracted managed care entities, SPBM, CMEs and OhioRISE' Plan network providers, care coordination entities (CCEs), and ODM to work collaboratively to share results of improvement activities, and to develop and implement strategies to have a collective impact in improving population health outcomes, including addressing health and race equity and social determinants of health (SDOH);
7. Ensure relevant staff (e.g., member services, provider relations, care management, Utilization Management [UM] staff) are engaged in population health improvement efforts (e.g., care coordination and quality improvement efforts) to inform and address barriers to optimal care and behavioral health outcomes;
8. Ensure transparent communication and coordination among the leadership team, CEO, and relevant functional areas of the organization;
9. Promote ongoing, rapid-cycle improvement of the quality of care and services provided by the OhioRISE Plan, CMEs, OhioRISE Plan's network providers, and other OhioRISE Plan's subcontractors; and
10. Engage in high-impact leadership activities as described in High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs.¹

c. Staffing Resource Allocation

i. General

1. The OhioRISE Plan must allocate sufficient staffing to support MCO population health activities and strategic initiatives, and to respond to the needs of internal and external stakeholders.

ii. Analytical Support

1. The OhioRISE Plan 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;

¹ Swensen S, Pugh M, McMullan C, Kabcenell A. High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2013. (Available at ihi.org)

- d. Descriptive and predictive analyses necessary to support population health strategies (e.g., care coordination and quality improvement efforts, alternative payment models);
- e. Collaboration with child-serving state agencies, including: Department of Developmental Disabilities (DODD), Ohio Department of Education (ODE), Ohio Department of Health (ODH), Ohio Department of Job and Family Services (ODJFS), Ohio Department of Mental Health and Addiction Services (OMHAS), Ohio Department of Rehabilitation and Correction (ODRC), Ohio Department of Youth Services (DYS), and Ohio Family and Children First (OFCF) for the purpose of analyzing information to improve the population health of enrolled OhioRISE Plan members; and
- f. Collaboration with MCOs, other ODM-contracted managed care entities, CMEs and OhioRISE Plan's network providers, 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 OhioRISE Plan must have sufficient health equity staffing resources, which may be organized under the Population Health Director, to:
 - a. Actively contribute to quality improvement projects within each of the ODM identified children's population health streams;
 - b. Attend ODM-led meetings and make connections with health equity staff from ODM, MCOs, and other ODM-contracted managed care entities;
 - c. Coordinate health equity work with other ODM-contracted managed care entities;
 - d. Provide support to CMEs and OhioRISE Plan's network providers related to OhioRISE Plan's health equity and quality improvement efforts; and
 - e. Establish relationships with communities and community-based entities to inform and address local health and race equity issues.

iv. Quality Improvement Staffing

- 1. The OhioRISE Plan must use quality improvement (QI) activities and initiatives to improve population health outcomes, including the creation of new processes and procedures through iterative testing and evaluation that incorporate insights from, at a minimum, data, research, members, and providers.

2. The OhioRISE Plan must dedicate sufficient staff to fulfill the OhioRISE Plan's set of clearly defined QI functions and responsibilities, including coordinating with the MCOs, SPBM, and other involved entities, so that staffing is proportionate to, and adequate for, support for the number and types of OhioRISE Plan-managed aspects of QI initiatives, including QI initiatives that are part of MCOs' population health management strategies.
3. The OhioRISE Plan must have staff fully dedicated to the OhioRISE Program who represent the following areas of expertise:
 - a. Continuous QI;
 - b. Analytics;
 - c. Subject matter expertise in clinical or non-clinical improvement topics being addressed through improvement efforts;
 - d. Population health and health and race equity;
 - e. Other child-serving systems;
 - f. OhioRISE Plan policies and processes related to child and youth behavioral health, care coordination, coordination with MCOs, and general operations of the OhioRISE Plan and CMEs; and
 - g. Member and provider perspectives (may be staff or liaisons with the OhioRISE Plan's member and provider services).

d. Population Health Information System

i. General

1. The OhioRISE Plan must have information systems necessary to integrate and analyze data from multiple data sources to support MCO population health management strategies for its members and OhioRISE Plan's quality improvement efforts as described in this appendix.

ii. System Capabilities

1. The OhioRISE Plan's information system must fully support all components of its role in the ODM's and MCOs' population health strategies, and comply with the requirements in Appendix K, Information Systems, Claims, and Data. At a minimum the OhioRISE Plan's data information system must have the capabilities necessary to support the OhioRISE Plan in performing the following essential activities:
 - a. Integration of multiple data and information sources (e.g., enrollment data, care coordination data, claims, member services, data from MCOs, data from CMEs, and prior authorization data) to facilitate internal OhioRISE Plan's communication and coordination related to a specific member (e.g., the Utilization Management

reviewer is able to see the OhioRISE Plan (including CME) care coordinator assigned to a particular member) or population;

- b. Inform population identification, risk assignment, stratification, and assignment of care coordination tier and status;
 - c. Identification of behavioral health providers and community-based organization involvement; and
 - d. House data to support each MCO's population health management strategies specific to OhioRISE Plan members, including:
 - i. OhioRISE Plan care coordination tier (Tier 3 - Intensive Care Coordination using a High Fidelity Wraparound, Tier – 2 Care Coordination using a Wraparound informed model, Tier – 1 OhioRISE Plan Care Coordination);
 - ii. Identification of the primary entity providing care coordination (e.g., CME or OhioRISE Plan Care Coordination);
 - iii. Child and family-centered care plan content, including goals, interventions, outcomes, and completion dates; and
 - iv. Data needed to monitor the effectiveness and impact of the each MCO's population health strategies as specified in the MCO/OhioRISE Plan's Model Agreement (referenced in Appendix A, General Requirements).
2. The OhioRISE Plan must coordinate with the MCOs and ODM to search for and proactively incorporate useful data sources that would assist in supporting each MCO's population health management strategies and improve the OhioRISE Plan's ability to serve its members, network providers, families, and communities.
 3. The OhioRISE Plan's information system must support the OhioRISE Plan to perform timely information system improvements, testing, and execution necessary to operationalize MCO- and ODM-coordinated population health efforts.
 4. The OhioRISE Plan'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 OhioRISE Plan's data systems must integrate key member information to facilitate internal OhioRISE Plan communication and care coordination related to a specific member, as well as to inform the MCO population stream initiatives. Key information includes, but is not limited to:

- a. Clinical data (including EHR and HIE data);
- b. Data provided by CCEs;
- c. Health risk assessments and other assessments (e.g., MCO Health Risk Assessment, Child and Adolescent Needs and Strengths [CANS] whether conducted by the OhioRISE Plan, MCO, Network Providers, or CMEs);
- d. Enrollment data;
- e. Financial data;
- f. Utilization data (e.g., professional, hospital, pharmacy, services provided by CMEs and network providers);
- g. Data from the OhioRISE Plan and MCO provider portal;
- h. Lab results;
- i. Programmatic data (e.g., level of care coordination);
- j. Improvement project outcome, process, and balancing measures;
- k. Survey data;
- l. Registry data (e.g., immunization data);
- m. Complaints, grievances, and appeals;
- n. Resource information from community-based behavioral health organizations serving Medicaid members;
- o. Data from state child-serving agencies (e.g., DODD, ODE, ODH, ODJFS, OMHAS, ODRC, DYS, and OFCF) for the purpose of analyzing information to improve the population health of enrolled OhioRISE Plan members;
- p. Local governmental data (e.g., data from County Alcohol, Drug and Mental Health Boards [ADAMH], County Boards of Developmental Disabilities [BDD], County Departments of Job and Family Services [CDFJS], County Juvenile Courts, Educational Service Centers [ESCs], Family and Children First Councils [FCFCs], Public Children Services Agencies [PCSAs], and School Districts);
- q. Data from CMEs;
- r. Data from MCOs;
- s. Data from the SPBM; and
- t. Administrative data from ODM.

6. The OhioRISE Plan'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 OhioRISE Plan-specific member survey 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 OhioRISE Plan's data system must efficiently and securely share data with ODM, the Centers of Excellence (COEs), CCEs, MCOs, the SPBM, CMEs, and other community-based behavioral health organizations, subject to state and federal privacy requirements, including:
 - a. Data to identify gaps in services for members;
 - b. Attribution file;
 - c. Risk factors related to SDOH and other relevant information; and
 - d. Data to support care coordination efforts by CMEs and OhioRISE Plan's Care Coordinators.
 8. The OhioRISE Plan's data system must be accessible to the COE(s) for providing support to the CMEs for data aggregation and analytics.
 9. The OhioRISE Plan's data system must efficiently and securely exchange care coordination data with CMEs, MCOs, 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).
4. Population Health Improvement Strategies
- a. General
 - i. The OhioRISE Plan will coordinate with each MCO to support its population health management strategies, including support for:
 1. Care coordination, consistent with the requirements in Appendix D, Care Coordination;
 2. Optimizing the delivery system through quality and performance improvement activities, health and race equity, and the identification and promotion of clinical and payer best practices; and
 3. Supportive payment structures to promote a system-wide population health management approach.

b. Care Coordination

- i. The OhioRISE Plan must develop a care coordination program as required in Appendix D, Care Coordination, that honors individual care preferences while supporting and enhancing partnerships with the MCOs, SPBM, CCEs, CMEs, and other community-based behavioral health entities providing care coordination.
- ii. The OhioRISE Plan's approach to care coordination must demonstrate the qualities of a high-performing system:
 1. Provide timely, proactive, planned communication and action;
 2. Be individualized, child-centered, strength-based, and family-focused with the strengths and needs of the child, youth, or young adult and their family/caregivers dictating the services received and the level of service coordination;
 3. Be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve;
 4. Be collaborative across the continuum of care and child- and youth- serving systems; and
 5. Demonstrate comprehensive consideration of physical, behavioral, and social determinants of health.

c. Health Equity

- i. The OhioRISE Plan must participate in and support ODM's efforts to reduce health disparities, address social risk factors, and achieve health equity for its members. The OhioRISE Plan's health equity efforts must include the following:
 1. Identifying disparities in health care access, service provision, satisfaction, and outcomes that includes:
 - a. Obtaining data on member demographics and social determinants; and
 - b. Stratifying OhioRISE Plan data (e.g., claims, CANS, care plan data, member-identified race and 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 OhioRISE Plan and with CMEs and other community-based behavioral health providers, including promoting awareness of implicit biases and how they impact policy and processes;
 3. Engaging youth and families when designing services and interventions that integrate care and address childhood adversity and trauma;

4. Obtaining ongoing input from members and families to:
 - a. Create strategies for reducing disparities that incorporate the perspective of the member and their family;
 - b. Define metrics, timelines, and milestones that indicate success; and
 - c. Establish credibility and accountability through active member and family involvement and feedback.
5. Ensuring that each functional area with outward-facing communications tests potential publications with members and families for understanding and conveyance of the intended message, as well as cultural appropriateness;
6. Collaboratively partnering with members, families, MCOs, other ODM-contracted managed care entities, SPBM, network providers, and internal staff to test, refine, and share successful strategies for reducing disparities;
7. Connecting and engaging with individuals, families, and organizations within the communities the OhioRISE Plan serves to understand community needs and resources;
8. Supporting CMEs to partner with community-based organizations to address SDOH-related needs, such as:
 - a. Lack of access to nutritious food (food insecurity, food deserts, and food swamps);
 - b. Employment;
 - c. Homelessness;
 - d. Housing stability;
 - e. Education;
 - f. Transportation;
 - g. Recreational and social supports;
 - h. Interpersonal safety; and
 - i. Toxic stress.
9. Ensuring the active referral to and follow-up on identified needs related to SDOH such as those outlined above by:
 - a. Supporting CMEs to maintain validated and up-to-date community resource lists for member and provider use;
 - b. Sharing Health Risk Assessments, CANS, and other sources identifying SDOH needs, subject to state and federal privacy

requirements, with CMEs, network providers, HUBS and community health workers;

- c. Ensuring SDOH needs and strategies are included in the child and family-centered care plans developed by the child and family teams;
- d. Reimbursing SDOH codes (z codes); and
- e. Reimbursing network providers for follow-up after referral to confirm that the member received the service (e.g., HIEs).

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 OhioRISE Plan must describe how the OhioRISE Plan meets the requirements for addressing health disparities as part of its Quality Assurance Performance Improvement (QAPI) submission as described below in this appendix.

d. Optimal Delivery System

- i. The OhioRISE Plan must continuously improve all aspects of the care delivery system to optimize the health of its members through inclusion of input from members, families, providers, and other partners across the care continuum into the design, execution, evaluation, and refinement of OhioRISE Plan service delivery policy and practice.
- ii. The OhioRISE Plan must develop and apply clinical and payer best practice guidelines for service delivery decisions pertaining to: utilization management, including medical necessity determinations, care coordination, member grievance and appeals, provider dispute resolution, member education, coverage of services, quality improvement projects, addressing disparities, and other areas to which these guidelines apply.

1. Clinical Best Practice Guidelines

- a. The OhioRISE Plan must develop and implement clinical practice guidelines that:
 - i. Are based on valid and reliable clinical evidence or consensus of behavioral health care professionals;
 - ii. Consider the needs of members;
 - iii. Are adopted in consultation with the CMEs and OhioRISE Plan's network providers, which may be done through a provider advisory group;

- iv. Include input from children, youth, and families who have received services, and from ODJFS, DYS, FCFC, OMHAS, ODRC, ODE, ODH and DODD;
- v. Are reviewed and updated quarterly, or more frequently if needed;
- vi. Are provided in an efficient and effective format to all affected providers, members, and potential members;
- vii. Incorporate the results of quality improvement projects when applicable; and
- viii. Are reported annually within the QAPI portion of ODM's Population Health Management Strategy template.

2. Payer Best Practices

- a. As a strategy for optimizing the care delivery system, the OhioRISE Plan must identify and demonstrate best payer practices that optimize member and provider experiences. The OhioRISE Plan 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, ADAMH, County BDD, CDFJS, County Juvenile Courts, ESCs, FCFCs, PCSAs, School Districts, and providers;
 - ii. Obtaining input from network providers on burdens generated by OhioRISE Plan's policies and procedures and efforts to minimize these burdens;
 - iii. Incorporating feedback from OhioRISE Program Member and Family Advisory Council and Provider Advisory Council on their needs and barriers;
 - iv. Researching industry standards;
 - v. Reviewing trade journals and other literature;
 - vi. Conversing with other lines of business within the OhioRISE Plan's parent company; and
 - vii. Testing strategies with members and providers through science-based quality improvement methods and incorporating successful strategies into OhioRISE Plan's operations and policy.

e. Coordination with MCO Specialized Services and Resources

- i. The OhioRISE Plan must ensure that care coordination efforts through the OhioRISE Plan and CMEs work in concert with specialized services and resources (e.g., home visiting, community workers) identified by the MCO in MCO population health management strategies and MCO care plans.

f. Utilization Management

- i. The OhioRISE Plan must monitor health care service under- and overutilization as outlined in Appendix B, Coverage and Services, and OAC rule 5160-59-03.1 to support the MCO population health management strategies for the children's behavioral health population stream. This includes:
 1. Analyzing utilization by subpopulation demographics to ensure optimal care for all populations;
 2. Analyzing utilization by service type and geographic area;
 3. Establishing a process for setting thresholds for selected types of utilization (e.g., clinical criteria);
 4. Establishing standards for timeliness of utilization management decisions and OhioRISE Plan's performance;
 5. Immediately investigating any identified under- or overutilization 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- or overutilization;
 6. Establishing methods to ensure that the OhioRISE Plan's UM decision-making process is as efficient and uncomplicated as possible for the member, the provider, and the provider's staff;
 7. Evaluating the consistency of the application of UM criteria through inter-rater reliability testing, as specified in Appendix B, Coverage and Services; and
 8. Communicating identified trends to OhioRISE Plan's staff, ODM, MCOs, SPBM, and providers, as appropriate.
- ii. In accordance with 42 CFR 438.330, the OhioRISE Plan must describe its mechanisms to detect both under- and over-utilization of services as part of its annual QAPI submission. The OhioRISE Plan must link the utilization analysis documented in the QAPI to population health outcomes, and incorporate the information obtained through this analysis into the OhioRISE Plan's QI strategy.

g. Community Reinvestment

- i. The OhioRISE Plan must demonstrate a commitment to improving health outcomes for its OhioRISE Plan-enrolled population in local communities in which it operates

through community reinvestment activities. The OhioRISE Plan's community reinvestment must be used to support population health strategies statewide.

1. The OhioRISE Plan must not use community reinvestment funding to pay for Medicaid covered services.
2. The OhioRISE Plan must contribute 3% of its annual profits to community reinvestment that directly benefits children, youth, and young adults with multi-system needs, and their families. The OhioRISE Plan must increase the percentage of the OhioRISE Plan's contributions by 1% each subsequent year, for a maximum of 5% of the OhioRISE Plan's annual profits.
3. ODM encourages the OhioRISE Plan to maximize the collective impact of community reinvestment funding by working collaboratively with child-serving state agencies and local community entities, including but not limited to: DODD, ODE, ODH, ODJFS, OMHAS, ODRC, DYS, OFCF, ADAMH Boards, County BDD, CDFJS, County Juvenile Courts, ESCs, FCFCs, PCSAs, School Districts, and family-and youth-run organizations.
4. The OhioRISE Plan must solicit Community Reinvestment opportunities from the Family and Youth Advisory Committee, child-serving state agencies, local community entities, and others as directed by ODM in order to ensure alignment of OhioRISE Plan's Community Reinvestment with other OhioRISE Plan population-specific initiatives.
5. The OhioRISE Plan must submit a proposed list of Community Reinvestment opportunities to ODM for review and approval to ensure consistency with ODM Quality strategy.
6. The OhioRISE Plan must submit its Community Reinvestment Plan and Evaluation to ODM as specified in Appendix P, Chart of Deliverables. The OhioRISE Plan's Community Reinvestment Plan must detail the OhioRISE Plan's anticipated community reinvestment activities and describe how those activities support the OhioRISE Plan's enrolled population.
7. After the first submission, the OhioRISE Plan must include an evaluation of the Community Reinvestment Plan in its annual Community Reinvestment Plan submission to ODM. The evaluation must describe and quantify the impact of community reinvestment funding on population health improvement. The evaluation should include evaluation data gathered from state and local community entities, members, and their families.

h. Quality Improvement

i. General Requirements

1. The OhioRISE Plan must establish and implement an ongoing, comprehensive Quality Improvement (QI) program in accordance with the requirements in 42 CFR 438.330.

2. The OhioRISE Plan's QI program must employ a deliberate, defined, and science-informed approach that is responsive to member and provider needs and incorporates systematic methods for discovering reliable approaches to improving the health outcomes and reducing health disparities for the OhioRISE Plan-enrolled population.
 3. The OhioRISE Plan's QI program must encompass all levels of the organization, clearly linking the OhioRISE Plan's QI strategy to the OhioRISE Plan's and ODM's mission and vision.
 4. The OhioRISE Plan's QI program must include the voice, experience, and participation of enrolled members and their families, including but not limited to the Member and Family Advisory Council, member complaints/appeals, surveys, and other methods.
 5. The OhioRISE Plan must provide the OhioRISE Plan's QI strategy, structure, execution, and evaluation of its QI program to ODM as part of its QAPI submission described below in this appendix.
- ii. Quality Improvement Strategy
1. As described in this appendix, the OhioRISE Plan must submit a clearly delineated, outcomes-driven QI strategy within the QAPI portion of its annual Population Health Management Strategy submission.
- iii. Quality Improvement Program Structure and Accountability
1. Organizational and Cross-Organizational Quality Improvement Efforts
 - a. The OhioRISE Plan must integrate QI efforts throughout the organization.
 - b. The OhioRISE Plan 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 OhioRISE Plan must openly communicate the results of successful and unsuccessful QI efforts, internally and externally, to foster a culture of innovation, including to child-serving state and local agencies, Member and Family Advisory Council, and others as determined by ODM.
 - d. The OhioRISE Plan 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 OhioRISE Plan must collaborate with ODM and ODM-contracted managed care entities, SPBM, and other contracted entities, on QI activities as required by ODM.

2. System of Care Quality Improvement Committee

- a. The OhioRISE Plan's QI program will include the establishment of a System of Care QI committee that provides input into the quality improvement activities related to serving and supporting OhioRISE Plan members. This committee will include a broad representation of System of Care stakeholders, including representatives from providers, members and their families, child-serving state and local entities, and others as directed by ODM.
- b. The OhioRISE Plan will maintain records of meetings, documenting representatives and attendance, as well as Committee's findings and recommendations.
- c. The OhioRISE Plan will solicit input and recommendations from the Committee on all of its System of Care QI related activities.
- d. The OhioRISE Plan is encouraged to establish other processes, in addition to the System of Care QI Committee to seek input on priorities and improvement opportunities, share findings and lessons learned from members and their families, child-serving state and local agencies, Medicaid contracted entities, and others as directed by ODM consistent with expectations for cross-system collaboration.

3. Collaboration to Support Quality Improvement

- a. The OhioRISE Plan must collaborate with the State's designated COE(s), child-serving state agencies and local agencies on QI activities as required by ODM.

4. Administrative Oversight by Senior Leadership

- a. The OhioRISE Plan must establish administrative oversight and accountability for its QI program.
- b. The OhioRISE Plan's oversight must include the assignment of an ODM-approved, senior QI leadership team responsible for the QI program (e.g., Quality Improvement Director, CMO).
- c. The OhioRISE Plan must ensure that the CMO is involved and provides oversight for all clinically-related improvement projects.

5. Quality Improvement Capacity Building

- a. General
 - i. The OhioRISE Plan must provide opportunities for staff training and hands-on application of ODM-approved, QI science-based tools, methods, and principles in daily work and strategic initiatives in order to build internal OhioRISE

Plan's 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 OhioRISE Plan must:
 1. Ensure the OhioRISE Plan's CMO, Behavioral Health Clinical Director, Population Health Director, QI Director, analytic support staff, and at least one OhioRISE Plan staff person assigned to each improvement team have completed training that covers the QI training content described below from an ODM-approved entity; and
 2. Document the OhioRISE Plan's ongoing efforts to build QI expertise and capacity in the QAPI portion of its annual Population Health Strategy submission to ODM.

c. Quality Improvement Training Content

- i. The OhioRISE Plan'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);²
 2. The Deming System of Profound Knowledge® (SoPK);
 3. Listening to and incorporating information and feedback from enrolled members and their families, providers, and other stakeholders, including child-serving state agencies and local entities;
 4. Process mapping/flow charting;
 5. SMART Aim development and the use of key driver diagrams for building testable hypotheses;³

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

³ <http://www.ihl.org/resources/Pages/Tools/Driver-Diagram.aspx>

6. Gemba walks and other methods for understanding the perspective of enrolled members and their families, providers, and other child-serving entities impacted by the improvement project, including barriers related to current OhioRISE Plan 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 "5 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, quality improvement 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 OhioRISE Plan must submit training curricula to ODM for approval prior to start of OhioRISE Plan operations under this Agreement, and prior to substantive changes to an existing training curricula.
- ii. The OhioRISE Plan must submit evidence of training completion as specified in Appendix P, Chart of Deliverables.
- iii. The CMO and 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 of the contract date. The CMO and Medical and Quality Directors are exempt from this requirement if they have evidence of course completion covering the content above within the two years prior to their effective OhioRISE Plan's start date.

e. Applying Quality Improvement Training Concepts

- i. The OhioRISE Plan must ensure that during and subsequent to quality improvement training, all OhioRISE Plan staff are actively involved as QI team members in at least one improvement project in order to continue to build the QI capacity of the OhioRISE Plan.
- ii. For purposes of this Agreement, "active involvement" means applying QI tools, methods, and concepts to a clinical or non-clinical problem, including the analysis of data to determine opportunities for improvement, root cause determinations, barrier assessment, intervention design, and testing using PDSA cycles, longitudinal measurement, and assessment of intervention impact on outcome measures using statistical process control methods.

iv. OhioRISE Plan's Clinical and Non-Clinical Improvement Projects

1. The OhioRISE Plan must design and conduct improvement projects in clinical and non-clinical topic areas that improve population health outcomes (including health equity) of enrolled members and their families.
2. The OhioRISE Plan must initiate improvement projects, as well as conduct improvement projects that ODM requires. ODM-required improvement projects may be coordinated with:
 - a. Other ODM-contracted managed care entities;
 - b. The SPBM to consult, coordinate, and train on prescriber patterns and other medication issues relevant to children for CMEs and prescribers in the OhioRISE Plan or MCO provider networks; and
 - c. Other child-serving state agencies or local agencies (e.g., reducing length of stay in inpatient behavioral health facilities for children in child welfare and juvenile justice, or improving timely access to mobile response services to support a child's tenure in a school/community setting).
3. The OhioRISE Plan's improvement projects must aim to achieve significant and sustained improvement over time in population health outcomes; quality of life; health disparities; child, youth, young adult, and family satisfaction; and provider satisfaction (e.g., increase utilization/penetration for evidence-based services, increased engagement in care, or increased tenure in the home/community and school).
4. In conducting improvement projects, the OhioRISE Plan 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 monthly meeting template; Key Driver Diagram [KDD] template; PDSA template) to document the OhioRISE Plan's manual, rapid-cycle, iterative work, as well as the lessons learned from this process;
 - e. Use data to identify improvement opportunities and longitudinally monitor project progress. This includes using data analysis methods such as statistical process control to differentiate common and special cause variation in order to identify improvement, sustained successes, and additional opportunities for improvement;
 - f. Analyze data to identify disparities in services or care, and tailor interventions to specific child, youth, and young adult populations when needed in order to reduce disparities; and
 - g. Actively incorporate children, youth, and family, provider, child-serving state and local agency perspectives into improvement activities.
- 5. The OhioRISE Plan must use ongoing analysis, data feedback, and the associated learning to determine improvement subjects and interventions.
 - 6. As required by ODM, the OhioRISE Plan must share knowledge gained from successful and unsuccessful intervention testing of improvement projects, as well as project outcomes, with ODM, other managed care contracted entities, child-serving state and local agencies, Member and Family Advisory Council, and other relevant stakeholders as directed by ODM to improve population health planning statewide.
- v. Performance Improvement Projects
- 1. Performance improvement projects (PIPs) are a subset of all OhioRISE Plan's improvement projects that must comply with 42 CFR 438.330. Each year, ODM designates at least one improvement project to serve as the OhioRISE Plan's PIPs. Based on the review of the OhioRISE Plan's quality improvement efforts, ODM may require other PIPs in subsequent years of the contract. As with all other improvement projects, ODM requires that PIPs are conducted using rapid cycle quality improvement science techniques.
 - a. The OhioRISE Plan must initiate and complete PIPs in topics selected by ODM.

- b. The OhioRISE Plan must work with ODM and ODM's External Quality Review Organization (EQRO), and others as directed by ODM (e.g., managed care entities, child-serving state and local agencies), to develop and implement the PIP designated by ODM.
 - c. As part of this process, the OhioRISE Plan must participate in PIP planning, including assisting in the recruitment of participating members, entities, or providers, determining initial key drivers and interventions.
 - d. The OhioRISE Plan must ensure that all PIPs designed or implemented demonstrate improvement and the OhioRISE Plan must clearly articulate lessons learned during the course of the initiative.
 - e. The OhioRISE Plan 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.
 - f. Upon request, the OhioRISE Plan 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.
 - g. The OhioRISE Plan must fully cooperate with ODM's EQRO in its PIP validation activities, performed in accordance with 42 CFR 438.338.
- vi. Quality Improvement Communication Strategy
- 1. The OhioRISE Plan must develop and use a clearly defined communication strategy for QI activities. The OhioRISE Plan's communication strategy must include:
 - a. Mechanisms for data receipt and exchange, analyzing and interpreting data, and transparently and proactively involving the input from the enrolled members and their families, child-serving state and local agencies, Member and Family Advisory Council, System of Care Quality Improvement Committee, and other stakeholders and partners identified by the OhioRISE Plan or as directed by ODM, in applying data to inform improvement efforts;
 - b. A description of the internal mechanisms used to frequently, transparently, and proactively communicate improvement status updates across the organization, to executive leadership, to ODM, and to others as directed by 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, state and local child-serving agencies, behavioral health stakeholders, and others as directed by ODM 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.

i. Child and Family-Centered Care Plan Review

i. Purpose of the Care Plan Review Process

- 1. The OhioRISE Plan shall ensure that child and family-centered care plans for members in all Tiers, are completed, submitted for review, and approved by the OhioRISE Plan according to standards approved by ODM. The QI/UM program is responsible for reviewing and monitoring:
 - a. The timeliness of care plan completion;
 - b. Comprehensiveness of the child and family-centered care plans to ensure that all necessary CME and other provider services and supports are incorporated into the child and family-centered plan of care at the needed intensity of service; and
 - c. Ensure the plans adhere and support a child and family-centered care planning process consistent with System of Care Principles, and High Fidelity Wraparound practice when that method is used.

ii. Care Plan Review Staffing and Qualifications

- 1. The care plan review process must be independent from the staff and organizational structure responsible for developing care plans.
- 2. The care plan review process must be closely coordinated with utilization management and the service authorization process to avoid duplication of review effort, ensure single voice in feedback to providers on care planning needs, and to ensure timeliness.
- 3. Staff conducting care plan reviews, if other than UM staff, shall have credentials, training and experience consistent with requirements for UM staff as defined in this agreement.

iii. Notice of Concurrence

- 1. When the care plan is found to meet requirements, the QI/UM program shall provide notice of concurrence to the OhioRISE Plan or CME care coordinator through an ODM agreed upon method.

iv. Care Plan Feedback

1. If the QI/UM program cannot determine that a care plan meets requirements, feedback must be provided to the OhioRISE Plan or CME care coordinator through an ODM agreed upon method. The feedback must occur within the timeframe specified by ODM and must specify:
 - a. The specific standard or requirement in question;
 - b. The additional information requested;
 - c. Additional information requested shall be limited to the minimum, essential information directly related to the question.
 - i. The OhioRISE Plan shall collaboratively develop with the CMEs an Additional Information Request Questions set that details the typical questions and additional documentation that can be requested during the Care Plan Feedback process.
 - d. The offer of verbal feedback and discussion between the OhioRISE Plan and the CME or OhioRISE Plan's Care Coordinator.

v. Care Plan Structure and Requirements

1. The structure of the child and family-centered care plans and the minimum requirements and standards associated with them shall be established by ODM. The OhioRISE Plan shall adhere to the structure, minimum requirements, and standards as approved by ODM when evaluating care plans. Any proposed additional standards, criteria, or changes must be approved in writing by ODM prior to implementation.

vi. Care Plan Submission Timeliness

1. The OhioRISE Plan shall have processes to track and report timeliness of care plan submission for review by the OhioRISE Plan and have processes to notify and prompt the CME or OhioRISE Plan's care coordinator when care plan submissions are due and past due.
2. The OhioRISE Plan shall have policies and procedures to ensure that needed services and supports are not delayed as a result of the care plan review process.

vii. Care Plan Review Timeliness

1. The OhioRISE Plan shall complete their initial review and provide notice of concurrence or feedback for improvement to the submitting care coordinator in the timeframe approved by ODM. The OhioRISE Plan must be able to track and report care plan review status, including timing and outcomes of all steps in the feedback cycle, through determination of concurrence.

viii. Care Plan Review Conflict Resolution

1. The OhioRISE Plan shall collaboratively work with the CMEs to develop a phased conflict resolution process that shall be followed when the OhioRISE Plan and the CME cannot reach concurrence on the adequacy and appropriateness of the care plan. This conflict resolution process shall be subject to ODM review and concurrence.
2. The Care Plan Review Conflict Resolution process applicability is limited to care plan review. It does not replace or impact the formal authorization of services or related denial and appeal rights, responsibilities, or procedures.

5. Cross System Collaboration

- a. The OhioRISE Plan must facilitate cross-system collaboration and coordination with other child-serving state and local agencies that impact the health of the enrolled population of children, youth, and their families. This includes developing knowledge of, aligning policy, and working toward shared outcomes with other state and local child-serving agencies on the policy areas they direct. All collaboration and coordination are subject to state and federal privacy requirements. Such agencies include but are not limited to:
 - i. Child-serving state agencies and local entities, including but not limited to: DODD, ODE, ODH, OMHAS, ODRC, DYS, OFCF; ADAMH Boards, County BDD, CDFJS, County Juvenile Courts, ESCs, FCFCs, PCSAs, and School Districts;
 - ii. ODJFS efforts with implementing the Family First Prevention Services Act (FFPSA);
 - iii. ODM-contracted entities, including but not limited to the MCOs, CCEs, ODM-funded entities associated with alternative payment approaches, and the SPBM;
 - iv. COE(s);
 - v. CMEs, CCEs, including ODM-funded entities associated with alternative payment models (Comprehensive Primary Care) and conflict-free case management agencies (PASSPORT Administrative Agencies, County Boards of Developmental Disabilities, Ohio Home Care Case Management Agencies); and
 - vi. Others as directed by ODM or identified by the OhioRISE Plan.
- b. Cross-system collaboration and coordination includes:
 - i. Developing a communication strategy with state and local child-serving agencies that includes:
 1. Disseminating relevant information on a regular basis regarding the policies and programs offered through the OhioRISE Plan;
 2. Attending meetings at the request of the child-serving agencies. Meetings may include but are not limited to technical assistance sessions, performance and compliance, provider network decisions, and policy and program development;

3. Responding to questions and concerns on a timely basis from state and local child-serving systems; and
 4. Incorporating feedback from the state and local child-serving systems into policy and program decisions (e.g., provider network development, quality improvement strategies).
- ii. Identification of service gaps and assistance in closing gaps in care (e.g., timely access to services, facilitating referrals and linkages to care, coordinating transitions and services across child-serving systems) in order to optimize health outcomes;
 - iii. Data sharing, subject to state and federal privacy requirements;
 - iv. Coordination between involved entities, including but not limited to care coordinators and primary care providers, child-serving systems, schools, and community organizations;
 - v. Ensuring seamless care transitions and follow-up as outlined in Appendix D, Care Coordination, including coordinating services and transitions across child-serving systems and community providers;
 - vi. Early identification of care needs (e.g., behavioral health screening and assessment, identification of SDOH needs, connection to natural supports, and community-based services);
 - vii. Promotion of services that facilitate care delivery (e.g., telehealth, home-based services, community-based services; engagement of families in a member's treatment);
 - viii. Integrating behavioral and physical health;
 - ix. Addressing SDOH, such as trauma and adverse experiences, food scarcity and insecurity, housing instability and unsafe conditions, school engagement and tenure, family and community violence, and transportation needs; and
 - x. Provider and workforce development activities, including coordination with the COE(s) and others as directed by ODM.

6. Evaluation

a. Support of MCOs' Population Health Management Strategy Evaluation

- i. The OhioRISE Plan must actively participate in each MCO's Population Health Management Strategy Evaluation. This must include but not be limited to monitoring data from multiple areas of the system (e.g., claims, assessments, member grievances and appeals, care coordination) in order to identify patterns (e.g., service utilization patterns), anticipate problem areas (e.g., unmet SDOH needs), and adapt as needed.
- ii. The OhioRISE Plan must utilize its monitoring of process and outcome measures to inform its own and the MCOs' risk stratification algorithms, as well as to inform

input and recommendations to the MCOs regarding their ongoing design or adaptation of strategies and initiatives to better serve the needs of the population.

- iii. The specific role and activities of the OhioRISE Plan in each MCO's Population Health Management Strategy Evaluation must be described in the MCO/OhioRISE Plan's Model Agreement (described in Appendix A, General Requirements) executed between the OhioRISE Plan and each MCO.

b. Quality Assessment and Performance Improvement Program and Evaluation

- i. The OhioRISE Plan's Quality Assessment and Performance Improvement (QAPI) Program, required by 42 CFR 438.330, is a subcomponent of the Population Health Management Strategy listed above in this appendix. The OhioRISE Plan's QAPI submission must include:
 - 1. A description of ODM- and OhioRISE Plan-initiated improvement projects, including the two annual Performance Improvement Projects;
 - 2. A summary of the OhioRISE Plan's assessment of the effectiveness of improvement projects based on statistical process control charts annotated with payer and clinical based interventions;
 - 3. A description of how the OhioRISE Plan meets the requirements for the development and dissemination of clinical practice guidelines described in this appendix;
 - 4. A description of mechanisms the OhioRISE Plan uses to detect both underutilization and overutilization;
 - 5. A description of mechanisms the OhioRISE Plan uses to assess the quality and appropriateness of care furnished to members;
 - 6. A description of the OhioRISE Plan's efforts to prevent, detect, and remediate critical incidents that are based, at a minimum, on state requirements for home and community-based waiver programs.
- ii. In addition to these federal requirements, the OhioRISE Plan must provide information regarding its QI strategy and the OhioRISE Plan's evaluation of the effectiveness of its QI strategy within its annual QAPI submission.
 - 1. The OhioRISE Plan's QI strategy must include and describe, at a minimum, the following:
 - a. The OhioRISE Plan's leadership team, including leadership positions and how each role supports and champions the OhioRISE Plan's QI strategy and related initiatives and projects;
 - b. The OhioRISE Plan's senior QI leadership team structure, reported in the Accountability Component of the ODM-QAPI template, that reflects:

- i. Senior QI leadership team roles and responsibilities for QI activities; and
 - ii. Senior QI leadership team QI training and experience related to both quality and knowledge of the needs of children and youth with complex behavioral health needs, and child-serving systems.
- c. The role and impact of the Member and Family Advisory Council;
- d. The role and impact of the System of Care Quality Improvement Committee;
- e. The OhioRISE Plan's mechanisms for frequently and transparently sharing information and data throughout the organization to inform improvement activities (e.g., dashboards, newsletters, staff meetings);
- f. Methods for identifying and ensuring the assignment of needed quality improvement resources, including the assurance of dedicated analytical and project management support and oversight;
- g. Methods for building and sustaining QI culture and capacity throughout the organization;
- h. How the OhioRISE Plan's QI strategy aligns with ODM's quality strategy, including how the OhioRISE Plan will collaborate with other ODM-contracted MCOs, state and local child-serving systems, and others as directed by ODM, on ODM-directed population health efforts;
- i. The OhioRISE Plan's improvement projects, including:
 - i. How the improvement project relates to the OhioRISE Plan's other population health initiatives, as well as to MCO and ODM quality improvement strategies; and
 - ii. The theory of change for each improvement initiative (e.g., cause and effect diagrams, key driver diagrams).
- j. Criteria considered when choosing and prioritizing the OhioRISE Plan's improvement projects such as input and recommendations from the Member and Family Advisory Council and the System of Care Quality Improvement Committee, data from multiple areas (e.g., claims, grievance/appeals, assessments, care coordination, service utilization patterns, penetration rates), and other input from child-serving state and local agencies, Medicaid contracted entities; and

- k. The OhioRISE Plan's evaluation strategy, including:
 - i. Process, outcome, and balancing measures for each initiative, including:
 - ii. Baseline, milestones, and target goals;
 - iii. Timeframes for baseline, milestones, and target goals;
 - iv. Data sources;
 - v. Numerator and denominators for each measure; and
 - vi. Frequency of measurement (e.g., daily, weekly, monthly).
- 2. The OhioRISE Plan's evaluation of its QAPI program must demonstrate how it meets all requirements above, as well as how the OhioRISE Plan evaluated the impact and effectiveness of each improvement activity within the QAPI program;
 - a. The OhioRISE Plan's evaluation must, at a minimum, include:
 - i. The outcomes and trended results of each improvement project, including documentation of successful and unsuccessful interventions;
 - ii. The results of any efforts to support improved health outcomes and reduced health inequities for members;
 - iii. How the OhioRISE Plan will incorporate the results into those efforts; and
 - iv. How the OhioRISE Plan plans to update its QI Strategy based on the findings of the self-evaluation.
- c. Monthly Quality Improvement Meeting Requirements
 - i. The OhioRISE Plan must document project learning using the ODM monthly QI meeting template and submit the template (*Documentation of Project Learning*) at least two business days prior to each monthly meeting, as specified in Appendix P, Chart of Deliverables.
 - 1. During the planning phase of an improvement project, the OhioRISE Plan must support ODM in their efforts to coordinate and lead the monthly QI meetings. The OhioRISE Plan should provide a monthly QI template that includes as appropriate to the topic the following:
 - a. Detailed and high-level process maps of the OhioRISE Plan's processes related to the outcome of interest;

- b. Results of obtaining member/family, provider, and relevant child-serving systems perspectives on the OhioRISE Plan'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 OhioRISE Plan must ensure its monthly QI template and accompanying meeting reflects the results of the OhioRISE Plan'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 OhioRISE Plan must begin actively testing in new circumstances for purposes of effectively spreading the improvement.
- d. 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 OhioRISE Plan.
 - ii. The OhioRISE Plan 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 OhioRISE Plan 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 OhioRISE Plan, if it is accredited by a national organization approved by the Centers for Medicare and Medicaid Services may request to be exempted (deemed) from certain portions of the administrative compliance review. ODM will inform the OhioRISE Plan if the OhioRISE Plan may request a non-duplication exemption.
 - b. The EQRO may conduct focused reviews of OhioRISE Plan's performance as directed by ODM in the following domains that include but are not limited to the following:
 - i. Availability of services;
 - ii. Assurances of adequate capacity and services;
 - iii. Coordination and continuity of care;
 - iv. Coverage and authorization of services;

- v. Provider selection;
 - vi. Confidentiality;
 - vii. Grievance and appeal systems;
 - viii. Sub contractual relationships and delegation;
 - ix. Practice guidelines; and
 - x. Health information systems.
- 2. Encounter data studies;
 - 3. Validation of performance measurement data;
 - 4. Review of information systems;
 - 5. Validation of performance improvement projects; and
 - 6. Provider surveys and member and family satisfaction and quality of life surveys.

APPENDIX D – CARE COORDINATION

1. OhioRISE Program Care Coordination

a. General Requirements

- i. The OhioRISE Plan must develop and implement a high performing care coordination program that meets the care coordination requirements in this appendix, and reflects guiding principles to optimize the health of the individual members and populations it serves.
- ii. The OhioRISE Plan's care coordination program must serve as the foundation to ensure that all members have access to quality care coordination for services identified in the members' child and family-centered care plan developed by the Child and Family Team (CFT), the OhioRISE Plan-contracted care management entity (CME), the OhioRISE Plan, or a combination thereof.
- iii. The OhioRISE Plan may delegate any requirement specified in this appendix to a CME in accordance with the requirements in the subcontractual relationships and delegation section in Appendix A, General Requirements.
- iv. The OhioRISE Plan must use a tiered care coordination model as described below, varying the intensity of care coordination in a manner that aligns with the needs of enrolled children, youth, and their families.
- v. The OhioRISE Plan's care coordination program must include processes and protocols for ensuring that its efforts support, but do not supplant, MCOs' care coordination and the care coordination entities (CCEs) for their shared members.
- vi. The OhioRISE Plan's care coordination program must include processes and protocols for ensuring that its efforts support, but do not duplicate, care coordination activities performed for members by state and local agencies and their designees.
- vii. The OhioRISE Plan'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 OhioRISE Program's approach to care coordination is built on a Systems of Care approach and is based on the guiding principles of a Wraparound Philosophy. These principles include:
 1. Family and child or youth perspectives are intentionally elicited and prioritized during all phases of the care coordination process.
 2. Planning is done by CFTs consisting of individuals agreed upon by the family and committed to the family through informal, formal, and community support and service relationships.

3. Planning is grounded in family members' perspectives, and the CFT strives to provide options and choices such that the plan reflects family values and preferences.
4. The process actively seeks out and encourages the full participation of CFT members drawn from family members' networks of interpersonal and community relationships.
5. Care coordinators work cooperatively with the CFT and share responsibility for developing, implementing, monitoring, and evaluating a single child and family-centered care plan.
6. The CFT implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible and that safely promote child or youth and family integration into home and community life.
7. The care coordination process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child or youth, their family, and their community.
8. The care coordination efforts develop and implement an individualized and customized set of strategies, supports, and services.
9. The care coordination process and the plan identify, build on, and enhance the strengths, capabilities, knowledge, skills, and assets of the child or youth and their family, their community, and other team members.
10. The care coordinator continues working towards meeting the needs of the child or youth and family and towards achieving the goals in the child and family-centered care plan until the CFT reaches agreement that a formal Wraparound process is no longer necessary.
11. The OhioRISE Plan 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. Care Coordination Tiers

- i. The OhioRISE Plan must use a tiered care coordination model, varying the intensity of care coordination in a purposeful way that aligns with the strengths and needs of the members enrolled in the OhioRISE Plan.
- ii. The OhioRISE Plan's care coordination approach must include three tiers:
 1. Tier 3 – Intensive Care Coordination using a High Fidelity Wraparound approach for members that have high behavioral health needs;
 2. Tier 2 – Moderate Care Coordination using a Wraparound informed model for members with more moderate behavioral health needs; and

3. Tier 1 – Limited Care Coordination for members who may refuse care coordination or may need lower intensity care coordination than in the Wraparound models.
 - iii. The care coordination continuum must be managed by the OhioRISE Plan and must include provider organizations referred to as care management entities (CMEs). The CMEs will be responsible for providing and/or coordinating the provision of intensive and moderate care coordination, community-based services, and other services and supports to improve health outcomes. Tier 2 and Tier 3 care coordination may only be provided by CMEs.
 - iv. OhioRISE Plan-employed care coordinators will provide Tier 1 Limited Care Coordination, the lowest intensity of the three tiers of care coordination.
- d. OhioRISE Program Care Coordination Description
- i. The OhioRISE Plan must submit a written Care Coordination Program Description as specified in Appendix P, Chart of Deliverables, which includes the care coordination approach in this appendix, for ODM approval prior to implementation. Following initial approval, the OhioRISE Plan must submit all changes to its care coordination program to ODM for approval prior to implementing the change.
 - ii. The OhioRISE Plan's care coordination program submission must describe the following components, described in more detail within this appendix:
 1. The process that the OhioRISE Plan will use to select and contract with local CMEs to provide Tier 3 – Intensive Care Coordination using High Fidelity Wraparound as established by the National Wraparound Initiative, and Tier 2 – Moderate Care Coordination using a Wraparound-informed model, including but not limited to provider minimum qualifications, geographic distribution, leadership, clinical supervision, caseload assignment methodology, and a process for addressing member or family complaints;
 2. Processes and protocols that the OhioRISE Plan will develop to ensure that all CMEs provide care coordination consistent with the principles and requirements in this appendix and requirements established by ODM, including coordination with MCOs, other child-serving systems case managers, and providers;
 3. The respective roles and responsibilities of the OhioRISE Plan and State's designated COE(s) for developing CMEs and providing training for Tier 3 – Intensive Care Coordination using High Fidelity Wraparound and Tier 2 – Moderate Care Coordination using a Wraparound-informed model;
 4. Transition of care processes for members who enrolled in the OhioRISE Plan prior to completing the CANS assessment, including activities performed by OhioRISE employed care coordinators, linkages to CMEs and timelines for each task to support appropriate care coordination engagement and activities for these transitioning members;

5. The process to be used to transition a member from one CME to another;
6. The process to be used to transition a member from one tier of care coordination provided by the OhioRISE Plan or CME to another;
7. The process for coordinating with other child-serving systems case managers and providers, including County Boards of Developmental Disability (BDD), Regional Department of Youth Services (DYS), Public Child Serving Agencies, Family and Children First Councils and providers certified by the Ohio Department of Mental Health and Addiction Services (OMHAS);
8. The OhioRISE Plan's roles and responsibilities for performing care coordination activities for Tier 1 – Limited Care Coordination. This includes:
 - a. Establishing a care coordination structure and staffing, including but not limited to:
 - i. Care coordinator activities and responsibilities as the single point of contact for care coordination;
 - ii. Care coordinator assignment with appropriate clinical expertise to coordinate care needs;
 - iii. Conducting assessments;
 - iv. Developing and updating the child and family-centered care plan;
 - v. Requirements for contacting members and their families;
 - vi. Monitoring the child and family-centered care plan;
 - vii. Coordinating across the care team; and
 - viii. Incident reporting.
 - b. Processes and protocols for ensuring the OhioRISE Plan care coordination efforts are consistent with the principles in this appendix;
 - c. The OhioRISE Plan's proposed care coordination caseloads and staffing (including care coordinators supervisors), as well as the number of staff by role, qualifications, and physical location; and
 - d. The training topics and frequency of training provided to OhioRISE Plan care coordination staff.
9. The methodology of assignment of members to the OhioRISE Plan's care coordination tiers;
10. The OhioRISE Plan's roles and responsibilities to support CMEs;

11. The OhioRISE Plan's data and information systems and how they will be used to support and exchange data with the CME (including an assessment of the CMEs Electronic Health Records capacities) and OhioRISE Plan's responsibilities for care coordination regardless of which entities are providing care coordination;
12. Methods used by the OhioRISE Plan to monitor the care coordination program for individual and systemic improvements;
13. The OhioRISE Plan's roles and responsibilities to support an integrated care approach with the MCOs' care coordination efforts (for OhioRISE Plan-enrolled members) and the MCOs' CCEs in providing care coordination to the OhioRISE Plan's members;
14. The OhioRISE Plan's strategy for communicating with the member's MCO and CCE (when appropriate) assignment of CME and CME care coordinator; and
15. Methods used by the OhioRISE Plan to provide oversight of the care coordination provided by the OhioRISE Plan's care coordinators and CMEs to ensure the needs of the OhioRISE Plan's membership are met.

2. Care Coordination Requirements

a. OhioRISE Plan Care Coordination Staffing and Training

- i. The OhioRISE Plan's care coordination staffing must include a range of behavioral health disciplines with complementary skills and knowledge to deliver a comprehensive, integrated care coordination program fully capable of addressing members' behavioral and psychosocial needs.
- ii. The OhioRISE Plan must ensure staff who are performing care coordination functions are operating within their professional scope of practice, are appropriate for the member's behavioral health care needs, and comply with the state's licensure and credentialing requirements.
- iii. The OhioRISE Plan must provide onboarding and ongoing training for OhioRISE Plan's care coordination staff that includes: health equity (cultural humility), racial equity, social determinants of health (SDOH) and health disparities, Child and Adolescents Needs and Strengths (CANS) process, child and family-centered care planning, needs for multi-system children and youth, early childhood development, member engagement, shared decision-making, trauma-informed care (including secondary trauma to caregivers and family members), motivational interviewing, grievance and appeal processes and procedures, community resources within the OhioRISE Plan's service areas, incident reporting requirements, and Health Insurance Portability and Accountability Act (HIPAA) requirements.

b. Assigning Care Coordination Tiers

- i. The OhioRISE Plan must develop and implement a framework and process for assigning members to care coordination tiers provided by the CMEs or the OhioRISE Plan's care coordination staff.
- ii. The OhioRISE Plan must assign a care coordination Tier 1 – 3 to each member (i.e., from lowest to highest: low need [Tier 1], moderate need [Tier 2], and high need [Tier 3]).
- iii. The OhioRISE Plan's tiering framework must include the criteria and thresholds to determine member assignments for each tier.
- iv. The OhioRISE Plan's tiering criteria and thresholds must identify the factors the OhioRISE Plan considers when determining a member's level of care coordination. At a minimum, the tiering criteria and thresholds must include the following current and historical factors:
 1. Acuity of substance use and mental health disorders as identified through the CANS;
 2. Encounter information on previous utilization of behavioral health services, including inpatient, emergency department (ED), or Mobile Response and Stabilization Services (MRSS) utilization;
 3. Information on SDOH and safety risk factors; and
 4. Information from the member's Health Risk Assessment, the MCO person-centered plan of care or other MCO data sources and information.
- v. The OhioRISE Plan must assign an initial care coordination tier and make a referral to a CME (Tier 2 or Tier 3) or OhioRISE Plan's care coordination department within two business days of OhioRISE Plan enrollment notification from ODM, except for crisis referrals.
 1. For crisis referrals, the initial care coordination tier must be assigned and referred to a CME or the OhioRISE Plan's care coordination department within 24 hours of enrollment notification from ODM.
- vi. Members and caregivers will be notified of the care coordination tier assignment using the following methods:
 1. Notification From Care Coordinator
 - a. The assigned care coordinator must communicate the care coordination tier to the member and caregiver as a part of the initial outreach contact. The initial care coordination contact must occur within two business days of the referral (except for crisis referrals).

- b. For crisis referrals, the assigned care coordinator must outreach to the member and caregiver as soon as possible, but not later than one business day following the referral.

2. Written Notification

- a. The OhioRISE Plan must mail a letter to the member and caregiver with the tier assignment level, a description of the outreach from the assigned care coordinator, and contact information if the outreach does not occur or if the member or caregiver has any questions. The content of the letter must be reviewed and approved by ODM.
- vii. The OhioRISE Plan must review and update the member's care coordination tier following the completion of an updated CANS or other information available to the OhioRISE Plan that informs appropriate assignment of care coordination tiers.
- viii. The OhioRISE Plan must evaluate a member's care coordination tier whenever there is a request from the CME or a significant change in the member's needs or circumstances. If the OhioRISE Plan changes the member's care coordination tier as a result of this evaluation, the OhioRISE Plan must document the tier change as well as the circumstances that led to this change, and must inform the member.
 1. Notification will be provided verbally by the assigned care coordinator from the CME or the OhioRISE Plan, and in writing in a letter from the OhioRISE Plan.
- ix. The OhioRISE Plan must communicate care coordination tiering information to ODM, CMEs, the member's MCO, and the single pharmacy benefits manager (SPBM) as specified by ODM.

- c. Care Coordination Assignment

- i. General

1. The OhioRISE Plan must ensure that members receive necessary and timely care coordination, whether the care coordination is performed by the OhioRISE Plan or its contracted CMEs (for OhioRISE Plan-enrolled members).
2. The OhioRISE Plan must ensure that, to the extent possible, care coordination is provided by CMEs within the member's community. The OhioRISE Plan must only provide care coordination for members who may refuse Tier 2 or Tier 3 care coordination or when the OhioRISE Plan determines the member may not need the intensity of care coordination offered by the CMEs.
3. The OhioRISE Plan must ensure that members and their families have a choice of assigned care coordinator, whether provided directly by the OhioRISE Plan (Tier 1) or by the CME (Tiers 2 and 3).

4. The OhioRISE Plan must ensure that care coordination staff (CME and OhioRISE Plan's staff) are not related by blood or marriage to the member or any paid caregiver, financially responsible for the member, or empowered to make financial or health related decisions on behalf of a member.
 5. The OhioRISE Plan must provide the member and their family or caregiver with up-to-date contact information for the care coordination staff (CME and OhioRISE Plan) assigned to the member.
 6. The OhioRISE Plan must provide the MCO and SPBM with up-to-date contact information for the care coordination staff (CME and OhioRISE Plan) assigned to the member within five business days of the assignment becoming effective or of contact information change.
- ii. Care Coordination Provided by the Members' MCO
1. If a member is enrolled in the OhioRISE Plan and has an assigned MCO care coordinator or CCE, the OhioRISE Plan must preserve and support the care coordination relationship between the MCO/CCE and the member.
 2. For those members enrolled in the OhioRISE Plan but not assigned to a care coordinator in the MCO or a CCE and for whom the OhioRISE Plan or CME identifies the need for care coordination from the MCO or CCE, the OhioRISE Plan must recommend evaluation for MCO or CCE care coordination according to requirements specified by ODM.
- iii. Care Coordination Caseloads
1. Caseload for care coordination provided by the CME and OhioRISE Plan will vary based on intensity:
 - a. Tier 3 – Intensive Care Coordination must require care coordinator to child and family ratio consistent with a High Fidelity Wraparound Approach;
 - b. Tier 2 – Moderate Care Coordination must require a care coordinator to child and family ratio as directed by ODM; and
 - c. Tier 1 – Limited Care Coordination provided by the OhioRISE Plan must have caseload standards consistent with the staffing ratios proposed in the program description required in this appendix.
 2. Maximum caseloads specified for Tier 3 – Intensive Care Coordination in this appendix or in the care coordination program description approved by ODM must not be exceeded.
 3. Maximum caseloads specified for Tier 2 – Moderate Care Coordination in this appendix or in the care coordination program description approved by ODM must not be exceeded without prior approval from ODM.

4. Maximum caseload sizes apply to care coordination provided by the OhioRISE Plan or the CMEs.

iv. Care Coordination Status

1. The OhioRISE Plan must assign and report a care coordination status for each member who is assigned to a CME or an OhioRISE Plan care coordinator. Care coordination status consists of the following indicators:

a. Status:

- i. Assigned, not yet active;
- ii. Active (care coordinator has made contact with member or family and the member or family consents to care coordination);
- iii. Declined; or
- iv. Withdrew.

b. Tier:

- i. Tier 1 – Limited Care Coordination;
- ii. Tier 2 – Moderate Care Coordination using a Wraparound informed model; or
- iii. Tier 3 – Intensive Care Coordination using a High Fidelity Wraparound.

c. CME (for those in Tier 2 or Tier 3);

d. Name of assigned care coordinator (CME and OhioRISE Plan).

2. The OhioRISE Plan must report care coordination status as specified in Appendix P, Chart of Deliverables, in a file submission as required in *ODM's Medicaid Managed Care: Care Management Status Submission Specifications*.

d. Care Coordination Activities

i. OhioRISE Plan Care Coordination Activities in support of Care Management Entity-Led Care Coordination

1. For members who are assigned to a care management entity (CME) care coordinator, the OhioRISE Plan must support care coordination performed by the CME.

2. The OhioRISE Plan's care coordination department is responsible for assisting the CME in a timely manner with the following care coordination activities upon CME request:
 - a. Supporting member outreach efforts;
 - b. Identifying, referring, and linking members to behavioral health network providers and social supports as needed (e.g., scheduling appointments, arranging transportation);
 - c. Assisting in the coordination of member access to OhioRISE Plan-covered services as needed (e.g., scheduling appointments, arranging transportation through the MCO, and making referrals);
 - d. Participating in the CME-led CFT to support the development and ongoing updates to the child and family-centered care plan;
 - e. Facilitating a timely CANS assessment, performed by an independent organization or practitioner external to the OhioRISE Plan, when needed based on a change in member's condition and for periodic re-enrollment in the OhioRISE Plan as specified by ODM;
 - f. Assisting in the coordination of member access to MCO-covered services as needed by linking to MCO or CCE care coordination resources (e.g., linking the member to MCO health education, disease management, and health and wellness programs);
 - g. Educating the member about available resources and services (e.g., OhioRISE Plan value-added benefits) and assisting the member in accessing those resources and services;
 - h. Arranging for OhioRISE Plan's staff to provide behavioral health clinical consultation upon MCO or CCE's request;
 - i. Assisting with bi-directional communication among the CME and other local child serving agencies providing care coordination, including County BDD, Regional DYS, Public Child Serving Agencies, and Family and Children First Councils and providers certified by the OMHAS;
 - j. Assisting with bi-directional communication among the MCO/CME, SPBM, and other providers as needed in order to facilitate timely exchange of information;
 - k. Communicating and exchanging information across relevant child-serving systems (e.g., child welfare case worker, school) consistent with appropriate releases of information signed by the member/guardian;

- l. Sharing care coordination data and information with ODM, the members' MCO/CCE, and the SPBM as applicable to prevent gaps in care and duplication of efforts;
 - m. Identifying gaps in care and taking action as necessary to close gaps in care;
 - n. Participating in discharge planning activities with the behavioral health inpatient or residential facility to support a safe discharge placement and to prevent unplanned or unnecessary readmissions, ED visits, and adverse outcomes;
 - o. Ensuring member access to post discharge services covered by the OhioRISE Plan as specified in the discharge and transition plan;
 - p. Facilitating clinical hand offs between the discharging facility and other OhioRISE Plan network providers involved in the care and treatment of the member;
 - q. Actively securing the necessary authorizations for the services in the child and family-centered care plan that are the responsibility of the OhioRISE Plan;
 - r. Coordinating with the MCO, CCE, SPBM, and providers to ensure the member's who are the responsibility of the MCO, CCE or SPBM have timely access to the services identified in the child and family-centered care plan; and
 - s. Monitoring to ensure that services correspond to the needs and goals as identified and recommended in the child and family-centered care plan.
 - ii. OhioRISE Plan Activities for OhioRISE Plan-Led Care Coordination
 - 1. For members who are assigned to a OhioRISE Plan care coordinator, the care coordinator is responsible for performing the following care coordination activities for members:
 - a. Reaching out to members to engage in care coordination within the timeframes established by ODM;
 - b. Identifying, referring, and linking members to behavioral health network providers and social supports as needed (e.g., scheduling appointments, arranging transportation);
 - c. Assisting in the coordination of member access to OhioRISE Plan's covered services as needed (e.g., scheduling appointments, arranging transportation through the MCO, and making referrals);
 - d. Leading the development and ongoing updates to the child and family-centered care plan;

- e. Facilitating a timely CANS assessment through an independent evaluator external to the OhioRISE Plan when needed, based on a change in member's condition and for periodic re-enrollment in the OhioRISE Plan as specified by ODM;
- f. Assisting in the coordination of member access to MCO covered services as needed by linking to MCO or CCE care coordination resources (e.g., linking the member to MCO health education, disease management, and health and wellness programs);
- g. Educating the member about available resources and services (e.g., OhioRISE Plan value-added benefits) and assisting the member in accessing those resources and services;
- h. Arranging for OhioRISE Plan staff to provide behavioral health clinical consultation upon MCO or CCE request;
- i. Communicating and exchanging information with providers (e.g., primary care provider [PCP], CCEs), ODM, MCOs, and the SPBM to coordinate the care of the member;
- j. Communicating and exchanging information across relevant child-serving systems (e.g., child welfare case worker, school) consistent with appropriate releases of information signed by the member/guardian;
- k. Sharing care coordination data and information with ODM, the members' MCO/CCE, and the SPBM as applicable to prevent gaps in care and duplication of efforts;
- l. Identifying gaps in care and taking action as necessary to close them;
- m. Participating in discharge planning activities with the behavioral health inpatient or residential facility to support a safe discharge placement and to prevent unplanned or unnecessary readmissions, ED visits, and adverse outcomes;
- n. Ensuring member access to post-discharge services covered by the OhioRISE Plan as specified in the discharge and transition plan;
- o. Facilitating clinical hand offs between the discharging facility and other OhioRISE Plan's network providers involved in the care and treatment of the member;
- p. Actively securing the necessary authorizations for the services in the child and family-centered care plan that are the responsibility of the OhioRISE Plan;

- q. Coordinating with the MCO, CCE, SPBM, and providers to ensure the member's timely access to the services identified in the child and family-centered care plan; and
- r. Monitoring to ensure that services are delivered as recommended in the child and family-centered care plan.

iii. Assessments

1. The CME will be responsible for performing initial assessments as directed by the OhioRISE Plan. Initial assessments consist of a comprehensive home-based assessment that occurs in the member's home or another location of the family's choice. The assessment must include information from the CANS and other tools as determined necessary; and include the development of an initial crisis/safety plan.
2. The CME or OhioRISE Plan will conduct a CANS through an independent evaluator external to the OhioRISE Plan on an annual basis or as specified by ODM and whenever there is a significant change in the member's behavioral health needs or circumstances.
3. The OhioRISE Plan must have a process for identifying and coordinating with the member's MCO/CCE for other assessment data appropriate to the members' unique circumstances and needs (e.g., physical, behavioral, social, and safety) when there is a change in the member's health status or needs or as requested by the member, caregiver, provider, or CME.

iv. Child and Family-Centered Care Plans

1. For members receiving Tier 2 – Intensive or Tier 3 – Moderate Care Coordination, CMEs must convene and facilitate a CFT, which develops and updates a child and family-centered care plan that is consistent with ODM guidelines and includes a crisis/safety plan.
2. For members receiving care coordination from the OhioRISE Plan (Tier 1), the OhioRISE Plan care manager must develop the child and family-centered care plan.
3. For all members, the OhioRISE Plan must have a child and family-centered care planning process that includes the following:
 - a. Developing the child and family-centered care plan that is based on the most recent assessment (e.g., CANS) and includes a crisis/safety plan;
 - b. Updating the individual child and family-centered care plan as set forth in ODM requirements;
 - c. Tracking and complying with timeframes for developing the initial child and family-centered care plan and making subsequent updates to the care plan;

- d. Developing measurable goals, interventions, and outcomes with the member in collaboration with the CFT and obtaining the member's family or caregiver's agreement;
- e. Aligning child and family-centered care plan goals with the priority issues identified by the CFT so the OhioRISE Plan and CME can support the provider-member relationship;
- f. Verifying that the member received the services in the child and family-centered care plan, or if services were not received, taking necessary action to address and close gaps in care;
- g. Providing the member and the caregiver with the child and family-centered care plan; and
- h. Retaining the child and family-centered care plan for Tiers 2 and Tier 3 and sharing it with members of the CFT.

v. Contacts

- 1. The OhioRISE Plan must follow the ODM-approved member and caregiver contact requirements for members assigned to a CME or OhioRISE Plan to facilitate ongoing communication with the member.
- 2. The ODM-approved contact schedule must include the number of subsequent attempts to reach the member if the member or caregiver do not respond to the initial attempt, and the OhioRISE Plan's or CME's initial engagement effort.
- 3. For members and caregivers who do not respond to the OhioRISE Plan's or CME's ongoing care coordination efforts, the OhioRISE Plan or CME must track and report the number of attempts to reach the member or caregiver.
- 4. The OhioRISE Plan or CME care coordination staff must contact the member as identified in the child and family-centered care plan, but not less frequently than the ODM-approved minimum contact schedule.
- 5. If a member, MCO, or SPBM reaches out to the OhioRISE Plan, unless a standard is established elsewhere in this Agreement, the OhioRISE Plan must respond in a timeframe to meet the presenting need of the member, but no later than one business day.

vi. Incident Reporting

- 1. Upon notification, the OhioRISE Plan must report any incidents of abuse, neglect, exploitation, misappropriation of greater than \$500, or unexplained death, by entering the incident into the Incident Management System (IMS) for all members with the exception of members set forth in Sections 2.d.vi.b and 2.d.vi.c below of this appendix.

- a. The OhioRISE Plan is responsible for entering the incident into the IMS and must work with the CCE and CME, if member is so assigned, to support a prevention plan and/or intervention (e.g., re-evaluating risk stratification, doing a home visit, offering services and resources, creating a prevention plan).
- b. For members participating in the future OhioRISE 1915c Waiver or other home and community based services waivers, the OhioRISE Plan or CME care coordinators must submit incidents in accordance with OAC 5160-44-05.
- c. For members with intellectual disabilities and developmental disabilities and receiving care coordination through the Individual Options Waiver (OAC 5160-40), Level One Waiver (OAC 5160-41) and the Self-Empowerment Life Funding Waiver (OAC 5160-41) or Targeted Case Management through local Boards of Development Disability, the CME's and OhioRISE Plan's care coordinators must submit incidents for these individuals in accordance with OAC 5123-17-02.

3. Transitions of Care Requirements

a. General

- i. All transitions of care in this section must be documented in the appropriate OhioRISE Plan and CME care coordination records and systems as specified by ODM.

b. New OhioRISE Plan Enrollments

i. General

1. The OhioRISE Plan must follow the transition of care requirements as outlined below for new members transitioning services to the OhioRISE Plan from an MCO or fee-for-service (FFS) for behavioral health services only.

ii. Provision of Member Information

1. For new members enrolled with the OhioRISE Plan and transitioning from an MCO or FFS, the OhioRISE Plan will receive member information as specified by ODM for members disenrolling for behavioral health services only from the MCO or from FFS.
2. Upon notification from ODM that an enrolled member will be disenrolling from receiving behavioral health services only from an MCO and transitioning to the OhioRISE Plan, the MCO must provide member information to the OhioRISE Plan as specified by ODM.

iii. OhioRISE Plan Responsibilities

1. For newly enrolled members in the OhioRISE Plan, the OhioRISE Plan must utilize CANS assessment and other data provided by other sources or

collected by the OhioRISE Plan (e.g., through assessments, new member/family/caregiver outreach in advance of the member's enrollment effective date) to identify existing sources of care. The data will be used to inform the child and family-centered care plan to ensure each new member is able to continue existing behavioral health services in accordance with this appendix or access different behavioral health services based on the needs of the member and their family/caregiver.

2. Based on the information available, the OhioRISE Plan must identify and assign an appropriate Tier 3 – Intensive or Tier 2 – Moderate Care Coordinator according to OhioRISE Plan's care coordination policies and procedures approved by ODM. The assignment must be completed according to timeframes specified by ODM.
3. The OhioRISE Plan or its designee must perform outreach to the member and/or member's family/caregiver for the purpose of engagement in the OhioRISE Plan's care coordination program. The required outreach is in addition to the OhioRISE Plan's responsibilities for new member materials described in Appendix E, Marketing and Member Materials.
4. For an urgent enrollment, ODM will determine processes and enrollment notification procedures necessary to allow the OhioRISE Plan (and CME if one is assigned) to initiate care coordination planning and engagement as soon as possible to meet member needs.
 - a. For urgent enrollments to the OhioRISE Plan, the processes and enrollment notification procedures will include the MCO or FFS provider to facilitate transfer of member information and assignment to an appropriate care coordinator according to timeframes specified by ODM.
5. For members who are enrolled in the OhioRISE Plan prior to completing the CANS assessment, the OhioRISE Plan will be responsible for performing transition of care activities, until a tier assignment and linkage to on-going care coordination can be completed in accordance with Section 2.d of this appendix. Activities include but are not limited to participation in discharge planning, gathering sufficient clinical data to inform care coordination tier assignment, linkage to a CME following tier assignment for Tier 2 or 3 members, and linkage to community services upon discharge.

c. MCO Transitions

- i. When the member makes a transition from one MCO to another MCO, the OhioRISE Plan (and CME if one is assigned) must have a process to complete the following activities:
 1. Ensure the name and contact information for any assigned MCO Care Manager Plus or Care Guide Plus is available to the member and caregiver, and recorded in the appropriate OhioRISE Plan's and CME's care coordination documents and systems;

2. Reach out to any Care Manager Plus or Care Guide Plus at the new MCO within a reasonable timeframe as specified by ODM; and
3. Support the member and caregiver in contacting the new MCO and appropriate care coordination resources as needed as a part of the MCO to MCO transition.

d. Care Management Entity Transitions

- i. When more than one care management entity (CME) is available and appropriate to meet the needs of the member and their family/caregiver, the OhioRISE Plan must have a process to transition the member from one CME to a different CME.
- ii. The OhioRISE Plan must ensure that relevant Ohio Department of Job and Family Services (ODJFS), Department of Developmental Disabilities (DODD), Department of Youth Services (DYS), and other state or county entities involved in the care of the child or youth must be notified within five business days when there is a transition between CMEs or between care coordinators within a CME.
- iii. The OhioRISE Plan transition process must include:
 1. Criteria to be used for CME transitions, including member/family/caregiver choice;
 2. Timelines for completing the transition, including assignment of the new care coordinator from the new CME; and
 3. Role of OhioRISE Plan care coordination staff to support the transition, assure continuity of care, and engagement with the new CME/care coordinator.

e. Transitions of Care from OhioRISE Plan to MCO Behavioral Health

i. General

1. The OhioRISE Plan must follow the transition of care requirements as outlined below for members transitioning from the OhioRISE Plan to an MCO or to MyCare Plan or to FFS for behavioral health.

ii. Provision of Member Information

1. For members enrolled with the OhioRISE Plan and transitioning to an MCO or FFS for behavioral health, the MCO or FFS must receive member information as specified by ODM from the disenrolling OhioRISE Plan.
2. Upon notification from ODM that an enrolled member will be disenrolling from the OhioRISE Plan and transitioning to an MCO or FFS for behavioral health, the OhioRISE Plan must provide member information to the MCO or FFS as specified by ODM.

iii. OhioRISE Plan Responsibilities

1. The OhioRISE Plan must ensure that the OhioRISE Plan, or CME if one is assigned, develops a transition of care plan for FFS providers or the MCO and its contracted CCEs or other providers, to inform member behavioral health care needs and support for 90 calendar days following disenrollment from the OhioRISE Plan.
2. The transition of care plan must be provided to the MCO or FFS behavioral health provider according to the timeframes specified by ODM.
3. The OhioRISE Plan must perform outreach to the enrolling FFS providers or the enrolling MCO and key behavioral health providers in the OhioRISE Plan or MCO provider network for input into the transition of care plan.
4. The OhioRISE Plan or CME, if one is assigned, must perform outreach to the member's family/caregiver during the development of the transition of care plan to solicit input and to inform regarding the planned OhioRISE Plan disenrollment and the services and supports that will be included in the transition of care plan.

f. Transitions of Care Between Health Care Settings

- i. The OhioRISE Plan, in coordination with CMEs as assigned, must effectively and comprehensively manage transitions of care settings in order to prevent unplanned or unnecessary readmissions, ED visits, or adverse outcomes. The OhioRISE Plan must:
 1. Identify members who require assistance transitioning between settings and notify the member's CME, if assigned;
 2. Develop a method for evaluating risk of readmission or deterioration in order to determine the intensity of follow up required for the member after the date of discharge, and share this information with the CME, MCO, and CCE, as assigned;
 3. Either directly or through the CME, if one is assigned, designate care coordination staff to communicate with the discharging facility and inform the facility of the designated contacts of the member's care team, including all care coordinators and providers of behavioral health services currently received by the member;
 4. Ensure timely notification and receipt of admission dates, discharge dates, and clinical information is communicated between OhioRISE Plan's departments, CME, MCO/CCE, other behavioral health providers, and the member's PCP, as appropriate;
 5. Either directly or through the CME, if one is assigned, 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 OhioRISE Plan or CME, if one is assigned;

6. Either directly or through the CME, if one is assigned, obtain a copy of the discharge/transition plan and share the plan with the member's care team;
7. Either directly or through the CME, if one is assigned, arrange and confirm services are authorized and delivered in accordance with the discharge/transition plan;
8. Ensure that providers are able to obtain copies of the member's medical records as appropriate and consistent with federal and state law; and
9. Either directly or through the CME, if one is assigned, conduct timely follow up with the member and the member's behavioral health providers to ensure post discharge services have been provided.

g. Continuity of Care

i. Continuation of Services for Members

1. The OhioRISE Plan must allow a new member to receive services from network and out-of-network providers in the following circumstances:
 - a. If the member has a prior authorization approved prior to the member's transition:
 - i. The OhioRISE Plan must honor the prior authorization through the expiration of the authorization, regardless of whether the authorized or treating provider is in- or out-of-network with the OhioRISE Plan.
 - ii. The OhioRISE Plan may conduct a medical necessity review for previously authorized services if the member's needs change to warrant a change in service. The OhioRISE Plan must render an authorization decision pursuant to OAC rule 5160-59-03.1.
 - iii. The OhioRISE Plan 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 OhioRISE Plan 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.

4. Care Coordination Information Systems and Data

a. OhioRISE Care Coordination Portal

- i. The OhioRISE Plan must provide a Care Coordination Portal, specific to the OhioRISE Program (OhioRISE Care Coordination Portal) that collects, stores, shares, and pushes out pertinent member information to the entities involved in coordinating the member's care (ODM, CCEs, CMEs, and SPBM as applicable). The OhioRISE Plan's Care Coordination Portal must have the capability of sending electronic notifications of sentinel events to entities involved in the member's care coordination. The OhioRISE Plan's Care Coordination Portal must link to the MCO's Care Coordination Portal.
- ii. When member is assigned to a CME care coordinator, the OhioRISE Care Coordination Portal must allow CMEs to provide data, through either direct data entry or data exchange. Requirements for CMEs for providing and updating member care coordination data must be specified in the provider contract between the OhioRISE Plan and the CMEs.
- iii. The OhioRISE Plan will be required to assess each CME's ability to provide data in an electronic format (e.g., electronic health record [EHR]) to the OhioRISE Care Coordination Portal and provide the necessary technical assistance to CMEs to meet the requirements in Section 4.a.ii of this appendix.
- iv. The OhioRISE Plan 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:
 1. Behavioral health inpatient hospitalizations/rehospitalizations must be reported on the same day as admission.
 2. ED visits for behavioral health purposes must be entered upon notification to the OhioRISE Plan.
 3. Identified gaps in care must be reported within 72 hours of identification, unless immediate action is necessary to ensure health or safety of the member.
 4. Admissions to out-of-home placement, including psychiatric residential treatment facilities (PRTFs), residential treatment centers, American Society of Addiction Medicine (ASAM) Level III residential programs, therapeutic group homes, therapeutic foster care and Qualified Residential Treatment Programs (QRTPs) must be reported within 72 hours.
 5. Discharges from all out-of-home placement referenced in Section 4.a.iv of this appendix must be reported at least 72 hours prior to the planned discharge.
 6. Members with MRSS contact must be reported within 24 hours.

- v. The OhioRISE Care Coordination Portal must be available to members, ODM, the SPBM, MCOs, CCEs, and the CMEs, subject to access controls and requirements necessary to comply with state and federal privacy requirements.
 - vi. The OhioRISE Plan must provide ODM full access to the OhioRISE Care Coordination Portal for Medicaid members, subject to the privacy requirements as specified in Appendix A, General Requirements.
 - vii. The OhioRISE Plan must create a "single sign on" as specified in Appendix K, Information System, Claims, and Data, for the Care Coordination Portal for state staff, as well as the MCO's, CCEs, and/or CMEs providing care coordination services.
- b. OhioRISE Plan's Responsibilities for Care Coordination Portal Data
- i. The OhioRISE Plan must report the following data in the OhioRISE Care Coordination Portal:
 - 1. Member name and all membership numbers assigned to the member (e.g., OhioRISE Plan's identifier, Medicaid number, and eligibility span);
 - 2. Member demographics and contact information;
 - 3. Care coordination assignment (OhioRISE Plan or CME care coordinator);
 - 4. OhioRISE Plan's or CME care coordinator's name and contact information;
 - 5. Care coordination tier;
 - 6. Access to care:
 - a. Referral information (e.g., date, referral source);
 - b. Initial and ongoing contact information (e.g., date of initial care coordination outreach, initial appointment).
 - 7. OhioRISE Plan's care coordination status (assigned, active, declined, withdrew);
 - 8. OhioRISE Plan/CME conducted assessments;
 - 9. Initial and subsequent CANS assessments;
 - 10. OhioRISE Plan- and CME-developed child and family-centered care plans and CFT members, including review status and plan update sentinel events;
 - 11. Utilization data (claims, pharmacy, prior authorizations, ED visits and hospitalizations, value-added benefits if applicable);
 - 12. Medication data;
 - 13. Grievances, appeals, and state hearings;
 - 14. Sentinel events;

15. Incidents; and
 16. OhioRISE Plan/CME care team contacts.
- ii. The OhioRISE Plan must have the capacity to add data elements to the OhioRISE Plan's Provider Portal in the future based on ODM's direction and specifications.
 - iii. The OhioRISE Plan must include portal data from the MCO set forth in Section 3.b.ii of this appendix.
- c. Member Access to the OhioRISE Care Coordination Portal
 - i. The OhioRISE Plan must ensure that members have access to the following data and functions in the OhioRISE Care Coordination Portal:
 1. Member assignment to the OhioRISE Plan;
 2. Member ability to request care coordination from the OhioRISE Plan;
 3. Assigned care coordinator and contact information (OhioRISE Plan and CME care coordinator as applicable);
 4. OhioRISE Plan- and CME-developed child and family-centered care plans and CFT members; and
 5. Care team contacts.
 - d. The OhioRISE Plan must train CMEs and other providers how to enter and review data in the portal appropriate to their role in the member's care and in compliance with state and federal privacy requirements.
 - e. The OhioRISE Care Coordination Portal must be designed using technology approved by ODM that permits operation of the system to be transferred to ODM or its designee upon termination of this Agreement. ODM shall own all of the data in the OhioRISE Care Coordination Portal, and the data must be made available in a format specified by ODM upon termination of this Agreement.
 - f. The OhioRISE Plan is prohibited from using the OhioRISE Care Coordination Portal system in other states or under other contracts without the prior written approval of ODM.
5. OhioRISE Care Coordination Portal Monitoring and Oversight
 - a. The OhioRISE Plan must monitor and provide oversight to ensure the care coordination needs of members are met.
 - b. The OhioRISE Plan, on an ongoing basis, must review data indicators (e.g., emergency department, inpatient, and crisis services utilization; prescription drug utilization data provided by the SPBM; utilization patterns stratified by race/ethnicity, gender, and aid category; readmissions; critical incidents; identified gaps in care) to inform the level and type of care coordination needed by the member.

- c. The OhioRISE Plan must perform oversight of the quality and effectiveness of OhioRISE Plan- and CME-provided care coordination through the review of member and provider surveys and case reviews. Case reviews must include whether the OhioRISE Plan and CME have met established quality, clinical best practice, and care coordination standards.
- d. Following the identification of unmet member needs or care coordination delivery deficiencies, the OhioRISE Plan, in coordination with ODM, the MCOs, CCEs, CMEs, and the SPBM, must ensure that the member needs are expediently met and that care coordination deficiencies are systemically corrected.

APPENDIX E – MARKETING AND MEMBER MATERIALS

1. Marketing

a. Marketing Activities

- i. The OhioRISE Plan shall not directly market to or solicit Medicaid members. Communication will be allowed with Medicaid members who are referred to it for evaluation of enrollment into the OhioRISE Plan or who are already enrolled into the OhioRISE Plan. These communications shall not constitute marketing and are subject to the requirements in the Member Communication section below.

b. Alleged Marketing Violations

- i. The OhioRISE Plan 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 Ohio Department of Insurance (ODI) and the Medicaid Fraud Control Unit (MCFU) as appropriate.

2. ODM-Requested Member Notifications

- a. The OhioRISE Plan must provide written notice to members as specified by ODM, including but not limited to notification of a change to member services or access to network providers.

3. Member Materials

a. General

- i. The OhioRISE Plan 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 OhioRISE Plan to fulfill OhioRISE Plan program requirements or to communicate to all members or a group of members. Member materials include member education, program explanations, and referral and linkage related materials. Member health education materials produced by a source other than the OhioRISE Plan and that do not include any reference to the OhioRISE Plan are not considered to be member materials.
- iii. Pursuant to OAC rule 5160-26-05.1, the OhioRISE Plan must adopt practice guidelines and provide a copy of them to eligible individuals and members upon their request.
- iv. The OhioRISE Plan must ensure that member materials do not include statements that are inaccurate, misleading, confusing, or otherwise misrepresentative, or that defraud eligible individuals or ODM.

b. ODM Member Material Approval

- i. The OhioRISE Plan must submit all new and revised member materials (including mailing and distribution) to ODM for approval prior to distribution to eligible individuals or members. The OhioRISE Plan must submit the materials into ODM's Marketing and Member Materials portal to request review and approval.
- ii. The OhioRISE Plan must comply with *ODM's Marketing Guidance Document* for determining what constitutes "new and revised" member materials that require ODM's review and prior approval. The OhioRISE Plan must submit all direct member contact materials (e.g., phone scripts and text messages) to ODM for review and approval.
- iii. The OhioRISE Plan must include an attestation with each member materials submission that the material is accurate and not intended to mislead, confuse, or defraud the eligible individuals or ODM.
- iv. In accordance with 42 CFR 438.104(c), ODM will consult with the Medical Care Advisory Committee or an advisory committee of similar membership in reviewing all OhioRISE Plan-submitted member materials.

c. New Member Materialsi. General

1. ODM will provide identification (ID) cards to each member or assistance group that is assigned to the OhioRISE Plan, and the card will include the member's MCO and OhioRISE Plan enrollment.
2. The OhioRISE Plan must provide each member or assistance group that is assigned to the OhioRISE Plan a new member letter, notice of advanced directives, provider directory postcard, the quick guide, and either the full member handbook or a postcard providing the link to the member handbook online.
3. The OhioRISE Plan shall not routinely include single pharmacy benefit manager (SPBM) or MCO information in member communications but shall refer and link OhioRISE Plan-enrolled members to the MCO in which they are enrolled for MCO responsibilities or SPBM for information related to SPBM.
4. In accordance with 42 CFR 438(c)(6) and 42 CFR 438.10(c)(6) if the OhioRISE Plan provides required member information or the member handbook electronically, it must meet all of the following conditions:
 - a. The format is readily accessible;
 - b. The information is located in a prominent and readily accessible place on the member page of the OhioRISE Plan's website;

- c. The information is provided in a form that 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; and
- f. The member is informed that the information is available in paper form without charge upon request; the information and process (e.g., phone number and/or email address) to request paper forms is included; and the requested information is provided within five business days.

ii. OhioRISE Plan ID Card

- 1. The ODM-issued OhioRISE Plan ID card will contain:
 - a. The OhioRISE Plan's name as stated in its article of incorporation along with any other trade or Doing Business As (DBA) name used;
 - b. The name of the member enrolled in the OhioRISE Plan and the member's medical management information system billing number;
 - c. Coordinated Services Program information;
 - d. Pharmacy benefit and SPBM contact information; and
 - e. The OhioRISE Plan's emergency procedures, including the toll-free call-in system phone numbers.

iii. New Member Letter

- 1. The OhioRISE Plan must use the model language specified by ODM for the new member letter. The OhioRISE Plan's New Member Letter must inform each member of the following:
 - a. The new member materials issued by the OhioRISE Plan, what action to take if the member did not receive those materials, and how to access the OhioRISE Plan's provider directory;
 - b. The new member will be assigned to a care management entity (CME) or OhioRISE Plan care coordinator who will be contacting the member and/or their family, and how to reach member services with any needs prior to contact from the care coordinator;
 - c. How to access MCO-provided transportation services, including how the OhioRISE Plan can assist the member with coordination of transportation services through the MCO; and

- d. The issues and circumstances upon which the member should contact their MCO rather than the OhioRISE Plan and an affirmation that the OhioRISE Plan member services line can also provide a warm transfer of the member to the MCO in which the member is enrolled.

iv. Member Handbook

1. The OhioRISE Plan must use the model language specified by ODM for the member handbook. The OhioRISE Plan's member handbook must be clearly labeled as such and include "OhioRISE Program" to clearly distinguish the applicability of the member handbook to members covered under this Agreement from those created for other OhioRISE Plan lines of business. The OhioRISE Plan must ensure the member handbook table of contents precedes all content, with the exception of the tagline to comply with Section 1557 of the Patient Protection and Affordable Care Act. The member handbook must include ODM definitions of managed care terminology in accordance with 42 CFR 438.10. The OhioRISE Plan must ensure the member handbook includes:
 - a. The rights of members, including all rights found in OAC rule 5160-26-08.3 and any member responsibilities specified by the OhioRISE Plan:
 - i. With the exception of any prior authorization requirements the OhioRISE Plan describes in the member handbook, the OhioRISE Plan cannot establish any member responsibility that would preclude the OhioRISE Plan's coverage of a Medicaid-covered service.
 - b. Information regarding the services and benefits available through the OhioRISE Program and how to obtain them including, at a minimum:
 - i. A summary comparing the services covered by the OhioRISE Plan, MCOs, and SPBM;
 - ii. All services and benefits requiring prior authorization or referral by the OhioRISE Plan.
 - c. Information regarding services excluded from OhioRISE Plan coverage;
 - d. Information regarding how members can access Mobile Response and Stabilization Services (MRSS) services;
 - e. Information distinguishing emergency services available from the MCO and from the OhioRISE Plan, including how to obtain more information about those services from the MCO and the OhioRISE Plan. The OhioRISE Plan shall include:

- i. An explanation of the terms "emergency medical condition," "emergency services," and "post-stabilization services," as defined in OAC rule 5160-26-01;
 - ii. A statement that prior authorization is not required for emergency services;
 - iii. An explanation of the availability of the 911 telephone system or its local equivalent;
 - iv. A statement that members have the right to use any hospital or other appropriate setting for emergency services; and
 - v. An explanation of the post-stabilization care services requirements specified in OAC rule 5160-59-03.
- f. Information required by ODM to promote member awareness and understanding of their rights under the Mental Health Parity and Addiction Act;
 - g. The procedure for members to express their recommendations for change to the OhioRISE Plan;
 - h. Identification of the categories of Medicaid recipients eligible for OhioRISE Program membership;
 - i. Information about the OhioRISE Plan's ID card issued by ODM, how often the card is issued, how to use it, and how to get a replacement card;
 - j. A statement that medically necessary health care services must be obtained through the providers in the OhioRISE Plan's provider network with any exceptions that apply, such as emergency care;
 - k. Information regarding the roles and duties of the OhioRISE Plan compared to the MCO;
 - l. Information on additional services available to members, including care coordination provided by the CME, OhioRISE Plan and roles of the MCO/care coordination entity (CCE) care coordinator;
 - m. A description of the OhioRISE Plan's policies regarding access to providers outside the state for non-emergency services and, if applicable, access to providers within or outside the state for non-emergency after hours services;
 - n. Information on how a member can initiate disenrollment from the OhioRISE Plan in accordance with OAC rule 5160-59-02;
 - o. Information about OhioRISE Plan-initiated terminations;

- p. An explanation of periodic OhioRISE Plan enrollment process as specified by ODM;
- q. The procedure for members to file a grievance, an appeal, a request for an external review, or state hearing request pursuant to OAC rule 5160-26-08.4, the OhioRISE Plan's mailing address, and copies of the optional forms that members may use to file an appeal or grievance with the OhioRISE Plan;
 - i. Copies of the forms to file an appeal or grievance must also be made available through the OhioRISE Plan's member services program.
- r. The standard and expedited state hearing resolution timeframes as outlined in 42 CFR 431.244;
- s. The member handbook issuance date;
- t. A statement that the OhioRISE Plan is prohibited from discriminating on the basis of race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, veteran status, ancestry, genetic information, health status, or need for health services in the receipt of health services;
- u. An explanation of subrogation and coordination of benefits;
- v. A clear identification of corporate or parent identity when a trade name or DBA is used for the Medicaid product;
- w. Information on the OhioRISE Plan's advance directives policies, including a member's right to formulate advance directives, a description of state law, and a statement of any conscience-based limitation regarding the implementation of advance directives;
- x. A statement that the OhioRISE Plan 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 OhioRISE Plan upon request including, at a minimum, the structure and operation of the OhioRISE Plan and any physician incentive plans the OhioRISE Plan operates;
- aa. Process for requesting or accessing additional OhioRISE Plan information or services including, at a minimum:
 - i. Oral interpretation, oral translation, and auxiliary aids and services;

- ii. Written information in the prevalent non-English languages; and
 - iii. Written information in alternative formats.
 - bb. How to access the OhioRISE Plan's provider directory; and
 - cc. Access to provider panel information for members via the OhioRISE Plan's website and printed provider directories.
- v. OhioRISE Plan Quick Guide
 - 1. The OhioRISE Plan must create a quick guide version of its member handbook that includes but is not limited to the following information:
 - a. The Section 1557 of the Patient Protection and Affordable Care Act compliant tagline;
 - b. The process for requesting or accessing additional OhioRISE Plan information or services including, at a minimum:
 - i. Oral interpretation, oral translation, and auxiliary aids and services;
 - ii. Written information in the prevalent non-English languages; and
 - iii. Written information in alternative formats.
 - c. A brief description of the roles of the OhioRISE Program, CME, MCO, and SPBM;
 - d. A statement that the OhioRISE Plan provides covered services to members through a provider agreement with ODM, and how members can contact ODM;
 - e. Toll-free phone numbers critical to accessing care, including the member services, behavioral health crisis services, MCO's transportation services, MCO's member services numbers and websites, and the SPBM's member services number and website;
 - f. The benefits available through the OhioRISE Plan, how to obtain them, and any limits or prior authorization applied;
 - g. Information regarding emergency services, the procedures for accessing emergency services, and a statement that emergency services do not require prior authorization;
 - h. Information that indicates medically necessary health care services must be obtained through the providers in the OhioRISE Plan's

provider network with any exceptions that apply, such as emergency care;

- i. How to access the OhioRISE Plan's provider directory; and
- j. The quick guide issuance date.

vi. Provider Panel Information and Notice of Non-Discrimination

- 1. In addition to a new member letter, quick guide, and a member handbook, the OhioRISE Plan must provide to each member or assistance group, as applicable, provider panel information, notice of non-discrimination, 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, ODM will issue a new ID card. The OhioRISE Plan must issue a new member handbook postcard to the member if the member handbook has been revised since the initial OhioRISE Plan membership date.

d. Issuance of New Member Materials

- i. The OhioRISE Plan must mail the new member letter, quick guide, and request postcard within ten business days of receiving the 834C enrollment file, except during state cutoff when OhioRISE Plans have the option to follow the 834 file loading process as specified by ODM.
- ii. The OhioRISE Plan may mail ODM prior-approved postcards in lieu of mailing printed advance directives, directories, quick guides, and member handbooks. At a minimum, the postcards must advise members to call the OhioRISE Plan or return the postcards to request a printed advance directive, provider directory, quick guide, or member handbook.
- iii. If the OhioRISE Plan does not use an ODM prior-approved postcard, the OhioRISE Plan must mail provider directories, quick guide, and member handbooks to all new members, within ten business days of receiving the 834C.
- iv. If requested by a member, the OhioRISE Plan must send a printed advance directive, provider directory, quick guide, and member handbook within seven calendar days of the request.
- v. The OhioRISE Plan must designate two OhioRISE Plan staff members to receive a copy of the new member materials on a monthly basis in order to monitor the timely receipt of these materials. At least one of the staff members must receive the materials at their home address. The OhioRISE Plan must provide documentation to ODM upon request that demonstrates compliance with this requirement.

APPENDIX F – PROVIDER NETWORK

1. General

- a. The OhioRISE Plan must comply with all state and federal provider network requirements, including but not limited to OAC rule 5160-26-05, 42 CFR 438.206, 42 CFR 438.207, 42 CFR 438.602, and the requirements of this appendix.
- b. In accordance with 42 CFR 438.206, the OhioRISE Plan must maintain a provider network that is sufficient to provide timely access to all medically necessary covered services stipulated in the OhioRISE Plan benefit package to all OhioRISE Plan-enrolled members, including those with limited English proficiency or physical or mental disabilities. The OhioRISE Plan must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities.
- c. The OhioRISE Plan must monitor compliance with provider network requirements and take corrective action as needed.
- d. ODM will screen, enroll, and credential all providers as necessary in accordance with 42 CFR 455 subpart e. The OhioRISE Plan shall review ODM's Provider Network Management (PNM) module (the system of record) for eligible and active providers.
- e. ODM must monitor access and availability using multiple data sources, including but not limited to member complaints, member grievances, appeals, member satisfaction surveys, provider complaints, quality data, performance measures, utilization data, demographic data, and results from other oversight and monitoring activities.
- f. The OhioRISE Plan must comport with ODM's Substance Use Disorder 1115 waiver requirements, including American Society of Addiction Medicine (ASAM) levels of care as outlined in Table F.2.

2. Documentation of Network Capacity

- a. In accordance with 42 CFR 438.207, the OhioRISE Plan must give assurance to ODM and provide supporting documentation that 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 OhioRISE Plan must submit documentation to ODM, in a format specified by ODM, demonstrating that:
 - i. The OhioRISE Plan offers an appropriate range of behavioral health services (including care coordination as offered through the care management entities [CMEs]) adequate for the anticipated number of members; and
 - ii. The OhioRISE Plan maintains a provider network sufficient in number, mix, and geographic distribution in accordance with any stipulated time and distance standards, contracting requirements and to directly meet the needs of the anticipated and existing members. This shall include providers in contiguous states needed for member access and care.
- c. In accordance with 42 CFR 438.207, the OhioRISE Plan must submit such documentation at each of the following:

- i. At the time the OhioRISE Plan enters into a contract with ODM;
 - ii. On a quarterly basis thereafter;
 - iii. At any time there is a significant change (as defined by ODM) in the OhioRISE Plan's operations that would affect adequate capacity and services, including but not limited to changes in services, benefits, service area, provider network, or payments;
 - iv. Any time there is enrollment of a new population in the OhioRISE Plan; and
 - v. As otherwise directed by ODM.
- d. The OhioRISE Plan must develop and maintain a Network Development and Management Plan to demonstrate that it maintains a network of providers that is sufficient in number and mix in accordance with any stipulated time and distance standards and contracting requirements. The Network Development and Management Plan must also demonstrate that the OhioRISE Plan directly meets the needs of the anticipated and existing members in the service area and ensures the provision of covered services.
 - i. The Network Development and Management Plan must include the information specified by ODM, which may include but is not limited to:
 - 1. Coordination with the MCO(s) on the behavioral health contracted continuum of care to minimize disruption of care as members transition between the OhioRISE Plan and MCO(s);
 - 2. Addresses special considerations for children and youth that transition between FFS and the MCO(s) while also enrolled in the OhioRISE Plan (See Appendix D for more detail on transition requirements and plans);
 - 3. Monitoring activities to ensure that access standards are met and that members have timely access to services;
 - 4. Provider capacity issues by service and county, the OhioRISE Plan's remediation and quality improvement (QI) activities, and the targeted and actual completion dates for those activities;
 - 5. Provider network deficiencies by service, stipulated time and distance standards (TDS) as specified in Tables F.2 and F.3, and interventions to address the deficiencies;
 - 6. Ongoing activities for provider network development and expansion taking into consideration identified provider capacity, network deficiencies, service delivery issues, network continuity between with the MCOs, and current and future member needs; and
 - 7. Collaboration and coordination with State's designated COE(s).
 - ii. The OhioRISE Plan must evaluate and update its Network Development and Management Plan on an annual basis and submit it to ODM as specified in Appendix P, Chart of Deliverables.

- iii. The OhioRISE Plan'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 CFR 438.214 and OAC rule 5160-26-05, the OhioRISE Plan must have policies and procedures for selection and retention of network providers. This shall include policies and procedures on selective contracting for psychiatric residential treatment facilities (PRTFs) and other providers upon approval by ODM:
- ii. The OhioRISE Plan, at the direction of ODM, will:
 - 1. Assist in developing program and administrative policies and requirements for CMEs in partnership with ODM, state child-serving agencies, the COE(s), and community stakeholders;
 - 2. Selectively contract with CMEs that meet the State's policy objectives and meet the requirements developed in Section 3.a.i. of this appendix;
 - 3. Provide technical assistance, in collaboration with ODM, state child-serving agencies and the CEO(s), to support the establishment, development, and growth of CMEs.

b. Written Contracts and Medicaid Addendum

- i. In accordance with CFR 438.206 and OAC rule 5160-26-05, the OhioRISE Plan must enter into written contracts with network providers.
- ii. Pursuant to OAC rule 5160-26-05, network provider contracts must include the appropriate ODM-approved Model Medicaid Addendum, which incorporates all applicable OAC rule requirements. The OhioRISE Plan must not modify the Model Medicaid Addendum except to add personalizing information such as the OhioRISE Plan's name.
- iii. The OhioRISE Plan must submit network provider contract templates to ODM for review prior to executing contracts using the applicable template.
- iv. The OhioRISE Plan 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 OhioRISE Plan must disclose to ODM all financial and other terms that apply between the OhioRISE Plan and any network provider.

c. Contracting with ODM-Enrolled Providers

- i. In accordance with 42 CFR 438.608 and this Agreement, the OhioRISE Plan must contract only with providers that are enrolled with or designated by ODM and are credentialed providers in ODM's provider network management system.
- ii. The OhioRISE plan is required to have initial contract with network providers by the date that is the earlier of the following dates:

1. Successful completion of the readiness review, or
 2. No later than 60 days before the OhioRISE Program go-live date.
- iii. Prior to contracting with a provider or listing the provider as a network provider, the OhioRISE Plan must verify that the provider is active in ODM's provider network management system and enrolled for the applicable service or specialty. If a provider is not active in ODM's provider network management system, the OhioRISE Plan must direct the provider to the ODM's portal to submit an application for screening, enrollment, and credentialing prior to contracting.
 - iv. The OhioRISE Plan must conduct a daily reconciliation of the OhioRISE Plan's provider network and ODM's provider network management system to ensure that network providers remain active in ODM's provider network management system.
- d. Centralized Credentialing
- i. If credentialing is required for a specific provider type, the OhioRISE Plan must only use providers credentialed or approved through ODM's process.
 - ii. A provider's credentialing status will be indicated in ODM's provider network management system.
 - iii. The OhioRISE Plan must accept ODM's credentialing status and must not request any additional credentialing or re-credentialing information from an ODM-enrolled provider.
 - iv. The OhioRISE Plan must not credential or re-credential any ODM-enrolled providers for provision of services under this Agreement, including provider types that are not credentialed by ODM.
 - v. The OhioRISE Plan must coordinate and cooperate with ODM in the credentialing and re-credentialing of the OhioRISE Plan's network providers.
 - vi. The OhioRISE Plan's Chief Medical Officer (CMO) must participate in ODM's credentialing committee.
 - vii. The OhioRISE Plan must provide to ODM, in the format and at the frequency specified by ODM, the information specified by ODM to inform ODM's credentialing and re-credentialing process. This information may include but is not limited to:
 1. Provider demographic information, any 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 OhioRISE Plan's ongoing monitoring of network providers, including but not limited to complaints, adverse events, and quality of care issues;

6. Information about the provider maintained by the OhioRISE Plan for credentialing or re-credentialing the provider for other lines of business.

- e. OhioRISE Plan Provider Network Information

- i. The OhioRISE Plan must submit provider network information, including provider additions and deletions, to ODM in the format and at the frequency specified by ODM to ODM's provider network management system.
- ii. As directed by ODM, the OhioRISE Plan must provide documentation verifying the accuracy of information submitted to ODM's provider network management system.
- iii. ODM will use the information provided by the OhioRISE Plan and uploaded into ODM's provider network management system to determine if the OhioRISE Plan meets the provider network access standards specified in this Agreement.
- iv. The OhioRISE Plan must immediately notify ODM of any discrepancy between the OhioRISE Plan's provider network information in ODM's provider network management system and the OhioRISE Plan's system and resubmit the correct information within one business day of becoming aware of the discrepancy.

- f. Sole Source Contracting

- i. The OhioRISE Plan 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 prior approval, the OhioRISE Plan must include the information and documentation specified by ODM.
- iii. If ODM approves a sole source contract, the OhioRISE Plan 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 OhioRISE Plan must comply, at a minimum, with the provider network access requirements specified in this appendix.
- ii. If ODM determines that changes have occurred in the availability of specific provider types or in the number and composition of the eligible population, ODM will, via amendment to this Agreement, revise the provider network access requirements.
- iii. The OhioRISE Plan must monitor compliance with provider network access requirements and take corrective action as needed to comply with this appendix.
- iv. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must submit quarterly time and distance reports (Time and Distance Report) to ODM in the format specified by ODM.

- v. ODM will use a time and distance geo mapping software that uses the Euclidean metric to measure the maximum time and distance for the OhioRISE Plan's membership and provider network. The OhioRISE Plan must ensure that at least 90% of the OhioRISE Plan's members residing in a given county have access to at least one provider/facility of each specialty type within the time and distance standards in Table F.2 as determined by ODM.
 - vi. The OhioRISE Plan must notify ODM within one business day of determining that the OhioRISE Plan is not in compliance with the provider network access requirements specified in this appendix.
- b. Behavioral Health Providers
- i. *Child and Adolescent Needs and Strengths Providers*
 - 1. The OhioRISE Plan must contract with all providers identified by ODM in ODM's provider network management system as eligible to complete the ongoing Child and Adolescent Needs and Strengths (CANS) assessments for continued eligibility for OhioRISE Plan enrollment (CANS providers) except where there are documented instances of quality concerns. The OhioRISE Plan must notify ODM if it is not willing to contract with a particular CANS provider and must collaborate with ODM on next steps. The OhioRISE Plan will not be responsible for completing the initial CANS assessment for initial OhioRISE Plan eligibility.
 - 2. For CANS providers identified by ODM after the effective date of this Agreement, the OhioRISE Plan must contract with the identified provider no later than 90 calendar days from the provider being identified as a CANS provider in ODM's provider network management system.
 - 3. The OhioRISE Plan must monitor CANS providers for compliance with ODM standards and guidance using a standardized protocol as specified by ODM. As directed by ODM, the OhioRISE Plan must coordinate monitoring with the MCO(s).
 - 4. For the purposes of ongoing CANS assessment following enrollment in the OhioRISE Plan, the OhioRISE Plan must ensure and monitor that the CMEs have individuals trained in the administration of the CANS or have access to CANS assessors.
 - ii. *Providers of Mobile Response and Stabilization Services*
 - 1. The OhioRISE Plan must contract with all providers identified by ODM as eligible to provide Mobile Response and Stabilization Services (MRSS), except where there are documented instances of quality concerns. The OhioRISE Plan must notify ODM if it is not willing to contract with a particular MRSS provider and must collaborate with ODM on next steps.
 - 2. For MRSS providers identified by ODM after the effective date of this Agreement, the OhioRISE Plan must contract with the identified provider no later than 90 calendar days from the provider being identified as an MRSS provider in ODM's provider network management system.
 - 3. The OhioRISE Plan must monitor MRSS providers for compliance with ODM standards and guidance using a standardized protocol as specified by ODM. As

directed by ODM, the OhioRISE Plan must coordinate monitoring activities with the MCOs.

iii. Community Mental Health Services Providers

1. The OhioRISE Plan must contract with community mental health providers that meet the requirements in OAC Chapter 5160-27-01 that serve children, youth, and caregivers to ensure adequate provider network capacity to provide its members with reasonable and timely access to all covered mental health services.

iv. Substance Use Disorder Treatment Providers

1. The OhioRISE Plan must contract with substance use disorder (SUD) treatment providers that meet the requirements in 5160-27-01 that serve adolescents and ensure adequate provider network capacity to provide its members with reasonable and timely access to all covered SUD treatment services.
2. The OhioRISE Plan must apply the TDS set forth in Table F.2 to contract with community behavioral health providers and other licensed practitioners in accordance with OAC Chapter 5160-27-01 and 5160-8-05 for each ASAM level of care.

v. Opioid Treatment Programs

1. The OhioRISE Plan must contract with all willing Opioid Treatment Programs (OTPs) licensed by OMHAS and certified by the United States Substance Abuse and Mental Health Services Administration (SAMHSA), except where there are documented instances of quality concerns. The OhioRISE Plan must notify ODM if it is not willing to contract with a particular OTP provider and must collaborate with ODM on next steps.

vi. Other Behavioral Health Providers

1. The OhioRISE Plan must contract with at least the minimum number of other behavioral health providers per the specified TDS in Table F.2.
2. For purposes of this standard, "other behavioral health providers" include independent marriage and family therapists, licensed independent chemical dependency counselors, licensed independent social workers, psychologists, etc., who provide services outside of a community mental health services provider or SUD treatment provider that meet the requirements in OAC 5160-27-01.
3. For purposes of this standard, "other behavioral health providers" also include outpatient hospital providers that render behavioral health services.

vii. General and Child/Adolescent Psychiatrists and Psychiatric Advanced Practice Registered Nurses (APRN)

1. In the first year of operations, the OhioRISE Plan must initially develop and implement a process for identifying the number and geographic location (by county)

of general and child/adolescent psychiatrists and psychiatric APRN throughout the state that will initially participate in the OhioRISE Plan's provide network.

2. The OhioRISE Plan will submit a Report on the Number and Geographic Location of General and Child and Adolescent Psychiatrists and Psychiatric APRNs, as specified in Appendix P, Chart of Deliverables. Based on this report ODM will establish time and distance standards for these practitioners for subsequent years.
3. In the first year, the OhioRISE vendor will contract as necessary with all known general and child/adolescent psychiatrists to meet the needs of its members.

viii. Psychiatric Hospitals

1. The OhioRISE Plan must contract with at least the minimum number of hospitals by type per county specified in Table F.3. In order to meet these requirements, the OhioRISE Plan may contract with an out-of-state hospital located in a state bordering Ohio if necessary.
2. If a hospital in the OhioRISE Plan's network elects not to provide specific covered services because of an objection on moral or religious grounds, the OhioRISE Plan must ensure these hospital services are available to its members through another network hospital in the specified county.

ix. General Acute Care Hospitals

1. The OhioRISE Plan must contract with at least the minimum number of general acute care hospitals with psychiatric beds per county specified in Table F.3 or make arrangements for a special/single case agreement for hospital admissions. In order to meet these requirements, the OhioRISE Plan may contract with an out-of-state hospital located in a state bordering Ohio if necessary.
2. In the case where outpatient behavioral health services are provided within a hospital setting, the OhioRISE Plan must cover those services under the hospital contract or through a single case agreement resulting from an emergency.
3. If a hospital in the OhioRISE Plan's network elects not to provide specific covered services because of an objection on moral or religious grounds, the OhioRISE Plan must ensure these hospital services are available to its members through another network hospital in the specified county.

x. Federally Qualified Health Centers/Rural Health Clinics

1. The OhioRISE Plan must support member access to any federally qualified health centers (FQHC)/rural health clinics (RHC) that offers behavioral health services, regardless of whether the FQHC/RHC is a network provider.
2. If no FQHC/RHC is available within a county, the OhioRISE Plan must cover behavioral health services provided by an FQHC/RCH outside of the county.

xi. Other

1. The OhioRISE Plan must provide all medically necessary covered services to its members; therefore, the OhioRISE Plan's provider network must include additional specialists and provider types not listed in this appendix, which pertains to the OhioRISE Plan-designated covered services and benefit package.
2. The OhioRISE Plan may contract with or make arrangements for a special/single case agreement with outpatient hospitals as they deem required to meet the behavioral health needs of its anticipated and existing members.

5. Exception Process for Provider Network Access Requirements

- a. Upon written request of the OhioRISE Plan, ODM will grant an exception to a provider network access requirement if action taken by ODM adversely impacted the OhioRISE Plan's ability to meet the requirement or if there is no provider available to meet the requirement.

6. Provider Network Changes

- a. The OhioRISE Plan must comply with the provider network notification requirements in OAC rule 5160-26-05.
- b. In addition to the notification requirements in OAC rule 5160-26-05, the OhioRISE Plan must notify ODM within one business day of becoming aware that a network provider that is a CME or that served 500 or more of the OhioRISE Plan's members in the previous 12 months failed to notify the OhioRISE Plan that they are no longer available to serve as an OhioRISE Plan network provider.
- c. In addition to the notification requirements in OAC rule 5160-26-05, the OhioRISE Plan must notify ODM no less than 90 calendar days before the end date of an OhioRISE Plan-initiated termination of a network provider contract when the provider is serving or has served 500 or more of the OhioRISE Plan's members in the previous 12 months. This includes individual practitioners in group practices that cumulatively have served 500 or more members in the previous 12 months. Unless otherwise approved by ODM, OhioRISE Plan-initiated terminations of network provider contracts that serve or could serve 500 or more of the OhioRISE Plan's members shall not take effect until 90 calendar days after the open enrollment month ends.
- d. In addition to the notification requirements in OAC rule 5160-26-05, the OhioRISE Plan must notify ODM at least 90 calendar days prior to implementing any OhioRISE Plan-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. OhioRISE Plan-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, OhioRISE Plan-initiated changes that could reduce the OhioRISE Plan's provider network by 10% or more may not take effect during the 90 calendar days after the open enrollment month ends.
- e. In addition to the provisions in OAC rule 5160-26-05, the OhioRISE Plan must notify ODM within one business day of becoming aware of a provider-initiated hospital psychiatric unit/service closure or PRTF unit/service reduction or closure.

- f. When the OhioRISE Plan has been notified of a general acute care hospital termination, the OhioRISE Plan may request ODM to approve an alternative notification of members, in accordance with OAC rule 5160-26-05. Upon request, ODM will respond no later than seven business days after receipt of the OhioRISE Plan's submission. The OhioRISE Plan must comply with the notification timelines outlined in OAC rule 5160-26-05 and is limited to those members receiving behavioral health and/or psychiatric services at the termed hospital within the last 12 months from the notification.
- g. When submitting notification to ODM about provider network changes, the OhioRISE Plan 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.

7. Timely Access

- a. In accordance with 42 CFR 438.206:
 - i. The OhioRISE Plan must ensure compliance with the appointment availability standards in this appendix.
 - ii. The OhioRISE Plan 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.
 - iii. The OhioRISE Plan must ensure services are available 24 hours a day, seven days a week, when medically necessary.
 - iv. The OhioRISE Plan 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 OhioRISE Plan must ensure the availability of behavioral health care appointments.
- b. At a minimum, the OhioRISE Plan must ensure compliance with the following appointment standards identified in the Table F.1 below.

Table F.1 Appointment Standards

Type of Visit	Description	Minimum Standard
Emergency Service	Services needed to evaluate, treat, or stabilize an emergency as a result of a behavior health condition.	24 hours, 7 days/week
Urgent Care for Behavioral Health Conditions	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care. This includes acute illness or substance dependence that impacts the ability to function, but does not present imminent danger.	24 hours, 7 days/week within 48 hours of request
Behavioral Health Non-Life-Threatening Emergency	A non-life-threatening situation in which a member is exhibiting extreme emotional disturbance or behavioral distress, has a compromised ability to function, or is otherwise agitated and unable to be calmed.	Within 6 hours
Behavioral Health Routine Care	Requests for routine mental health or substance abuse treatment from behavioral health providers.	Within 10 business days or 14 calendar days, whichever is earlier
CANS Ongoing Assessment	Assessment of functional progress within the course of OhioRISE Plan treatment as facilitated by the CME.	Every 6 months or when a change in member's condition warrants a re-assessment
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
Psychiatric Residential Treatment Facilities	Initial screening for admission.	Within 48 hours of request
Specialty Behavioral Health Care Appointment	Care provided for a non-emergent/non-urgent illness requiring consultation, diagnosis, and/or treatment from a specialist (e.g., eating disorders, fire-setting).	Within 6 weeks

- c. The OhioRISE Plan shall include in its provider contract that if the provider is unable to meet the standards above they must contact the OhioRISE Plan within three business days.
- d. The OhioRISE Plan must disseminate the appointment standards to network providers and must educate network providers about the appointment standards.
- e. The OhioRISE Plan must have and implement policies and procedures for triage to assist OhioRISE Plan 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 OhioRISE Plan's triage process must be transparent and compliant with Mental Health Parity and Addiction Equity Act (MHPAEA).

- f. The OhioRISE Plan must conduct regular reviews of appointment availability and report this information in an appointment availability report (Appointment Availability Report), as specified in Appendix P, Chart of Deliverables.

9. Telehealth

- a. The OhioRISE Plan must offer, promote, support, and expand the appropriate and effective use of telehealth.
- b. The OhioRISE Plan 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.
- c. The OhioRISE Plan must ensure that telehealth does not replace provider choice or member preference for in-person service delivery.
- d. ODM will not consider telehealth as an alternative to meeting provider network access requirements.
- e. The OhioRISE Plan must support providers in offering telehealth, including providing "how to" guides on the technical requirements, workflows, and coding, and billing.
- f. The OhioRISE Plan must ensure that providers comply with state requirements regarding telehealth, including but not limited to in OAC rule 5160-1-18.
- g. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must submit an annual telehealth report (Telehealth Report) to ODM that includes but is not limited to:
 - i. The OhioRISE Plan's goals for telehealth and progress on meeting those goals, including performance measures;
 - ii. Barriers to increased use of telehealth and the OhioRISE Plan's strategies to overcome those barriers;
 - iii. Telehealth utilization, including any changes from the previous year;
 - iv. The OhioRISE Plan'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. Network and Workforce Development

- a. The OhioRISE Plan must work with ODM, ODM-contracted managed care entities, the State's-designated COE(s), behavioral health network providers, child-serving provider associations, and other stakeholders to develop and implement workforce development and other initiatives designed to support provider network adequacy and access. This includes but is not limited to:
 - i. Identifying and implementing strategies that develop the network of new services or enhance the development of existing services in the OhioRISE Program including:

1. Developing and implementing initiatives that will assist providers in identifying and recruiting staff for key supervisory and direct service positions;
 2. Creating opportunities for network providers to locate formal and informal supports for OhioRISE members with unique services and support needs; and
 3. Partnering with providers to develop and implement innovative approaches to workforce and network development, including new service and payment strategies.
- ii. Conducting and sharing workforce analyses as requested by ODM.
 - iii. Assisting ODM and state and local child-serving agencies with developing and implementing workforce development strategies, as specified by ODM.

11. Out-of-Network Requirements

- a. In accordance with 42 CFR 438.206 and OAC rule 5160-59-03, if the OhioRISE Plan is unable to provide medically necessary covered services to a member in a timely manner through its provider network, the OhioRISE Plan must adequately and timely cover these services by an out-of-network provider for as long as the OhioRISE Plan's provider network is unable to provide the services.
- b. In accordance with 42 CFR 438.206 and OAC rule 5160-26-05, the OhioRISE Plan must coordinate with the out-of-network provider with respect to payment and must ensure the cost to the member is no greater than it would be if the services were furnished by a network provider.
- c. If the out-of-network provider is not an active provider in ODM's provider network management system, the OhioRISE Plan 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 OhioRISE Plan must direct all out-of-network providers who are not active providers in ODM's provider network management system to the ODM portal to submit an application for screening, enrollment, and credentialing (if applicable). In addition, the OhioRISE Plan must report all single case agreements with providers who are not active in ODM's provider network management system to ODM within seven calendar days of becoming aware of the need to execute a single case agreement with such a provider. If a provider who is not active in ODM's provider network management system is not willing or able to become an active provider, the OhioRISE Plan 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 OhioRISE Plan 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 OhioRISE Plan's reimbursement rate or rates for a program, service, or provider type is not sufficient, the OhioRISE Plan, 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 after the contract start date to this Agreement, the OhioRISE Plan 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 OhioRISE Plan must require, as a condition of payment, that a provider (network or out-of-network) accepts the amount paid by the OhioRISE Plan or appropriate denial made by the OhioRISE Plan (or, if applicable, payment by the OhioRISE Plan that is supplementary to the member's third party payor) and, in addition, any applicable co-payment or patient liability amount due from the member as payment in full for the service.
 - v. The OhioRISE Plan must ensure that members are held harmless by providers for the costs of medically necessary covered services and additional services offered by the OhioRISE Plan.
 - vi. The OhioRISE Plan must only pay providers for services performed while they are enrolled with the ODM and are active in ODM's provider network management system, unless the provider is rendering service under a single case agreement or providing emergency services in accordance with 42 CFR 438.114. Except for emergency services, the OhioRISE Plan 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 OhioRISE Plan must make timely payments to providers in accordance with the timeliness standards in Appendix L, Payment and Financial Performance.
- b. Rate Changes
- i. The OhioRISE Plan must inform ODM of any rate changes that may adversely impact 50 or more network providers, prior to implementation of the rate change.
- c. Child and Adolescent Needs and Strengths Assessments
- i. The OhioRISE Plan must reimburse for Child and Adolescent Needs and Strengths (CANS) assessments conducted by CANS providers at 100% of the current Medicaid FFS rate.
 - ii. The OhioRISE Plan must comply with ODM guidance for coding and billing requirements for CANS assessments.
- d. Mobile Response and Stabilization Services
- i. The OhioRISE Plan must reimburse for Mobile Response and Stabilization Services (MRSS) rendered by MRSS providers at 100% of the current Medicaid FFS rate.

- ii. The OhioRISE Plan must comply with ODM guidance for coding and billing requirements for MRSS.
- e. Federally Qualified Health Centers/Rural Health Clinics
 - i. In order to ensure a federally qualified health centers (FQHC) or rural health clinics (RHC) has the ability to submit a claim to ODM for the state's Wraparound payment, the OhioRISE Plan must comply with the following for both network and out-of-network FQHCs/RHCs:
 - 1. The OhioRISE Plan must provide expedited payment (within a shorter timeframe than the prompt payment requirements in Appendix L, Payment and Financial Performance) in an amount no less than the rate paid to other providers for the same or a similar service.
 - 2. If the OhioRISE Plan does not have a rate for the same or a similar service, the OhioRISE Plan must reimburse the FQHC/RHC no less than 100% of the current Medicaid FFS rate for the same or a similar service provided by a non-FQHC/RHC provider.
 - 3. The OhioRISE Plan must provide FQHCs/RHCs the OhioRISE Plan's Medicaid provider number to enable FQHC/RHC providers to bill for the ODM Wraparound payment.
- f. Out-of-Network Emergency Services
 - i. In accordance with 42 CFR 438.114 and OAC rule 5160-59-03, the OhioRISE Plan must reimburse out-of-network providers of emergency services either billed charges or 100% of the current Medicaid FFS rate, whichever is less.
- g. Out-of-Network Psychiatric Hospital Referrals
 - i. Pursuant to OAC rule 5160-59-03, if ODM approves a member's referral to certain out-of-network hospitals for psychiatric services, the OhioRISE Plan must reimburse the hospital at 100% of the current Medicaid FFS rate.
- h. Out-of-Network Providers During Transition
 - i. In accordance with Appendix C, Population Health and Quality, the OhioRISE Plan must reimburse out-of-network providers who provide services during the transition at 100% of the current Medicaid FFS rate.

13. Provider Directory

- a. General
 - i. The OhioRISE Plan's provider directory must include all of the OhioRISE Plan's network providers.
 - ii. The OhioRISE Plan must ensure that the information in the OhioRISE Plan's provider directory exactly matches the data in ODM's provider network management system for the OhioRISE Plan's network providers.

- iii. The OhioRISE Plan's provider directory must be in the format specified by or otherwise prior approved by ODM.
- iv. The OhioRISE Plan's provider directory must include information on how the member can locate available pharmacies, including a link to ODM's provider directory, and how to contact the single pharmacy benefit manager (SPBM). The OhioRISE Plan's provider directory must include information on how the member can search for MCO network providers, including a link to ODM's provider directory, the MCOs' provider directory, and how to contact the MCOs.

b. Content

- i. In accordance with 42 CFR 438.10, the OhioRISE Plan's provider directory must include the following information about each provider:
 - 1. Provider's name as well as any group affiliation;
 - 2. Provider's street address or addresses;
 - 3. Provider's telephone number or numbers;
 - 4. Provider's website URL, as appropriate;
 - 5. Provider's specialty, when applicable;
 - 6. Indication of the provider's office/facility accessibility and accommodations (e.g., clinics, residential facilities), 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/behavioral health interpreter at the provider's office; and
 - 10. Provider's cultural competence training status, when available.
- ii. The OhioRISE Plan'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. The description must clearly identify:
 - a. The services 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.
- c. Printed Provider Directory
 - i. The OhioRISE Plan's printed provider directory format must be approved by ODM prior to distribution. Once approved, the provider directory content may be updated with provider additions or deletions by the OhioRISE Plan without ODM prior-approval. Any revisions to the printed provider directory format must be approved by ODM before distribution. The printed provider directory must be available for on-demand printing using the same data set as that supplying the online provider directory to ensure the same level of accuracy and timeliness of updates.
- d. Online Provider Directory
 - i. The OhioRISE Plan's website must have a link to ODM's provider directory and PNM.
 - ii. The OhioRISE Plan's website must have links to the MCOs' provider directories.
 - iii. The OhioRISE Plan must have an internet-based provider directory.
 - iv. The OhioRISE Plan's internet-based provider directory must comply with 42 CFR 438.242 regarding a publicly accessible standard-based Application Programming Interface (API).
 - v. The OhioRISE Plan's internet-based provider directory must be updated at the same frequency as ODM's online provider directory so that the two are synchronized.
 - vi. The OhioRISE Plan'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.
 - vii. The OhioRISE Plan's internet-based provider directory must be easy to understand, use, and allow members to electronically search for OhioRISE Plan network providers based on, at a minimum, name, provider type, provider specialty, geographic proximity, language, gender, and whether the provider is accepting new Medicaid members.
 - viii. If the OhioRISE Plan's internet-based provider directory includes information for both members enrolled pursuant to this Agreement and for those subject to another agreement with ODM, the OhioRISE Plan must ensure that the results of any search by a member enrolled pursuant to this Agreement only include providers available to such members.

14. Verification of Provider Network Information

- a. General
 - i. ODM contracts with an external quality review organization to conduct telephone surveys of a statistically valid sample of providers' offices to verify information submitted to ODM's provider network management system. ODM will use these results to evaluate OhioRISE Plan performance.

Table F.2 Time and Distance Standards

Specialty	Geographic Type							
	Large Metro		Metro		Micro		Rural	
	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)
Other BH Services – Including Other Licensed Practitioners and Outpatient Hospital	20	10	30	20	50	35	75	60
Community MH Services	20	10	30	20	50	35	75	60
ASAM – Outpatient Services 1.0	20	10	30	20	50	35	75	60
ASAM – Intensive Outpatient Services/Partial Hospitalization Services –2	20	10	45	30	80	60	85	70
ASAM– All levels of Level 3 Residential Services	20	10	45	30	80	60	85	70
ASAM – Ambulatory Withdrawal Management (WM) without Extended On-site Monitoring – 1.0	20	10	30	20	50	35	75	60
ASAM – Ambulatory WM with Extended On-site Monitoring – 2.0	20	10	30	20	50	35	75	60
ASAM – Clinically Managed Residential WM – 3.2	20	10	45	30	80	60	85	70
ASAM – Medically Monitored Inpatient WM – 3.7	20	10	45	30	80	60	85	70

Table F.3 Minimum Number of General Acute Care Hospital and Psychiatric Hospital Providers
(includes Children, Adolescents, and Adults)

County	Inpatient Psych and General Hospital with Psych Units	County	Inpatient Psych and General Hospital with Psych Units	County	Inpatient Psych and General Hospital with Psych Units
ADAMS	0	HAMILTON	1	NOBLE	0
ALLEN	0	HANCOCK	0	OTTAWA	0
ASHLAND	0	HARDIN	0	PAULDING	0
ASHTABULA	0	HARRISON	0	PERRY	0
ATHENS	0	HENRY	0	PICKAWAY	0
AUGLAIZE	0	HIGHLAND	0	PIKE	0
BELMONT	0	HOCKING	0	PORTAGE	0
BROWN	0	HOLMES	0	PREBLE	0
BUTLER	0	HURON	0	PUTNAM	0
CARROLL	0	JACKSON	0	RICHLAND	1
CHAMPAIGN	0	JEFFERSON	0	ROSS	0
CLARK	0	KNOX	0	SANDUSKY	0
CLERMONT	0	LAKE	1	SCIOTO	0
CLINTON	0	LAWRENCE	0	SENECA	0
COLUMBIANA	0	LICKING	0	SHELBY	0
COSHOCTON	0	LOGAN	0	STARK	0
CRAWFORD	0	LORAIN	0	SUMMIT	1
CUYAHOGA	1	LUCAS	1	TRUMBULL	1
DARKE	0	MADISON	0	TUSCARAWAS	0
DEFIANCE	0	MAHONING	0	UNION	0
DELAWARE	0	MARION	0	VANWERT	0
ERIE	0	MEDINA	0	VINTON	0
FAIRFIELD	0	MEIGS	0	WARREN	1
FAYETTE	0	MERCER	0	WASHINGTON	0
FRANKLIN	2	MIAMI	0	WAYNE	0
FULTON	0	MONROE	0	WILLIAMS	0
GALLIA	0	MONTGOMERY	1	WOOD	0
GEAUGA	0	MORGAN	0	WYANDOT	0
GREENE	0	MORROW	0		
GUERNSEY	0	MUSKINGUM	1		

APPENDIX G – PROGRAM INTEGRITY

1. General

- a. The OhioRISE Plan must comply with all applicable state and federal program integrity requirements, including but not limited to those specified in OAC rule 5160-26-06, 42 CFR Part 455, 42 CFR Part 1002, and 42 CFR Part 438 Subpart H.
- b. The OhioRISE Plan 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 OhioRISE Plan 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 OhioRISE Plan's compliance program and its compliance with this Agreement;
 - iv. A system for training and education for the Chief Compliance Officer, the OhioRISE Plan's senior management, and the OhioRISE Plan's employees regarding the OhioRISE Plan's compliance program and the requirements of this Agreement;
 - v. Effective lines of communication between the Chief Compliance Officer and the OhioRISE Plan's employees;
 - vi. Enforcement of standards through well-publicized disciplinary guidelines;
 - vii. A system of designated 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 OhioRISE Plan 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 OhioRISE Plan and ODM;
 - x. Establishment or modification of internal OhioRISE Plan controls to ensure the proper submission and payment of claims; and
 - xi. Prompt reporting to ODM of all instances of suspected fraud, waste, and abuse.
- c. The OhioRISE Plan must develop an Ohio-specific compliance plan that describes the OhioRISE Plan's compliance program for this Agreement and includes the OhioRISE Plan's monitoring and auditing work plan for the upcoming year. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must submit its compliance plan (Compliance Plan), including annual updates, to ODM for approval.
3. Employee Education about False Claims Recovery
- a. Pursuant to 42 CFR 438.608(a)(6), the OhioRISE Plan must provide written policies to all OhioRISE Plan employees, and the employees of any OhioRISE Plan subcontractor or agent, with 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 OhioRISE Plan's policies must include the following whistleblower fraud and abuse reporting contacts:
 - i. ODM by phone at 1-614-466-0722 or online at <http://medicaid.ohio.gov/RESOURCES/HelpfulLinks/ReportingSuspectedMedicaidFraud.aspx>;
 - ii. Ohio Attorney General's Office Medicaid Fraud Control Unit (MFCU) by phone at 1-800-642-2873 or online at <http://www.ohioattorneygeneral.gov/Individuals-and-Families/Victims/Submit-a-Tip/Report-Medicaid-Fraud>; and
 - iii. The Ohio Auditor of State (AOS) by phone at 1-866-FRAUD-OH or by email at fraudohio@ohioauditor.gov.
 - c. The OhioRISE Plan's policies must include detailed provisions regarding the OhioRISE Plan's policies and procedures for preventing and detecting fraud, waste, and abuse.
 - d. The OhioRISE Plan's policies must be included in the OhioRISE Plan's employee handbook.
 - e. The OhioRISE Plan must disseminate its policies to its subcontractors and agents and ensure that its subcontractors and agents abide by these policies.
4. OhioRISE Plan Disclosures
- a. In accordance with 42 CFR 438.608, the OhioRISE Plan must disclose to ODM any prohibited affiliations under 42 CFR 438.610.
 - b. In accordance with 42 CFR 455.104 and OAC rule 5160-1-17.3, the OhioRISE Plan must disclose ownership and control information, including any change in this information.

- c. In accordance with 42 CFR 438.602, the OhioRISE Plan 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 OhioRISE Plan must submit within 35 calendar days of the date requested by ODM or the U.S. Department of Health and Human Services full and complete information about:
 - i. The ownership of any subcontractor with whom the OhioRISE Plan 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 OhioRISE Plan 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 OhioRISE Plan 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.

5. ODM-Enrolled Providers

- a. As specified in Appendix F, Provider Network, the OhioRISE Plan must only contract with and issue payment to providers for service provided when they are enrolled with ODM and are active providers in ODM's provider network management system.
- b. Except as otherwise allowed by federal law or regulations for single case agreements and emergency services, in accordance with 42 CFR 455.410 and this Agreement, the OhioRISE Plan must ensure that any ordering or referring provider is enrolled with ODM and is an active provider in ODM's provider network management system.
- c. In accordance with 42 CFR 438.608, the OhioRISE Plan 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 provider contract is terminated.
- d. The OhioRISE Plan must notify ODM when the OhioRISE Plan denies a request for a provider contract from a provider that is active in ODM's provider network management system, including the reason for the denial. The OhioRISE Plan must indicate the reason or reasons for the denial using ODM-specified reasons.
- e. Except as otherwise provided in Appendix F, Provider Network, the OhioRISE Plan must notify ODM at least 45 calendar days prior to the termination/non-renewal of a provider contract, whether by the OhioRISE Plan or the provider. If the OhioRISE Plan receives less than 45 calendar days' notice of a provider's termination/non-renewal or terminates a

provider contract with less than 45 calendar days' notice, the OhioRISE Plan must notify ODM within one business day of becoming aware of the termination/non-renewal.

- i. The OhioRISE Plan must provide the reason for the termination/non-renewal using ODM-specified reasons.
 - ii. The OhioRISE Plan must only terminate or decline to renew provider contracts for cause, as defined by ODM.
 - iii. The OhioRISE Plan must not suspend, terminate, or decline to renew a provider agreement when the OhioRISE Plan suspects fraud, waste, or abuse until it receives permission from ODM to proceed.
- f. Except for emergency services, the OhioRISE Plan 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 (CHIP).
 - g. When ODM notifies the OhioRISE Plan that a provider has been suspended, the OhioRISE Plan must immediately suspend the provider, including any payments to the provider. The OhioRISE Plan must continue to suspend the provider until it receives notice from the ODM to lift the suspension. When ODM notifies the OhioRISE Plan that a provider is no longer suspended, the OhioRISE Plan must lift the suspension and process any suspended claims.
 - h. The OhioRISE Plan 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.

6. Data Certification

a. General

- i. In accordance with 42 CFR 438.604 and 42 CFR 438.606, the OhioRISE Plan must certify data, documentation, and information submitted to ODM.

b. Submissions

- i. The OhioRISE Plan must submit the appropriate ODM-developed certification concurrently with the submission of the following data, documentation, or information:
 1. Encounter data as specified in Appendix K, Information Systems, Claims, and Data;
 2. Care coordination data, as specified in Appendix D, Care Coordination;
 3. Health Care Effectiveness Data and Information Set (HEDIS) data and Consumer Assessment of Healthcare Providers (CAHPS) data as specified in Appendix I, Quality Measures;
 4. Prompt pay reports, cost reports, and medical loss ratio data, as specified in Appendix L, Payment and Financial Performance;

5. Data submitted to the Ohio Department of Insurance (ODI) to determine that the OhioRISE Plan has made adequate provisions against the risk of insolvency;
6. Documentation used by ODM to certify that the OhioRISE Plan 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;
7. Information on ownership and control as specified in this appendix;
8. Information on overpayment recoveries as specified in this appendix; and
9. Any other data, documentation, or information related to the OhioRISE Plan's obligations under this Agreement as specified by ODM.

c. Source, Content, and Timing of Certification

- i. The above OhioRISE Plan data submissions must be certified by one of the following:
 1. The OhioRISE Plan's Chief Executive Officer (CEO);
 2. The OhioRISE Plan's Chief Financial Officer (CFO); or
 3. An individual who reports directly to the OhioRISE Plan'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 OhioRISE Plan must submit the certification concurrently with the submission of the applicable data, documentation, or information.

7. Explanation of Benefits Mailings

- a. In accordance with to 42 CFR 455.20, the OhioRISE Plan must have a method for verifying with members or caregivers whether services billed by providers were received.
- b. The OhioRISE Plan 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 OhioRISE Plan's members once a year and upon request as directed by ODM.
- c. As an option, the OhioRISE Plan 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 OhioRISE Plan opts to use a targeted mailing, it must submit the proposed strategy in writing to ODM, and receive written prior approval from ODM.
- d. The EOBs mailing must only include those members that have received behavioral health care services within the last six months, comply with all state and federal regulations regarding release of personal health information, outline the recent behavioral health

services identified as having been provided to the member, and request that the member or caregiver report any discrepancies to the OhioRISE Plan.

- e. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must inform ODM of the date of the explanation of benefits (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 OhioRISE Plan 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 OhioRISE Plan's fraud, waste, and abuse plan.
- b. The OhioRISE Plan's proposed SIU staffing must comply with the requirements in Appendix A, General Requirements, and must be included in the OhioRISE Plan's Ohio-specific fraud, waste, and abuse plan described in this appendix.

9. Fraud, Waste, and Abuse Plan

- a. The OhioRISE Plan must have a program that includes administrative and management arrangements or procedures to prevent, detect, and report both internal (e.g., OhioRISE Plan staff) and external (e.g., provider, member, subcontractor) fraud, waste, and abuse.
- b. The OhioRISE Plan must develop and implement an Ohio-specific fraud, waste, and abuse plan for Ohio 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 OhioRISE Plan 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 OhioRISE Plan'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 OhioRISE Plan for the next reporting year based on the results of the risk-based assessment, including the OhioRISE Plan's top five risk areas;
 - iii. A description of the OhioRISE Plan'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 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 prepayment review activities, including but not limited to prepayment 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 utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services.
- v. A description of the OhioRISE Plan'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 OhioRISE Plan will manually review all claims for providers placed on prepayment review status as requested by ODM and how the OhioRISE Plan will identify providers that should be placed on prepayment review and place them on prepayment review if deconfliction approved by ODM;
- vii. A description of how the OhioRISE Plan 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 OhioRISE Plan will vet every allegation of fraud, waste, or abuse and will investigate every allegation that passes vetting;
- ix. A description of how the OhioRISE Plan will track and ensure that at least 3% of total 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 OhioRISE Plan 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 OhioRISE Plan 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 OhioRISE Plan will identify and address overutilization, underutilization, or inappropriate utilization of covered services, including but not limited to review of the OhioRISE Plan'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 OhioRISE Plan to ensure services are rendered and billed correctly.
- d. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must submit its Fraud, Waste, and Abuse plan to ODM for approval on at least an annual basis.

10. Reporting and Investigating Fraud, Waste, and Abuse

a. General

- i. The OhioRISE Plan must promptly report all instances of suspected provider and member fraud, waste, and abuse to ODM.

b. Reporting and Retention of Recovery

- i. If the OhioRISE Plan 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 OhioRISE Plan may share in any recovery from the reported fraud, waste, or abuse. If the OhioRISE Plan fails to properly report a case of suspected fraud, waste, or abuse before the suspected fraud, waste, or abuse is identified by the state or federal authorities, it may not share in any portion of the recovery from the fraud, waste, or abuse.

c. Reporting Provider Fraud, Waste, or Abuse

- i. The OhioRISE Plan must, within one business day identifying suspected provider fraud, waste, or abuse, submit a referral to ODM using the ODM Referral form to ProgramIntegritySIU@medicaid.ohio.gov.
- 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 OhioRISE Plan for additional investigation and recovery, if appropriate. The OhioRISE Plan must request deconfliction before beginning this investigation or recovery.
- iv. ODM will distribute each fraud referral to the OhioRISE Plan.
- v. The OhioRISE Plan must respond to all fraud referrals distributed by ODM pursuant to Section 10.c.iv above by submitting the ODM Attestation form to ODM at ProgramIntegritySIU@medicaid.ohio.gov within 90 calendar days. The OhioRISE Plan's failure to file an attestation promptly, completely, and accurately waives the OhioRISE Plan's right to participate in any MFCU recoveries.

d. Reporting Member Fraud or Abuse

- i. The OhioRISE Plan must, within one business day of learning of suspected member fraud or abuse, report suspected member fraud and abuse to ODM's Bureau of

Program Integrity (BPI) at Program_Integrity_County_Referral@medicaid.ohio.gov and copy the appropriate county department of job and family services (CDJFS).

e. Coordination with Law Enforcement

i. Stand Down

1. The OhioRISE Plan 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 OhioRISE Plan 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 OhioRISE Plan submission of a fraud, waste, or abuse referral to ODM, the OhioRISE Plan must stand down until notified by ODM that the stand down period has ended.
2. The stand down time period will last until any one of the following events has taken place:
 - a. ODM determines there is no credible allegation of fraud contained in the referral;
 - b. MFCU closes its investigation for lack of prosecutorial merit; or
 - c. An initial period of one year, starting when the referral is received by ODM, has passed; 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 terminating a provider for a program integrity reason, the OhioRISE Plan must request deconfliction from ODM and stand down until it receives permission from ODM to proceed.
2. ODM will either grant the deconfliction request or notify the OhioRISE Plan 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 OhioRISE Plan 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 to do so by ODM, the OhioRISE Plan 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 OhioRISE Plan must stand down until the case is closed or completed.

f. Coordinating Provider On-site Audits

- i. The OhioRISE Plan must coordinate on-site provider reviews/audits (announced or unannounced) with ODM and MCOs, and must participate in joint reviews/audits as requested by ODM.

g. ODM Investigation and Recovery

- i. ODM has the right to audit, review, investigate, and recover payment from the OhioRISE Plan's network providers at any time and without notice to the OhioRISE Plan.

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 OhioRISE Plan 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 OhioRISE Plan must require network providers to report to the OhioRISE Plan when it has received an overpayment, to return the overpayment to the OhioRISE Plan within 60 calendar days after the date on which the overpayment was identified, and to notify the OhioRISE Plan in writing of the reason for the overpayment.
- ii. If the MFCU has an open case on a provider, the OhioRISE Plan retains the right to recover any overpayments it identifies arising out of that provider's fraud, waste, or abuse, as defined by OAC rule 5160-26-01, in the following circumstances:
 - 1. The OhioRISE Plan requested deconfliction and received leave to proceed, since there was not a conflict with an active law enforcement investigation; or the deconfliction request was made prior to the date that the MFCU opened its case on the same provider; and
 - 2. The OhioRISE Plan submitted a referral regarding the same provider after completion of its previously approved audit, investigation, or review.
- iii. The OhioRISE Plan 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 OhioRISE Plan had no right of participation; or
 2. The improperly paid funds are currently being investigated by the state of Ohio, are the subject of pending federal or state litigation or investigation, or are being audited by ODM, the AOS, the Centers for Medicare and Medicaid Services (CMS), the Office of Inspector General (OIG), or their agents; or
 3. The overpayments relate to fraud, waste, or abuse, and the MCO has not requested a deconfliction and received leave to proceed. If the OhioRISE Plan obtains funds in cases where recoupment is prohibited by Section 11.b.iii of this appendix, the OhioRISE Plan must notify ODM and take action in accordance with ODM's instructions, which may include forfeiture of the funds.
- iv. Absent any restrictions on recovery, the OhioRISE Plan may otherwise recover from a provider any amount collected from the OhioRISE Plan by ODM, the AOS, the federal government, any other regulatory agency, or their designees, relating to an improper payment to such provider by the OhioRISE Plan that resulted from an audit, review, or investigation of the provider. The OhioRISE Plan retains recovery rights to any amount paid to ODM when a provider self-reports an overpayment arising from a payment made by the OhioRISE Plan to the provider or from another reason.

c. Notice

- i. Prior to recovering an overpayment from a provider, the OhioRISE Plan must give the provider a notice of intent to recover due to an overpayment.
- ii. The OhioRISE Plan must submit the template for its notice of intent to recover an overpayment to ODM for review 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 OhioRISE Plan, the OhioRISE Plan 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. Dispute Process

- i. The OhioRISE Plan must allow the provider 30 calendar days from receipt of the notice to submit a written response disputing the overpayment and/or requesting an extended payment arrangement or settlement. If the provider fails to submit a written response within the time period provided, the OhioRISE Plan may execute the recovery as specified in the notice.
- ii. Upon receipt of a written response disputing the overpayment, the OhioRISE Plan 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 OhioRISE Plan must provide a written notice of determination that includes the rationale for the determination. If the OhioRISE Plan determines the facts justify the recovery, the OhioRISE Plan may execute the recovery within three business days of sending the notice of determination.
- iv. The OhioRISE Plan 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 OhioRISE Plan 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 OhioRISE Plan must provide a written notice of determination and, as applicable, the proposed extended payment arrangement or settlement terms.
 1. The OhioRISE Plan must not settle for less than amount specified in the notice of intent to recover unless there is the inability to collect.
 2. The OhioRISE Plan must submit any extended payment arrangement or settlement terms to ODM for prior approval.
 3. The OhioRISE Plan 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 OhioRISE Plan settles for less than the amount specified in the notice of intent to recover, the OhioRISE Plan must report to ODM the amount specified in the notice and the settlement amount in the quarterly inventory report.
- f. Accounting
 - i. The OhioRISE Plan 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 OhioRISE Plan must void or adjust (as applicable) all claims to reflect any identified provider overpayments, regardless of whether they have been recovered.
 - h. ODM Recovery of Provider Overpayments from the OhioRISE Plan
 - i. If ODM identifies a provider overpayment, ODM will notify the OhioRISE Plan, and the OhioRISE Plan will be responsible for recovering the payment from the provider. Regardless of whether the OhioRISE Plan is able to recover the payment, after six months from notification, ODM will recover the amount of the provider overpayment from the OhioRISE Plan. Recovery will, at ODM's discretion, be effectuated as a remittance by the OhioRISE Plan or a reduction to future capitation payments.
 - i. In accordance with 42 CFR 438.608, provisions regarding treatment of recoveries of provider overpayments made by the OhioRISE Plan 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 OhioRISE Plan Overpayments

- a. In accordance with 42 CFR 438.2, OhioRISE Plan overpayment means any payment made to the OhioRISE Plan by the state of Ohio to which the OhioRISE Plan is not entitled to under Title XIX of the Social Security Act. OhioRISE Plan overpayments include but are not limited to capitation payments made for members who are retroactively disenrolled.
- b. In accordance with 42 CFR 438.608, the OhioRISE Plan must report any OhioRISE Plan overpayments to ODM within 60 calendar days of identifying the overpayment.
- c. ODM will recover OhioRISE Plan overpayments. Recovery will, at ODM's discretion, be effectuated as a remittance by the OhioRISE Plan or a reduction to future capitation payments.
- d. The OhioRISE Plan may recover payments made to a provider for services rendered to a member who was retroactively disenrolled from the OhioRISE Plan in accordance with the following.
 - i. The OhioRISE Plan must initiate such recovery within 30 calendar days of notice of the capitation recovery.

- ii. If the recovery is for payments made more than two years from the date of payment of the provider, the OhioRISE Plan must notify ODM and receive permission to proceed with the recovery.
- iii. The OhioRISE Plan's recovery process must comply with the requirements for recovery of overpayments as described in this appendix. In addition, the OhioRISE Plan 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 OhioRISE Plan.
- iv. The OhioRISE Plan 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 OhioRISE Plan, unless the OhioRISE Plan is directed to do so by CMS or ODM.

13. Cooperation with State and Federal Authorities

- a. The OhioRISE Plan must cooperate fully and promptly with state and federal authorities, including but not limited to ODM, the Ohio Attorney General, the OAS, law enforcement, and the U. S. Department of Health and Human Services.
- b. The OhioRISE Plan 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 OhioRISE Plan must produce copies of all OhioRISE Plan 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 OhioRISE Plan must provide this information within 30 calendar days of the request.
- d. The OhioRISE Plan 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 OhioRISE Plan must provide the requested data, documentation, or other information within 30 calendar days of the request.
- e. The OhioRISE Plan 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 OhioRISE Plan employees, subcontractors, and consultants; and
 - iv. Providing qualified individuals to testify at or be a witness at any hearings, trials, or other judicial or administrative proceedings.
- f. Upon request, the OhioRISE Plan must make available to state and federal authorities any and all administrative, financial, and medical data, documentation, and other information

relating to the delivery of items or services under this Agreement. The OhioRISE Plan must provide such data, documentation, and other information at no cost to the requesting entity.

14. Additional Reporting Requirements

- a. Pursuant to OAC rule 5160-26-06 and as specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must submit an annual fraud, waste, and abuse report (Fraud, Waste, and Abuse Report) to ODM that summarizes the OhioRISE Plan'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 OhioRISE Plan's prevention actions; referrals, reviews, and recoveries; provider terminations; and meeting attendance.
- b. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must provide to ODM a quarterly "inventory" report on fraud, waste, and abuse activities (the Fraud, Waste, and Abuse Inventory Report). The report must include the information specified by ODM, including but not limited to tips received; investigations and audits started; provider referrals; overpayments identified; overpayments recovered; program integrity actions taken against providers; denied network applications; member fraud referrals; cost avoidance as a result of prepayment review activities; and planned fraud, waste, and abuse activities for the upcoming quarter.
- c. The OhioRISE Plan must regularly communicate with ODM about the OhioRISE Plan's program integrity work through the OhioRISE Plan's annual and quarterly reports, regular meetings, and, as needed, additional communications. The OhioRISE Plan 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 OhioRISE Plan 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 OhioRISE Plan's value based payment efforts must include the following:

- i. Value-Oriented Payment

1. The OhioRISE Plan 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 promote the "delivery of effective and efficient health care by their design" reduce unnecessary payment and unnecessary care (e.g., unnecessary non-emergent use of hospital emergency departments due to behavioral health conditions), shift utilization to more evidence-based practices for children, reduce the use of out-of-state placements, and reduce inpatient or psychiatric residential treatment facility (PRTF) days.
 3. For the purposes of this Agreement, "opportunities for practice transformation and added 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 for the Medicaid program" means the level of the quality of care in return for the amount of payment to an individual provider or a network of providers. Payments designed to reflect value are those tied to provider performance or efficiency; payments may rise or fall in a predetermined fashion commensurate with the level of performance assessed against standard quality measures.

- ii. Transparency

1. The OhioRISE Plan must participate in ODM initiatives to design and implement member-accessible comparisons of provider information, including quality, cost, and member experience among providers.

2. The OhioRISE Plan must contribute to the design of ODM initiatives, provide data as specified by ODM, and publish results in accordance with standards established by ODM.

iii. Provider Partnerships

1. The OhioRISE Plan must encourage provider participation in value based payment initiatives, and partner with providers to support the success of these 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.
 - b. Supporting provider readiness (e.g., data and analytic capabilities, financial stability);
 - c. Recognizing that the OhioRISE Plan's payment reform strategies must be tailored to different provider types (e.g., care management entities [CMEs], Mobile Response and Stabilization Services [MRSS], in home behavioral therapy providers) and for different provider characteristics (e.g., small providers, rural providers, hospital systems);
 - d. Assisting providers to identify and address barriers; and
 - e. Encouraging member utilization of providers that demonstrate value and quality.

iv. Payer Partnerships

1. The OhioRISE Plan may initiate, or ODM may require, value based payment initiatives in coordination with ODM, the MCOs, or the single pharmacy benefit manager (SPBM) for special projects or pilot programs that depend on participation across ODM-contracted managed care entities. OhioRISE Plan-initiated value based payment initiatives that involve the MCOs or the SPBM require prior approval by ODM.

v. OhioRISE Plan Proposals for Value Based Payment and Payment Reform Initiatives

1. As early as the date of execution of this agreement, but no later than June 30, 2022, the OhioRISE Plan must provide to ODM an initial proposal as specified in Appendix P, Chart of Deliverables (Proposal for Value Based Payment and Payment Reform Initiatives), for consideration of new or alternate value based care and payment reform initiatives. Subsequent Proposals for Value Based Payment and Payment Reform Initiatives submitted to ODM on an annual basis must provide actionable proposals for

increasingly systemic initiatives that promote the use of alternative payment models and population-based payments.

2. ODM may require, at its sole discretion, that the OhioRISE Plan implement any of the initiatives in the submitted proposals.

2. Alternative Payment Methodology Targets

- a. ODM may impose alternative payment methodology (APM) targets in future years of this Agreement at its sole discretion. Targets may be based on a percentage of overall expenditures by provider type (e.g., 30% of spending on outpatient claims must be tied to an APM).
- b. ODM will notify the OhioRISE Plan at least six months prior to the implementation of any APM targets to allow the OhioRISE Plan to change needed provider agreements.

3. Reporting

- a. The OhioRISE Plan must submit a Value Based Progress Report semi-annually that addresses the OhioRISE Plan's progress towards meeting the requirements for value based payment and APM targets outlined above. The OhioRISE Plan 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:
 - i. Description of the OhioRISE Plan's value based payment strategy;
 - ii. Type and size of providers and provider networks;
 - iii. Objective of each value based payment strategy and progress in meeting each objective;
 - iv. Type of value based payment arrangement as specified by the Health Care Payment Learning and Action Network framework (e.g., 3A or 3B);
 - v. Sum of total medical spend; and
 - vi. Sum of total net payments.

4. Value Based Initiatives

a. General

- i. The OhioRISE Plan must implement the value based initiatives as required in this section of this appendix as directed by ODM.

b. Care Coordination Payments

- i. The OhioRISE Plan must pay CME providers no less than the rates specified in the Medicaid state plan for at least the first two years of the contract term for Tier 3 – Intensive Care Coordination and Tier 2 – Moderate Care Coordination, unless otherwise approved by ODM. ODM may, at its sole discretion, choose to extend this

requirement into future contracting years unless the OhioRISE Plan determines and ODM approves an alternate value based arrangement for these providers.

- ii. The OhioRISE plan is encouraged to immediately pursue value based payment arrangements with CMEs. Within the first two years of the contract, value based payment arrangements for CMEs that differ from the Medicaid state plan payment rates must be approved by ODM prior to implementation.
- c. Mobile Response and Stabilization Services and Intensive Home Based Treatment
 - i. The OhioRISE Plan must pay Mobile Response and Stabilization Services (MRSS) and Intensive Home Based Treatment (IHBT) providers no less than the rates specified in the Medicaid state plan for at least the first two years of the contract term for these services. ODM may, at its sole discretion, choose to extend this requirement into future contracting years unless the OhioRISE Plan determines and ODM approves an alternate value based arrangement for these providers.
- d. Episode Based Payments
 - i. The OhioRISE Plan must implement episode based payments pursuant to OAC rule 5160-19-4, to the extent that the episode based payments are applicable to the benefits provided through the OhioRISE Plan.
 - ii. In the event the OhioRISE Plan has data quality errors with episodes reporting that cause significant errors, as determined by ODM, the OhioRISE Plan must pay applicable positive incentive payments; however, the OhioRISE Plan must not collect the negative incentive payments.
 - iii. Significant errors may include but are not limited to encounter data errors that lead to episodes misattributed to Principal Accountable Providers, encounter data errors that lead to incorrect quality metric results for those tied to payment, and large amounts of missing encounter data that cause misleading or delayed reports.
 - iv. The OhioRISE Plan must pay episode based positive and negative incentive payments within 180 calendar days of when the provider receives the ODM-developed episodes report, unless otherwise specified by ODM.

APPENDIX I – QUALITY MEASURES

1. General

- a. ODM uses the quality measures and standards shown in Table I.1 of this appendix to evaluate OhioRISE Plan performance in key program areas (e.g., access, clinical quality, member satisfaction). The selected measures align with specific priorities, goals, and focus areas of the ODM Quality Strategy.
- b. As part of ODM's Quality Strategy, the OhioRISE Plan must collaborate with the MCOs on certain MCO performance measures that are impacted by the scope of the OhioRISE Plan. The OhioRISE Plan must collaborate with the MCO on the performance measures listed in Table I.2, and must share data to achieve ODM targets for the MCO performance measures. ODM will assess the OhioRISE Plan's collaboration with the MCOs on Table I.2 measures as part of the OhioRISE Plan performance evaluation.
- c. The OhioRISE Plan will also support the MCO in its efforts to improve children's health outcomes. Table I.3 lists MCO performance measures which the OhioRISE Plan will use in contracts with the care management entities (CMEs) to support members and promote their overall health (e.g., well child and adolescent visits, dental visits, immunization status). The MCO/OhioRISE Plan Model Agreement (referenced in Appendix A, General Requirements) executed with each MCO will establish a process for the MCOs to provide information regarding the measures in Table I.3 to the OhioRISE Plan for their members.
- d. Measures utilized for OhioRISE Plan performance evaluation derive from national Systems of Care implementation in Medicaid, and Medicaid managed care, in other jurisdictions. These measures are developed by ODM to measure OhioRISE Plan performance specific to the Ohio Medicaid managed care program service delivery system. For these Table I.1 measures, the OhioRISE Plan must collect and report valid and reliable data in accordance with associated measure specifications, as well as technical guidance and instructions provided by ODM or ODM's External Quality Review Organization conducting validation activities.
- e. Most measures utilized for MCO performance evaluation, on which the OhioRISE Plan will collaborate, derive from national measurement sets (e.g., Healthcare Effectiveness Data and Information Set [HEDIS], Agency for Healthcare Research and Quality [AHRQ]) widely used for evaluation of Medicaid and managed care industry data.
- f. OhioRISE Plan performance measures and any established standards are subject to ODM change based on the revision or update of applicable national measures, methods, benchmarks, or other factors as determined by ODM.
- g. MCO performance measures, any established standards, and the responsibilities of the OhioRISE Plan to collaborate with ODM and the MCOs on MCO performance measures are subject to change by ODM based on the revision or update of applicable national measures, methods, benchmarks, or other factors as determined by ODM.
- h. The establishment of quality measures and standards in this appendix does not limit ODM's evaluation and compliance assessments of other indicators of OhioRISE Plan performance under this Agreement.

- i. ODM will assess and report OhioRISE Plan performance on multiple measures to the OhioRISE Plan and others, including Medicaid members.
2. OhioRISE Plan Quality Measures (Table I.1)
 - a. The OhioRISE Plan must report on all measures described in Table I.1. For state fiscal years (SFY) one and two, measures are for informational/reporting purposes only, and do not have associated standards, incentives, or sanctions.
 - b. ODM will evaluate the OhioRISE Plan on each measure using statewide results.
 - c. ODM will use performance measure results to assess the quality of care provided by the OhioRISE Plan to the enrolled population and ODM may use OhioRISE Plan results for federal reporting and ODM public reporting purposes (e.g., OhioRISE Program report card).
 - d. The OhioRISE Plan must submit aggregated and member-level self-reported and audited data to ODM as described in this appendix.
 - e. The OhioRISE Plan must engage an independent contractor subject to ODM approval with expertise in measure development and implementation of these measures.
 - f. ODM posts the methodology for all measures on the Ohio Medicaid managed care program page of the ODM website.
 - g. All measures in Table I.1 will be reported in accordance with the methodology and time period defined for each measure.
 - h. Minimum performance standards (MSP), incentives, and withholds may be established at the discretion of ODM for subsequent SFY for any Table I.1 measure. ODM will actively seek opportunities to incentivize the OhioRISE Plan for its performance in areas that demonstrate access to and appropriate use of community-based behavioral health services.
3. Reporting on MCO Measures (Table I.2)
 - a. The OhioRISE Plan must report any applicable data to the MCOs for its shared members. For those data elements or measures impacted by the scope of work of the MCO, the OhioRISE Plan must coordinate and collaborate with the MCO to achieve targets.
 - b. The measures, the measurement set, time periods, and the methodology are posted on the Ohio Medicaid managed care program page of the ODM website. The HEDIS measures and HEDIS/Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey measures in Table I.2 are in accordance with *National Committee for Quality Assurance's (NCQA) Volume 2: Technical Specifications and NCQA's Volume 3: Specifications for Survey Measures*, respectively.
4. Collaborating on MCO Measure (Table I.3)
 - a. For all measures in Table I.3, the OhioRISE Plan will provide guidance to the CMEs regarding strategies for enhancing performance towards these measures for OhioRISE Plan members.
 - b. The OhioRISE Plan and MCO will develop strategies to share data and reports that will allow the OhioRISE Plan to develop and oversee CME performance for each measure in Table I.3.

Table I.1. OhioRISE Plan Measures that the OhioRISE Plan will report to ODM. State Fiscal Years 2022, 2023, 2024, and 2025 Performance Measures, Measurements Sets, and Measurement Time Periods

Measure	Measurement Set	SFY 2022 Minimum Perf. Std.	SFY 2022 Measurement Year	SFY 2023 Minimum Perf. Std.	SFY 2023 Measurement Year	SFY 2024 Minimum Perf. Std.	SFY 2024 Measurement Year	SFY 2025 Minimum Perf. Std.	SFY 2025 Measurement Year
<p>Rate of Out-of-Home Placement: Rate of children in out-of-home placement per 1,000 eligible beneficiaries aggregate and by service type for each quarter of the SFY and annual aggregate</p> <p>Methodology: # of enrolled children with a claim for an out-of-home service type X/total # of eligible beneficiaries * 1,000</p>	<p>ODM</p> <p>Source: CANS or Claims</p>	Reporting Only	<p>Quarterly 2022</p> <p>Aggregate Annual 2022</p>	Reporting Only	<p>Quarterly 2023</p> <p>Aggregate Annual 2023</p>	<p>MPS TBD</p>	<p>Quarterly 2024</p> <p>Aggregate Annual 2024</p>	<p>MPS TBD</p>	<p>Quarterly 2025</p> <p>Aggregate Annual 2025</p>
<p>Rate of Out-of-State Residential Placements</p> <p>Methodology: Year One: Report on the # of out-of-state residential placements. Year 2 ODM will develop the specifications for this measure from baseline data collected in Year 1.</p>	<p>ODM</p> <p>Source: Claims</p>	Report Only	<p>Quarterly 2022</p> <p>Aggregate Annual</p>	Possible MPS	<p>Quarterly 2023</p> <p>Aggregate Annual 2023</p>	<p>Possible Quality Withhold</p> <p>Aggregate Annual</p>	<p>Quarterly 2024</p> <p>Aggregate Annual 2024</p>	Possible MPS	<p>Quarterly 2025</p> <p>Aggregate Annual 2025</p>
<p>Length of Stay (LOS) for Behavioral Health (BH) Inpatient Hospitals: Average LOS per utilizer for BH Inpatient Hospital stratified by service type for each quarter of the SFY and annual aggregate</p> <p>Methodology: Sum of LOS for each service type X/# of children in service type X</p>	<p>ODM</p> <p>Source: Claims</p>	Reporting Only	<p>Quarterly 2022</p> <p>Aggregate Annual 2022</p>	Reporting Only	<p>Quarterly 2023</p> <p>Aggregate Annual 2023</p>	<p>MPS TBD</p>	<p>Quarterly 2024</p> <p>Aggregate Annual 2024</p>	<p>MPS TBD</p>	<p>Quarterly 2025</p> <p>Aggregate Annual 2025</p>
<p>LOS for Psychiatric Residential Treatment Facility (PRTF): Average LOS per utilizer for PRTF stratified by service type for each quarter of the SFY and annual aggregate</p> <p>Methodology: Sum of LOS for each service type X/# of children in service type X</p>	<p>ODM</p> <p>Source: Claims</p>	Reporting Only	<p>Quarterly 2022</p> <p>Aggregate Annual 2022</p>	Reporting Only	<p>Quarterly 2023</p> <p>Aggregate Annual 2023</p>	<p>MPS TBD</p>	<p>Quarterly 2024</p> <p>Aggregate Annual 2024</p>	<p>MPS TBD</p>	<p>Quarterly 2025</p> <p>Aggregate Annual 2025</p>

Measure	Measurement Set	SFY 2022 Minimum Perf. Std.	SFY 2022 Measurement Year	SFY 2023 Minimum Perf. Std.	SFY 2023 Measurement Year	SFY 2024 Minimum Perf. Std.	SFY 2024 Measurement Year	SFY 2025 Minimum Perf. Std.	SFY 2025 Measurement Year
<p>Awaiting Discharge: Rate of children in BH Inpatient or PRTF who could be discharged medically but are awaiting discharge per 1,000 eligible beneficiaries by service type for each quarter of the SFY and annual aggregate</p> <p>Methodology: # of enrolled children awaiting discharge from BH Inpatient or PRTF/# of eligible beneficiaries in BH Inpatient or PRTF * 1,000</p>	<p>ODM</p> <p>Source: daily report from BH Inpatient/ PRTF facilities Or possibly Auth</p>	Reporting Only	<p>Quarterly 2022</p> <p>Aggregate Annual 2022</p>	Reporting Only	<p>Quarterly 2023</p> <p>Aggregate Annual 2023</p>	MPS TBD	<p>Quarterly 2024</p> <p>Aggregate Annual 2024</p>	MPS TBD	<p>Quarterly 2025</p> <p>Aggregate Annual 2025</p>
<p>Length of Time Awaiting Discharge: Average LOS per utilizer in BH inpatient or PRTF who could be discharged but are awaiting placements (stuck youth) by service type for each quarter of the SFY and annual aggregate</p> <p>Methodology: Sum of LOS for enrolled children awaiting placement in BH inpatient or PRTF/# of enrolled children in BH Inpatient or PRTF awaiting placement</p>	<p>ODM</p> <p>Source: daily report from BH Inpatient/ PRTF facilities Or possibly Auth</p>	Reporting Only	<p>Quarterly 2022</p> <p>Aggregate Annual 2022</p>	Reporting Only	<p>Quarterly 2023</p> <p>Aggregate Annual 2023</p>	MPS TBD	<p>Quarterly 2024</p> <p>Aggregate Annual 2024</p>	MPS TBD	<p>Quarterly 2025</p> <p>Aggregate Annual 2025</p>
<p>Emergency Department (ED) Utilization: Rate of children with a claim for an ED encounter for BH related issue per 1,000 eligible beneficiaries for each quarter of the SFY and annual aggregate</p> <p>Methodology: # of enrolled children with a claim for an ED encounter for BH/# of enrolled beneficiaries * 1,000</p>	<p>ODM</p> <p>Source: Claims</p>	Reporting Only	<p>Quarterly 2022</p> <p>Aggregate Annual 2022</p>	Reporting Only	<p>Quarterly 2023</p> <p>Aggregate Annual 2023</p>	MPS TBD	<p>Quarterly 2024</p> <p>Aggregate Annual 2024</p>	MPS TBD	<p>Quarterly 2025</p> <p>Aggregate Annual 2025</p>

Measure	Measurement Set	SFY 2022 Minimum Perf. Std.	SFY 2022 Measurement Year	SFY 2023 Minimum Perf. Std.	SFY 2023 Measurement Year	SFY 2024 Minimum Perf. Std.	SFY 2024 Measurement Year	SFY 2025 Minimum Perf. Std.	SFY 2025 Measurement Year
<p>Antipsychotic Medications: Rate of children on any antipsychotic medication stratified by with and without a claim for Medicaid BH service per 1,000 eligible beneficiaries for each quarter of the SFY and annual aggregate</p> <p>Methodology A: # of enrolled children on antipsychotic medication with a claim for Medicaid BH services/# of eligible beneficiaries with a claim for Medicaid BH services * 1,000</p> <p>Methodology B: # of enrolled children on antipsychotic medication without a claim for Medicaid BH services/# of eligible beneficiaries without a claim for Medicaid BH services * 1,000</p>	<p>ODM</p> <p>Source: SPBM</p>	Reporting Only	<p>Quarterly 2022</p> <p>Aggregate Annual 2022</p>	Reporting Only	<p>Quarterly 2023</p> <p>Aggregate Annual 2023</p>	MPS TBD	<p>Quarterly 2024</p> <p>Aggregate Annual 2024</p>	MPS TBD	<p>Quarterly 2025</p> <p>Aggregate Annual 2025</p>
<p>Antipsychotic Medications: Rate of children on 4 or more antipsychotics per 1,000 eligible beneficiaries stratified by age for each quarter of the SFY and annual aggregate</p> <p>Methodology: # of enrolled children on 4 or more antipsychotics/# of eligible beneficiaries * 1,000</p> <p>Ages 0 – 6, 7 – 12, 13 – 17, 18 – 21</p>	<p>ODM</p> <p>Source: Claims</p>	Reporting Only	<p>Quarterly 2022</p> <p>Aggregate Annual 2022</p>	Reporting Only	<p>Quarterly 2023</p> <p>Aggregate Annual 2023</p>	MPS TBD	<p>Quarterly 2024</p> <p>Aggregate Annual 2024</p>	MPS TBD	<p>Quarterly 2025</p> <p>Aggregate Annual 2025</p>

Measure	Measurement Set	SFY 2022 Minimum Perf. Std.	SFY 2022 Measurement Year	SFY 2023 Minimum Perf. Std.	SFY 2023 Measurement Year	SFY 2024 Minimum Perf. Std.	SFY 2024 Measurement Year	SFY 2025 Minimum Perf. Std.	SFY 2025 Measurement Year
Follow-Up After Hospitalization for Mental Illness	NCQA/HEDIS	7-Day Follow-up, Ages 6 – 17 Ages 18-20 Reporting Only	MY 2022	7-Day Follow-up, Ages 6 – 17 Ages 18-20	MY 2023	7-Day Follow-up, Ages 6 – 17 Ages 18-20	MY 2024	MY 2022	7-Day Follow-up, Ages 6 – 17 Ages 18-20
		7-Day Follow-up, Total Reporting Only		7-Day Follow-up, Total Reporting Only		7-Day Follow-up, Total Reporting Only			7-Day Follow-up, Total Reporting Only
		30-Day Follow-up, Total MPS		30-Day Follow-up, Total MPS		30-Day Follow-up, Total MPS			30-Day Follow-up, Total MPS
Mental Health Utilization, all rates (except Inpatient)	NCQA/HEDIS	Reporting Only	MY 2022	Reporting Only	MY 2023	Reporting Only	MY 2024	Mental Health Utilization, all rates (except Inpatient)	NCQA/HEDIS
Mental Health Utilization — Inpatient	NCQA/HEDIS	MPS	MY 2022	MPS	MY 2023	MPS	MY 2024	Mental Health Utilization — Inpatient	NCQA/HEDIS
Follow-Up After ED Visit for Mental Illness	NCQA/HEDIS	7-Day Follow-up Reporting Only	MY 2022	7-Day Follow-up MPS	MY 2023	7-Day Follow-up MPS	MY 2024	Follow-Up After ED Visit for Mental Illness	NCQA/HEDIS
		30-Day Follow-up Reporting Only		30-Day Follow-up MPS		30-Day Follow-up MPS			

Measure	Measurement Set	SFY 2022 Minimum Perf. Std.	SFY 2022 Measurement Year	SFY 2023 Minimum Perf. Std.	SFY 2023 Measurement Year	SFY 2024 Minimum Perf. Std.	SFY 2024 Measurement Year	SFY 2025 Minimum Perf. Std.	SFY 2025 Measurement Year
<p>Timely Access to Services: Rate of timely access to services per 1,000 eligible beneficiaries by Mobile Response and Stabilization Services (MRSS), Intensive Care Coordination (ICC) and Intensive Home Based Treatment (IHBT) service types for each quarter of the SFY and annual aggregate</p> <p>Methodology: # of children with a claim for service X within defined timeframe/# of eligible beneficiaries with a claim for service X * 1,000</p>	<p>ODM</p> <p>Source: Shadow billing within the case rate or provider report</p>	Reporting Only	<p>Quarterly 2022</p> <p>Aggregate Annual 2022</p>	Reporting Only	<p>Quarterly 2023</p> <p>Aggregate Annual 2023</p>	MPS TBD	<p>Quarterly 2024</p> <p>Aggregate Annual 2024</p>	MPS TBD	<p>Quarterly 2025</p> <p>Aggregate Annual 2025</p>
<p>Charged Offenses: Rate of children with any charged offense per 1,000 eligible beneficiaries for each quarter of the SFY and annual aggregate</p> <p>Methodology: # of youth with any charged offense/ # of eligible beneficiaries * 1,000</p>	<p>ODM</p> <p>Source: CANS</p>	Reporting Only	<p>Quarterly 2022</p> <p>Aggregate Annual 2022</p>	Reporting Only	<p>Quarterly 2023</p> <p>Aggregate Annual 2023</p>	MPS TBD	<p>Quarterly 2024</p> <p>Aggregate Annual 2024</p>	MPS TBD	<p>Quarterly 2025</p> <p>Aggregate Annual 2025</p>
<p>Foster Care Placement Disruptions Due to Behavioral Health: Rate of children who had an unplanned change in foster care placement due to a BH issue per 1,000 eligible beneficiaries for each quarter of the SFY and annual aggregate</p> <p>Methodology: # of enrolled youth in foster care who had an unplanned change in placement due to a BH need/# of eligible beneficiaries in foster care * 1,000</p>	<p>ODM</p> <p>Source: CANS or Provider report</p>	Reporting Only	<p>Quarterly 2022</p> <p>Aggregate Annual 2022</p>	Reporting Only	<p>Quarterly 2023</p> <p>Aggregate Annual 2023</p>	MPS TBD	<p>Quarterly 2024</p> <p>Aggregate Annual 2024</p>	MPS TBD	<p>Quarterly 2025</p> <p>Aggregate Annual 2025</p>

Measure	Measurement Set	SFY 2022 Minimum Perf. Std.	SFY 2022 Measurement Year	SFY 2023 Minimum Perf. Std.	SFY 2023 Measurement Year	SFY 2024 Minimum Perf. Std.	SFY 2024 Measurement Year	SFY 2025 Minimum Perf. Std.	SFY 2025 Measurement Year
Suspensions: Rate of suspensions (in-school and out of school) per 1,000 eligible beneficiaries for each quarter of the SFY and annual aggregate Methodology: A: # of eligible beneficiaries suspended/# of eligible beneficiaries enrolled school * 1,000	ODM Source: CANS	Reporting Only	Quarterly 2022 Aggregate Annual 2022	Reporting Only	Quarterly 2023 Aggregate Annual 2023	MPS TBD	Quarterly 2024 Aggregate Annual 2024	MPS TBD	Quarterly 2025 Aggregate Annual 2025
Expulsions: Rate of expulsions per 1,000 eligible beneficiaries for each quarter of the SFY and annual aggregate Methodology: # of eligible beneficiaries who were expelled/# of eligible beneficiaries who were enrolled in school * 1,000	ODM Source: CANS	Reporting Only	Quarterly 2022 Aggregate Annual 2022	Reporting Only	Quarterly 2023 Aggregate Annual 2023	MPS TBD	Quarterly 2024 Aggregate Annual 2024	MPS TBD	Quarterly 2025 Aggregate Annual 2025
CAHPS Family/Youth Rating of Health Plan (Consumer Assessment of Healthcare providers and Systems)	NCQA/ HEDIS/ CAHPS			≥ TBD	MY 2022 (Survey conducted in CY 2023)	≥ TBD	MY 2023 (Survey conducted in CY 2024)	≥ TBD	MY 2024 (Survey conducted in CY 2025)
Satisfaction: Satisfaction Survey for MRSS (Families/Youth)	ODM	Reporting Only	Every 6 months	Reporting Only	Every 6 months	TBD	Annual	TBD	Annual
Satisfaction: Satisfaction Survey for Intensive Care Coordination (Families/Youth)	ODM	Reporting Only	Every 6 months	Reporting Only	Every 6 months	MPS	Annual	MPS	Annual
Satisfaction: Satisfaction Survey for Intensive Home Based Treatment (Families/Youth)	ODM	Reporting Only	Every 6 months	Reporting Only	Every 6 months	TBD	Annual	TBD	Annual
Satisfaction: Satisfaction Survey of OhioRISE Plan providers SFY	ODM	Reporting Only	Annual	Reporting Only	Annual	MPS	Annual	MPS	Annual

Table I.2. MCO Measures that the OhioRISE Plan will report to MCO. State Fiscal Years 2023, 2024, and 2025 Performance Measures, Measurements Sets, and Measurement Years

Measure	Measurement Set	SFY 2023 Minimum Perf. Std.	SFY 2023 Measurement Year	SFY 2024 Minimum Perf. Std.	SFY 2024 Measurement Year	SFY 2025 Minimum Perf. Std.	SFY 2025 Measurement Year
Quality Strategy Population Stream: Behavioral Health for Children and Adults (18 – 20)							
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA/HEDIS	Initiation Total	MY 2022	Initiation Total	MY 2023	Initiation Total	MY 2024
		Engagement Ages 13 – 17 Ages 18-20 Reporting Only		Engagement Ages 13 – 17 Ages 18-20 Reporting Only		Engagement Ages 13 – 17 Ages 18-20 Reporting Only	
Follow-Up After Hospitalization for Mental Illness	NCQA/HEDIS	7-Day Follow-up, Ages 6-17 18-20 Reporting Only	MY 2022	7-Day Follow-up, Ages 6-17 18-20	MY 2023	7-Day Follow-up, Ages 6-17 18-20	MY 2024
		7-Day Follow-up, Total Reporting Only		7-Day Follow-up, Total Reporting Only		7-Day Follow-up, Total Reporting Only	
		30-Day Follow-up, Total Reporting Only		30-Day Follow-up, Total Reporting Only		30-Day Follow-up, Total Reporting Only	
Antidepressant Medication Management — Effective Acute Phase Treatment, Effective Continuation Phase Treatment	NCQA/HEDIS	Acute Phase ≥ TBD	MY 2022	Acute Phase ≥ TBD	MY 2023	Acute Phase ≥ TBD	MY 2024
		Continuation Phase Reporting Only		Continuation Phase Reporting Only		Continuation Phase Reporting Only	
Mental Health Utilization, all rates (except Inpatient)	NCQA/HEDIS	Reporting Only	MY 2022	Reporting Only	MY 2023	Reporting Only	MY 2024
Mental Health Utilization — Inpatient	NCQA/HEDIS	Reporting Only	MY 2022	Reporting Only	MY 2023	Reporting Only	MY 2024
Follow-Up After ED Visit for Mental Illness	NCQA/HEDIS	7-Day Follow-up Reporting Only	MY 2022	7-Day Follow-up Reporting Only	MY 2023	7-Day Follow-up Reporting Only	MY 2024
		30-Day Follow-up Reporting Only		30-Day Follow-up Reporting Only		30-Day Follow-up Reporting Only	
Follow-Up After ED Visit for Alcohol and Other Drug Dependence, Total	NCQA/HEDIS	30-Day Follow-up Reporting Only	MY 2022	30-Day Follow-up Reporting Only	MY 2023	30-Day Follow-up Reporting Only	MY 2024
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics, Total	NCQA/HEDIS	Reporting Only for OhioRISE Plan QW for MCO	MY 2022	Reporting Only for OhioRISE Plan QW for MCO	MY 2023	Reporting Only for OhioRISE Plan QW for MCO	MY 2024

Measure	Measurement Set	SFY 2023 Minimum Perf. Std.	SFY 2023 Measurement Year	SFY 2024 Minimum Perf. Std.	SFY 2024 Measurement Year	SFY 2025 Minimum Perf. Std.	SFY 2025 Measurement Year
Quality Strategy Population Stream: Behavioral Health for Children and Adults (18 – 20)							
Antidepressant Medication Management — Effective Acute Phase Treatment, Effective Continuation Phase Treatment	NCQA/HEDIS	Acute Phase Reporting Only Continuation Phase MPS	MY 2022	Acute Phase Reporting Only Continuation Phase MPS	MY 2023	Acute Phase Reporting Only Continuation Phase MPS	MY 2024
Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder(ADHD) Medication — Initiation Phase	NCQA/HEDIS	Reporting Only	MY 2022	Reporting Only	MY 2023	Reporting Only	MY 2024
Follow-Up Care for Children Prescribed ADHD Medication — Continuation and Maintenance Phase	NCQA/HEDIS	Reporting Only	MY 2022	Reporting Only	MY 2023	Reporting Only	MY 2024
Tobacco Use: Screening and Cessation (Ages 12 – 17)	AMA-PCPI	Reporting Only	MY 2022	Reporting Only	MY 2023	Reporting Only	MY 2024

Table I.3. MCO Measures that the OhioRISE Plan must include in Contracts with CMEs. State Fiscal Years 2023, 2024, and 2025 Performance Measures, Measurements Sets, and Measurement Years

Measure	Measurement Set	SFY 2023 Minimum Perf. Std.	SFY 2023 Measurement Year	SFY 2024 Minimum Perf. Std.	SFY 2024 Measurement Year	SFY 2025 Minimum Perf. Std.	SFY 2025 Measurement Year
Quality Strategy Population Stream: Healthy Children							
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	NCQA/HEDIS	QW for MCO	MY 2022	QW for MCO	MY 2023	QW for MCO	MY 2024
Adolescent Well-Care Visits	NCQA/HEDIS	QW for MCO	MY 2022	QW for MCO	MY 2023	QW for MCO	MY 2024
Kindergarten Readiness	ODM	Collaboration Only	MY 2022	Collaboration Only	MY 2023	Collaboration Only	MY 2024
Chronic Absenteeism	ODM	Collaboration Only	MY 2022	Collaboration Only	MY 2023	Collaboration Only	MY 2024
3rd Grade Reading	ODM	Collaboration Only	MY 2022	Collaboration Only	MY 2023	Collaboration Only	MY 2024
Graduation Rates	ODM	Collaboration Only	MY 2022	Collaboration Only	MY 2023	Collaboration Only	MY 2024
Annual Dental Visits, Total Rate ⁴	NCQA/HEDIS	Collaboration Only	MY 2022	Collaboration Only	MY 2023	Collaboration Only	MY 2024
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Percentile Documentation	NCQA/HEDIS	QW for MCO	MY 2022	QW for MCO	MY 2023	QW for MCO	MY 2024

Note: No standard will be established or compliance assessed for the measures designated 'reporting only' or 'QW' in the Minimum Performance Standard column for the corresponding year.

*** = Minimum Performance Standard will be established for the subsequent state fiscal year*

TBD = Minimum Performance Standard is yet to be determined

QW = Quality Withhold measure (MCO for reference only)

5. Data and Reporting

a. OhioRISE Plan Table I.1 Measures

i. Quarterly and Annual Submission of Data

1. The OhioRISE Plan must collect, report, and submit self-reported, audited data to ODM (see *ODM Specifications for the Submission of OhioRISE Plan Self-Reported, Audited Results* on ODM's website) for the full set of

⁴ HEDIS has proposed that this measure be retired and will be replaced with a new measure prior to the effective date of this Agreement.

measures in Table I.1 reported by the OhioRISE Plan for enrolled members. The OhioRISE Plan must submit its self-reported, audited data to ODM as specified in Appendix P, Chart of Deliverables.

b. OhioRISE Plan Table I.2 Measures

i. Annual Submission of Data

1. The OhioRISE Plan must collect, report, and submit self-reported, audited data for its shared members to each MCO for the full set of measures in Table I.2. The OhioRISE Plan must submit its confirmation of submission of the required performance measure information to each MCO as specified in Appendix P, Chart of Deliverables.

c. OhioRISE Plan Table I.3 Measures

i. Care Management Entity Performance Measures from MCOs

1. The OhioRISE Plan must routinely confirm that performance measurement data from MCOs has been supplied to the CMEs in a timely manner and in accordance with the OhioRISE Plan's contract with the CMEs. The OhioRISE Plan must submit its confirmation of submission of the required performance measure information to the CMEs as specified in Appendix P, Chart of Deliverables.

d. Satisfaction Surveys of Families and Youth Receiving MRSS, ICC, and IHIT

i. Biannual and Annual Submission of Data

1. The OhioRISE Plan will conduct a service-specific survey of families and youth of MRSS, Tier 2 and Tier 3 care coordination, and IHBT to assess satisfaction, access, and quality of services received. The survey tool will be developed in conjunction with ODM, its Member and Family Advisory Council, and others as determined and approved by ODM. OhioRISE Plan must collect, report, and submit self-reported, audited data to ODM (see *ODM Specifications for the Submission of OhioRISE Plan Self-Reported, Audited Results* on ODM's website). The OhioRISE Plan must submit its self-reported, audited data to ODM as specified in Appendix P, Chart of Deliverables.

e. Satisfaction Survey of Providers

i. Annual Submission of Data

1. The OhioRISE Plan will implement a survey of providers to assess satisfaction, access, quality, and provider guidance needed. The survey tool will be developed in conjunction with ODM, its Provider Advisory Council; and approved by ODM. OhioRISE Plan must collect, report, and submit self-reported, audited data to ODM (see *ODM Specifications for the Submission of OhioRISE Plan Self-Reported, Audited Results* on ODM's website). The

OhioRISE Plan must submit its self-reported, audited data to ODM as specified in Appendix P, Chart of Deliverables.

f. HEDIS Data

i. Annual Submission of HEDIS Interactive Data Storage System Data

1. The OhioRISE Plan must collect, report, and submit self-reported, audited HEDIS data to ODM (see *ODM Specifications for the Submission of OhioRISE Plan Self-Reported, Audited HEDIS Results* on ODM's website) for the HEDIS measures in Table I.1. The OhioRISE Plan must submit its self-reported, audited HEDIS data to ODM as specified in Appendix P, Chart of Deliverables.

ii. Annual Submission of HEDIS Final Audit Report

1. The OhioRISE Plan must submit its HEDIS Final Audit Report that contains the audited results for the HEDIS measures in Table I.1 for enrolled members to ODM (see *ODM Specifications for the Submission of OhioRISE Plan Self-Reported, Audited HEDIS Results* on ODM's website). The OhioRISE Plan must submit its HEDIS Final Audit Report to ODM as specified in Appendix P, Chart of Deliverables.

g. Data Certification Requirements for HEDIS Interactive Data Storage System Data and HEDIS Final Audit Report

i. General

1. In accordance with 42 CFR 438.604 and 42 CFR 438.606 and ODM requirements, the OhioRISE Plan 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. The OhioRISE Plan must submit these data certification letters per the instructions and by the due dates provided in the *ODM Specifications for the Submission of OhioRISE Plan 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 OhioRISE Plan's Chief Executive Officer (CEO), Chief Finance Officer (CFO) or an individual who reports directly to the OhioRISE Plan'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. Annual Submission of Member Level Detail Records for Specified HEDIS Measures

1. The OhioRISE Plan must submit member-level detail records for specific HEDIS measures to the MCOs, in accordance with *ODM Specifications for the Submission of OhioRISE Plan Self-Reported, Audited HEDIS Results*. The required member-level detail will be used to meet Centers for Medicare and

Medicaid Services (CMS) reporting requirements for the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set).

6. Additional Operational Considerations

a. Measures and Measurement Periods

- i. ODM reserves the right to revise the measures and measurement time periods 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 OhioRISE Plan's performance level for that contract period.

b. Performance Standards – Compliance Determination

- i. In the event that the OhioRISE Plan's performance cannot be evaluated for a performance measure and measurement time period established in Table I.1 of this appendix, ODM in its sole discretion will determine whether the OhioRISE Plan has or has not met the standard(s) for that particular measure and measurement time period depending on the circumstances involved. For example, if ODM assigned a "Not Report" audit result on a measure on the OhioRISE Plan's Final Audit Report and the "Not Report" designation was determined to be the result of a material bias caused by the OhioRISE Plan, ODM would deem the OhioRISE Plan not to have met the standard(s) for that measure and measurement time period.

c. Performance Standards – Retrospective Adjustment

- i. ODM will implement the use of a uniform methodology as needed for the retrospective adjustment of any MPS listed in Table I.1 of this appendix, except for the CAHPS measure standards. ODM will implement this methodology at ODM's sole discretion.

d. Standard Adjustment Methodology

- i. For a comprehensive description of the standard adjustment methodology, see ODM Methods for the Retrospective Adjustment of Quality, P4P and Quality Withhold Measure Standards on ODM's website.

APPENDIX J – QUALITY WITHHOLD OR INCENTIVE

7. Quality Withhold or Incentive Program

- a. ODM is not imposing a quality withhold program on the OhioRISE Plan in state fiscal year (SFY) 2022 or 2023. Additionally, ODM is not imposing an incentive program on the OhioRISE Plan in SFY 2022. ODM may implement a quality withhold or incentive program in any future SFY at its sole discretion.
- b. Any quality withhold or incentive program will be conducted in accordance with 42 CFR 438.6(b)(2) and (3).
- c. Any quality withhold or incentive program will be designed to improve quality measure outcomes tied to the goals and objectives described in Appendix C, Population Health and Quality, and Appendix I, Quality Measures, of this Agreement.
- d. ODM will notify the OhioRISE Plan at least six months prior to the implementation of any quality withhold or incentive program.

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 OhioRISE Plan 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 OhioRISE Plan membership terminations for reasons other than loss of Medicaid eligibility.
2. The OhioRISE Plan 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 OhioRISE Plan must collect data on member and provider characteristics and on all services furnished to its members.
4. The OhioRISE Plan must ensure data received from providers is accurate and complete by verifying the accuracy and timeliness of reported data, screening the data for completeness, logic, and consistency, and collecting service information in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies used for ODM's quality improvement and care coordination efforts.
5. The OhioRISE Plan must make all collected data available upon request by ODM or the Centers for Medicare and Medicaid Services (CMS).

b. ODM Access to the OhioRISE Plan's Systems and Data

- i. The OhioRISE Plan 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 OhioRISE Plan must provide ODM the schematic, data dictionary, and other systems documentation necessary for ODM to interpret and use the data.
- ii. The OhioRISE Plan (including subcontractors) must provide ODM staff query access to real-time operational data and information relevant to members.
- iii. The OhioRISE Plan'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. Data and Systems Integration

- i. The OhioRISE Plan must have an integrated system that allows the different OhioRISE Plan functions to work seamlessly within the OhioRISE Plan.
- ii. If the OhioRISE Plan has separate claims processing systems for physical and behavioral health, the OhioRISE Plan 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 OhioRISE Plan receives claims containing both physical and behavioral health services, the OhioRISE Plan must adjudicate both service types without requiring resubmission.
- iii. The OhioRISE Plan must collect data from all subcontractors relevant to care of its members and integrate that data into the OhioRISE Plan's systems.
- iv. The OhioRISE Plan's system must capture and maintain all ODM-identified data necessary to support business functions.
- v. The OhioRISE Plan's system must integrate data with all Ohio Medicaid Enterprise System (OMES) modules (e.g., member module, provider module, fiscal intermediary module), through the systems integrator in real-time and batch (based on data currency needs), to support the Ohio Medicaid managed care program.
- vi. The OhioRISE Plan'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.
- vii. The OhioRISE Plan's system must use role-based authorization and access to ensure minimal necessary access to data and screens.
- viii. The OhioRISE Plan must have the ability to submit, accept, and integrate all data transmission protocols necessary to support the Ohio Medicaid managed care program, including internal and external entities.
- ix. The OhioRISE Plan must comply with the population health information system and data requirements in Appendix C, Population Health and Quality.
- x. The OhioRISE Plan must comply with the care coordination information system and data requirements in Appendix D, Care Coordination.
- xi. The OhioRISE Plan must accept, maintain, and use data received from ODM or the MCOs related to behavioral health services provided to members who are enrolled in the MCO and OhioRISE Plan. This includes but is not limited to care coordination data, including the name of the member's care coordinator and contact information, assessments, care plans, critical incidents, and admission, discharge, and transfer (ADT) data; prior authorization data; and claims adjudication data. The OhioRISE Plan must use this data to support its responsibilities under this Agreement, including but not limited to ensuring members are receiving necessary services, informing the OhioRISE Plan's efforts to assist MCOs with their population health activities, risk stratification, supporting care coordination activities, and informing quality improvement (QI) activities.

- xii. The OhioRISE Plan must provide data to the MCOs and/or ODM as directed by ODM. This data may include but is not limited to assessment data, child and family centered plans, population health data, care coordination data, prior authorization data, admission, discharge, and transfer (ADT) data, and claims data.
- xiii. The OhioRISE Plan must accept, maintain, and use pharmacy data received from ODM or the single pharmacy benefit manager (SPBM). This includes but is not limited to real-time access to view targeted member pharmacy data, including claims adjudication and prior authorization data, daily pharmacy claims data, and daily prior authorization data. The OhioRISE Plan must use this data to support its responsibilities under this Agreement, including but not limited to ensuring members are receiving necessary pharmacy services, developing and monitoring medication therapy management (MTM) activities, informing the OhioRISE Plan's efforts to assist the MCO's with their population health activities, risk stratification, identifying members in need of care coordination, assisting ODM, MCOs and SPBM with prescriber education, supporting care coordination activities, and informing QI activities.
- xiv. The OhioRISE Plan must provide data to the SPBM and/or ODM as directed by ODM. This data may include but is not limited to population health data, care coordination data, MTM data, claims data, diagnosis codes on claims and prior authorization data.

d. General

- i. If the OhioRISE Plan has systems and information technology staff and operations supported at the enterprise-level, the OhioRISE Plan 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 OhioRISE Plan must conduct thorough end-to-end testing for all new program implementations, system upgrades, software updates, and new or revised data requirements. The OhioRISE Plan 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 OhioRISE Plan'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 OhioRISE Plan's systems and user environment must comply with National Institute of Standards and Technology (NIST) 800-53 R4 (or current release) moderate baseline and Minimum Acceptable Risk Standards for Exchanges (MARS-e) 2.0 (or current release) or a similar standard that demonstrates comparable controls by mapping a crosswalk to NIST 800-53 and MARS-e.
- v. The OhioRISE Plan's application systems foundation must employ a relational data model in its architecture (RDBMS). The OhioRISE Plan's application systems must

support query access using Structure Query Language. The OhioRISE Plan's application systems must support open database connectivity (ODBC) and/or Object Linking and Embedding (OLE).

- vi. The OhioRISE Plan must implement updates to national standard code sets as of their effective date. The OhioRISE Plan must implement any other ODM specified updates (e.g., fee schedule changes) within 30 calendar days unless otherwise specified by ODM.
- vii. The OhioRISE Plan 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 OhioRISE Plan prior to implementation and when the OhioRISE Plan undergoes a major information system upgrade or change, when there is identification of significant information system problems, or at ODM's discretion.
- b. The OhioRISE Plan must support the needs of reviewers.
- c. The review will assess the extent to which the OhioRISE Plan 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 OhioRISE Plan must complete;
 - ii. Review the completed ISCA and accompanying documents;
 - iii. Conduct interviews with OhioRISE Plan staff responsible for completing the ISCA, as well as staff responsible for the OhioRISE Plan's information systems;
 - iv. Analyze the information obtained through the ISCA, conduct follow-up interviews with OhioRISE Plan staff, and write a statement of findings about the OhioRISE Plan's information system;
 - v. Assess the ability of the OhioRISE Plan to link data from multiple sources;
 - vi. Examine OhioRISE Plan processes for data transfers;
 - vii. If the OhioRISE Plan has a data warehouse, evaluate its structure and reporting capabilities;
 - viii. Review OhioRISE Plan 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 OhioRISE Plan.

3. Business Continuity and Disaster Recovery

- a. The OhioRISE Plan 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 OhioRISE Plan'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 OhioRISE Plan 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 OhioRISE Plan must provide a summary of its BC-DR test results (Summary of BC-DR Plan Test Results), including any corrective actions, to ODM within 30 calendar days of receiving the results.

4. Acceptance Testing

a. General

- i. The OhioRISE Plan must conduct acceptance testing of any data electronically submitted to ODM as follows:
 1. Before the OhioRISE Plan may submit production files;
 2. Whenever the OhioRISE Plan changes the method, preparer, or file layout of the electronic data; and/or
 3. When ODM determines that the OhioRISE Plan's data submissions have an error or failure rate of 2% or higher.

b. New or Modified Information System

- i. The OhioRISE Plan 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 components 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.

- ii. User acceptance testing must include training if there is a perceivable change to workflows or user screens.
- iii. Data files that are submitted to ODM must be tested and accepted prior to implementing in production. ODM will notify the OhioRISE Plan in writing when a test has been deemed successful and the changes are approved.
- iv. ODM reserves the right to verify the OhioRISE Plan'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 OhioRISE Plan must accept claims for 365 calendar days from the date of service.

b. Claims Adjudication

- i. The OhioRISE Plan must integrate with the fiscal intermediary for claims, third party liability (TPL), authorizations, and any other types of data or processes as directed by ODM.
- ii. The OhioRISE Plan must electronically accept claims from the fiscal intermediary and adjudicate all claims to final status (payment or denial) within the timeframes specified in Appendix L, Payment and Financial Performance. The diagram in Exhibit K.1 provides a high-level overview of the claims flow.
- iii. The OhioRISE Plan must provide updated claims status demonstrating all claims activity on a daily basis to ODM.
- iv. The OhioRISE Plan must provide its network providers detailed instructions on claims submission procedures, including information provided by ODM about the role of ODM's fiscal intermediary, prior to the provider's delivery of services pursuant to this Agreement.
- v. The OhioRISE Plan must provide out-of-network providers detailed instructions on claims submission procedures, including information provided by ODM about the role of ODM's fiscal intermediary, within one business day 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.
- vi. The OhioRISE Plan must notify providers via ODM's fiscal intermediary, who have submitted claims of claims status (paid, denied, and all claims not in a final paid or denied adjudicated status [hereinafter referred to as "pending/suspended"]) within 30 calendar days of receipt by the OhioRISE Plan 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.

- vii. If a provider and/or a provider's clearinghouse submits a Health Insurance Portability and Accountability Act (HIPAA) compliant 276 electronic data interchange (EDI) transaction to the OhioRISE Plan and/or the OhioRISE Plan's clearinghouse via ODM's fiscal intermediary, the OhioRISE Plan/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 pending claims to the submitter.
 - viii. The OhioRISE Plan must accept and use, and must require its providers to use, third party liability (TPL) data maintained by ODM's fiscal intermediary for the OhioRISE Plan's and provider's TPL activities.
- c. Edits
 - i. The OhioRISE Plan must implement claims edits (e.g., Strategic National Implementation Process [SNIP], National Correct Coding Initiative [NCCI]) at the direction of ODM.
- d. Grouping Methodology
 - i. When the OhioRISE Plan uses a grouping methodology to pay inpatient and/or outpatient hospital claims the OhioRISE Plan is expected to use the same grouper software and inpatient only procedure listing (determined by Medicare, 3M, or other grouping product) that ODM uses to process fee-for-service (FFS) claims.
- e. Systems Audit
 - i. The OhioRISE Plan and any subcontractor systems must undergo an annual third party audit that confirms that the OhioRISE Plan's systems and environment comply with the NIST 800-53 Rev 4 (or current release) moderate baseline.
 - ii. The OhioRISE Plan and any subcontractor systems must also utilize a third party to determine compliance with MARS-E 2.0 (or current release) standards.
 - iii. If the OhioRISE Plan or any subcontractor systems utilizes a cloud hosting provider, the cloud provider must be Fed-RAMP certified or undergo an annual third party audit that certifies compliance with NIST 800-53 Rev 4 (or current version) moderate baseline.
 - iv. The OhioRISE Plan, 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.
 - v. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must submit the results of the systems audit (Systems Audit Results), including any corrective action, to ODM within two weeks of receiving the final report.

f. Claims Payment Systemic Errors

- i. For the purpose of this appendix, a claims payment systemic error (CPSE) is defined as the OhioRISE Plan's claims adjudication incorrectly underpaying, overpaying, denying, or suspending claims that impact, or has the potential to impact, five or more providers.
- ii. The OhioRISE Plan must submit the OhioRISE Plan's CPSE report (CPSE Report) to ODM as specified in Appendix P, Chart of Deliverables.
- iii. The OhioRISE Plan must submit all communications regarding CPSEs to MedicaidCPSE@medicaid.ohio.gov, unless otherwise directed by ODM.
- iv. The OhioRISE Plan must follow all CPSE instructions as directed by ODM, including the CPSE reporting template instructions and guidelines.
- v. The OhioRISE Plan must report systemic errors to ODM within two business days of adjudication or identification, whichever is earlier. The OhioRISE Plan must update the status of all active CPSEs on a weekly basis. The OhioRISE Plan 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 OhioRISE Plan must ensure each identified error has a unique error ID to tie each reported line to a specific error the OhioRISE Plan is addressing. For each error, the OhioRISE Plan 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 weekly 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 OhioRISE Plan must report all CPSEs on a monthly CPSE report posted on the OhioRISE Plan's Ohio Medicaid website.
 1. The CPSE report must be public facing for anyone to view and/or on the OhioRISE Plan'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 OhioRISE Plan must update the CPSE report at a minimum once a month and must label the report to reflect the updated date.
3. The OhioRISE Plan'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 OhioRISE Plan must have policies and procedures to identify, communicate, and correct CPSEs. The OhioRISE Plan must keep its CPSE policies and procedures current to reflect the CPSE requirements. Upon request, the OhioRISE Plan must submit its CPSE policies and procedures to ODM for review.
- viii. The OhioRISE Plan'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.

g. Non-CPSE Errors

- i. The OhioRISE Plan 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.

h. Software Updates

- i. The OhioRISE Plan's claims adjudication systems must apply software updates based on a validated risk analysis and no less frequently than quarterly. The OhioRISE Plan must implement major software version releases based on a validated risk analysis and not less than 180 calendar days from release date. If the OhioRISE Plan maintains its own software, the schedule and description of changes for future updates must be provided to ODM for review and approval.

i. Implementing ODM Rate Changes

- i. The OhioRISE Plan 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 OhioRISE Plan's system(s) are updated. If necessary, the OhioRISE Plan 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.

j. Processing Delays

- i. The OhioRISE Plan must not engage in any practice that unfairly or unnecessarily delays the processing or payment of any claim for services to a member.

k. Notice to Providers

- i. The OhioRISE Plan 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 OhioRISE Plan must provide a notice of intent to recover an overpayment in accordance with Appendix G, Program Integrity.

6. Electronic Data Interchange

- a. The OhioRISE Plan's technology strategy and systems must have the capability to accept and transmit real-time transactions as directed by ODM.
- b. The OhioRISE Plan must comply with all applicable provisions of HIPAA, including EDI standards for code sets and the following electronic transactions:
 - i. ASC X12 837 – Health care claims (institutional, professional, and dental);

- ii. ASC X12 837 Post-adjudicated claims data reporting (PACDR) — Health care claims (institutional, professional, and dental);
 - iii. ASC X12 270/271 – Eligibility and benefit verification and response;
 - iv. ASC X12 276/277 – Health care claim status request and response;
 - v. ASC X12 Unsolicited 277 Claim Status transaction and/or the 277 Claim Acknowledgement (CA);
 - vi. ASC X12 269 – Health care benefit coordination verification;
 - vii. ASC X12 274 – Health care provider information/directory;
 - viii. ASC X12 275 – Patient information;
 - ix. ASC X12 278 – Authorization/referral request and response;
 - x. ASC X12 824 – Application Advice; and
 - xi. ASC X12 835 – Health care payment and remittance status (or electronic funds transfer).
- c. The OhioRISE Plan must implement EDI transactions in conformance with the appropriate version of the transaction implementation guide, as specified by applicable federal requirements.
- d. The OhioRISE Plan must be able to accept, send, and process multiple versions of X12 transactions concurrently.
- e. The OhioRISE Plan must have the capacity to accept the following transactions consistent with EDI processing specifications in the transaction implementation guides and in conformance with the 820 and 834 Transaction Companion Guides issued by ODM:
 - i. ASC X12 820 – Payroll deducted and other group premium payment for insurance products; and
 - ii. ASC X12 834 – Benefit enrollment and maintenance.
- f. The OhioRISE Plan must comply with the HIPAA-mandated EDI transaction standards and code sets as set forth in federal requirements. The OhioRISE Plan must keep codes up to date and meet all implementation dates as directed by ODM.
- g. The capacity of the OhioRISE Plan 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 OhioRISE Plan must complete and submit to ODM an EDI trading partner agreement by the timeframe and in a format specified by ODM.
- i. If the OhioRISE Plan 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.

7. Encounter Data Submission Requirements

- a. The OhioRISE Plan must collect data on services furnished to members through a claims system and must report encounter data to ODM. The OhioRISE Plan must submit encounters electronically to ODM as specified in this appendix.
- b. Information concerning the proper submission of electronic data interchange (EDI) encounter transactions is available on ODM's website. ODM's website contains Encounter Data Companion Guides for the Managed Care 837 professional, and institutional transactions. Additional Companion Guides for transactions that should be used in conjunction with encounters, including the U277 Unsolicited Claim/Encounter Status Notifications, the 824 Application Advice, and the TA1 Transmission Acknowledgement are also available on ODM's website. The OhioRISE Plan must use the Encounter Data Companion Guides in conjunction with the X12 Implementation Guides for EDI transactions.
- c. The OhioRISE Plan 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 OhioRISE Plan submitting production encounter data files.
- d. For subcontracted payment arrangements in which the subcontractor directly pays particular claims (i.e., delegated arrangements in which the delegate is responsible for paying claims on behalf of the OhioRISE Plan to providers), the OhioRISE Plan 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 OhioRISE Plan 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 OhioRISE Plan must submit encounters no later than seven calendar days from completion of the claim (i.e., remittance advice generated). The OhioRISE Plan 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 OhioRISE Plan must submit a certification letter with the submission of an encounter data file.
- h. The OhioRISE Plan must submit valid encounter submissions that include the application of specific edits, including checking for member eligibility, OhioRISE Plan 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 OhioRISE Plan's editing and payment.

- i. The OhioRISE Plan must submit valid claim and line-level denials that reflect the data submitted on the claim and accurately reflect the adjudication results.
- j. The OhioRISE Plan must submit encounters for all claim activities, including instances when the OhioRISE Plan applies adjustments at the individual line level or in a mass adjustment update. Encounter submissions must reflect all claims activity.
- k. The OhioRISE Plan must have software edits that check for and prevent duplicates on encounter data submissions.
- l. The OhioRISE Plan must follow the 837 PACDR standards for encounter data submissions.
- m. The OhioRISE Plan must have processes and staffing to ensure that if ODM discovers errors or a conflict with a previously adjudicated encounter or claim, the OhioRISE Plan is able to adjust or void the encounter within the specified number of days as directed by ODM.
- n. The OhioRISE Plan must comply with the encounter data quality measures as calculated by ODM. Information concerning ODM's encounter data quality measures, including the methodology, is available in the Methodology for Encounter Data Quality Measures document located on the ODM website. ODM reserves the right to revise this document as needed.
- o. Exceptions to any of the requirements in this section must be prior approved by ODM.

8. Non-Claims Data Submission Requirements

- a. All data on any services provided to members that are not reflected as claims or encounters will be submitted through the fiscal intermediary and forwarded to the OhioRISE Plan. This includes but is not limited to care coordination and other value-added/additional services.
- b. The OhioRISE Plan must collaborate with the state's OMES systems integrator for the integration of the OhioRISE Plan'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 file transfer protocol (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 OhioRISE Plan 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 OhioRISE Plan 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 OhioRISE Plan must submit an annual 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 OhioRISE Plan's activities to support provider adoption and effective use of EHRs.

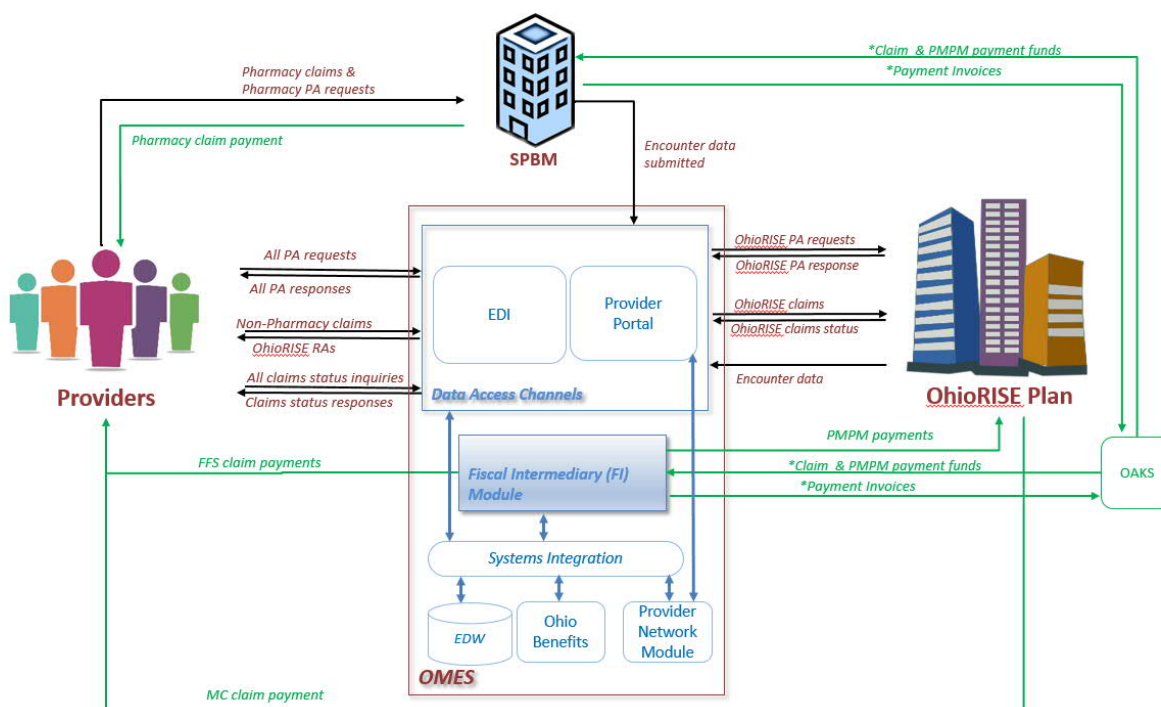
10. Health Information Exchanges

- a. The OhioRISE Plan must participate with both of Ohio's health information exchanges (HIEs) and be capable of exchanging protected health information, connecting to inpatient and ambulatory electronic health records, connecting to care coordination information technology system records, and supporting secure messaging or electronic querying between providers, patients, and the OhioRISE Plan. This must include but is not be limited to using the HIEs for admission, discharge, and transfer (ADT) data and closing referral loops for social determinants of health (SDOH).
- b. The OhioRISE Plan will be required to assess each CME's ability to provide data in an electronic format (e.g. EHR) to the OhioRISE portal and provide the necessary technical assistance to CMEs to participate with Ohio's two HIEs.
- c. The OhioRISE Plan must require its network hospitals to provide ADT data to both HIEs.
- d. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must submit an annual report (Network Provider HIE Participation Report) to ODM providing the number and percentage of network providers, by provider type, connected to one or both HIEs and the type of participation.
- e. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must submit to ODM an annual plan to support use of EHRs and HIEs (EHR and HIE Provider Support Plan), including, for example, offering incentives for providers to join an HIE.

11. Interoperability

- a. In accordance with 42 CFR 438.242, the OhioRISE Plan must implement and maintain an application programming interface (API) that permits third party applications to retrieve, with the approval and at the direction of a member, member health information and data maintained by the OhioRISE Plan.
- b. In accordance with 42 CFR 438.62, the MCO must implement a process for the electronic exchange of the United States core data for interoperability (USCDI) data classes and elements with MCOs, the SPBM, ODM, and any other payer designated by the member.
- c. The OhioRISE Plan must implement a process for the electronic exchange of the USCDI data classes and elements with care coordination entities and providers serving 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 OhioRISE Plan 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 OhioRISE Plan during the month via a monthly remittance advice (RA).
- c. ODM will provide a record of each recipient detail level payment via Health Insurance Portability and Accountability Act (HIPAA) compliant 820 transactions.

2. Submission of Financial Statements

a. Quarterly and Annual NAIC Financial Statements

- i. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan 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 OhioRISE Plan must provide ODM with an electronic copy of the NAIC statements in the NAIC-approved format.
- iv. The OhioRISE Plan must submit NAIC financial statements to ODM even if the Ohio Department of Insurance (ODI) does not require the OhioRISE Plan to submit these statements to ODI.

b. Annual NAIC/Cost Report Reconciliation

- i. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must submit an annual NAIC/cost report reconciliation (NAIC/Cost Report Reconciliation).

c. Health Insuring Corporation Tax

- i. As specified in Appendix P, Chart of Deliverables, the MCO must submit quarterly Health Insuring Corporation (HIC) tax reports (HIC Tax Report) to ODM.

d. Other Financial Reports and Information

- i. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must submit annually, and upon ODM's request, information that shows all profit and losses at the entity level for administrative or health care services provided through a subcontract, first tier, downstream, and related entities (FDR) agreement, or cost allocation agreement with an entity that is a related party (Related Party Profit and Loss Report).

- ii. The OhioRISE Plan must maintain a system to evaluate and monitor the financial viability of all risk bearing subcontractors, FDRs, or network providers, including but not limited to accountable care organizations (ACOs), health maintenance organizations (HMOs), and all other risk-bearing OhioRISE Plan subcontractors.
- iii. The OhioRISE Plan must provide any financial reports and information as deemed necessary by ODM, in a format determined by ODM, to properly monitor the financial condition of the MCO, its subcontractors, FDRs, and network providers.

3. Financial Performance Measures and Standards

- a. The OhioRISE Plan must comply with the following financial performance measures and standards.
 - i. Current Ratio
 - 1. The OhioRISE Plan's current ratio, calculated in accordance with the ODM Methods for Financial Performance Measures, must not fall below 1.00.
 - ii. Medical Loss Ratio
 - 1. As specified in Appendix P, Chart of Deliverables, the MCO must submit an annual medical loss ratio (MLR) reporting tool and documentation (MLR Reporting Tool and Documentation).
 - iii. Defensive Interval
 - 1. The OhioRISE Plan's defensive interval, calculated in accordance with the ODM Methods for Financial Performance Measures, must not fall below 30 calendar days.

4. Insurance Requirements

- a. General
 - i. The OhioRISE Plan 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 OhioRISE Plan's performance under this Agreement.
 - ii. The OhioRISE Plan 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 OhioRISE Plan'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 OhioRISE Plan 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 OhioRISE Plan is a sole proprietor, partnership, or has no statutory requirement for workers' compensation, the OhioRISE Plan 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 OhioRISE Plan's policy is written on a "claims made" basis, the OhioRISE Plan 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 OhioRISE Plan must purchase and maintain "tail" coverage through the applicable statute of limitations.
 5. Technology Professional Liability (Errors and Omissions) insurance: appropriate to the OhioRISE Plan's professional services provided under this Agreement, with limits of 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 OhioRISE Plan in this Agreement and must cover all applicable OhioRISE Plan 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 OhioRISE Plan 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 OhioRISE Plan under this Agreement.

c. Required Provisions

- i. The OhioRISE Plan'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 OhioRISE Plan 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 OhioRISE Plan's insurance.

- 2. Primary Coverage

- a. For any claims related to this Agreement, the OhioRISE Plan'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 OhioRISE Plan's insurance and must not contribute with it.

- 3. Umbrella or Excess Insurance Policies

- a. The OhioRISE Plan 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 OhioRISE Plan 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 OhioRISE Plan must grant to the state of Ohio a waiver of any right to subrogation, which any insurer of the OhioRISE Plan may acquire against the state of Ohio by virtue of the payment of any loss under such insurance.
- ii. The OhioRISE Plan must obtain any endorsement necessary to affect this waiver of subrogation; however, the waiver of subrogation provision applies regardless of whether or not the state of Ohio has received a waiver of subrogation endorsement from the insurer.

f. Deductibles and Self-Insured Retentions

- i. Deductibles and self-insured retentions must be declared to and approved by ODM. ODM may require the OhioRISE Plan 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 OhioRISE Plan 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 OhioRISE Plan 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 OhioRISE Plan'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 OhioRISE Plan must require and verify that all subcontractors maintain insurance meeting all the requirements stated herein, and the OhioRISE Plan 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.

5. Reinsurance Requirements

a. General

- i. The OhioRISE Plan must carry reinsurance coverage from a licensed commercial carrier to protect against catastrophic inpatient-related behavioral health expenses (including Psychiatric Residential Treatment Facilities [PRTF]) incurred by members.
- ii. To the extent that the risk for inpatient-related medical expenses is transferred to a subcontractor or FDR, the OhioRISE Plan must provide proof of reinsurance coverage for that subcontractor or FDR.
- iii. The OhioRISE Plan'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 OhioRISE Plan or the reinsurance carrier, the OhioRISE Plan 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 OhioRISE Plan'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 OhioRISE Plan with prior approval in writing for a higher deductible amount or alternate reinsurance arrangement. The OhioRISE Plan's reinsurance must cover, at a minimum, 80% of inpatient costs (including PRTF) incurred by one member in one year in excess of \$100,000, unless ODM has provided the OhioRISE Plan with prior approval in writing for a higher deductible amount or alternate reinsurance arrangement. The OhioRISE Plan may request a higher deductible amount and/or that the reinsurance covers less than 80% of inpatient costs in excess of the deductible amount. If the OhioRISE Plan has less than one year of Ohio Medicaid managed care contracting experience, the OhioRISE Plan must demonstrate sufficient capital resources, as determined by ODM.

c. 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 OhioRISE Plan has sufficient reserves available to pay unexpected claims;
 2. The OhioRISE Plan's history in complying with financial indicators as specified in this appendix;
 3. The number of members covered by the OhioRISE Plan;
 4. The length of time the OhioRISE Plan has been covering Medicaid or other members on a full or partial 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.

d. ODM Notification of Claims

- i. If directed by ODM, the OhioRISE Plan 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.

e. Submission of Reinsurance Agreements to ODM

- i. The OhioRISE Plan must submit fully executed reinsurance agreements to ODM prior to the effective date of this Agreement.
- ii. The OhioRISE Plan 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 OhioRISE Plan must provide copies of new or modified reinsurance agreements to ODM within 30 calendar days of execution.

6. Prompt Pay Requirements

a. Standard

- i. In accordance with 42 CFR 447.46 and this Agreement, except if the OhioRISE Plan and its network provider has established an alternative payment schedule mutually agreed upon and described in the provider contract, the OhioRISE Plan must:
 1. Pay or deny 90% of all submitted clean claims within 21 calendar days of the date of receipt;

2. Pay or deny 99% of clean claims within 60 calendar days of the date of receipt; and
3. Pay or deny 100% of all claims within 90 calendar days of receipt.

b. Separate Measurement

- i. The OhioRISE Plan must measure and comply with the prompt payment standards by the claim types specified below:
 1. Mobile Response and Stabilization Services (MRSS) claims;
 2. Care management entities (CME) claims for Tier 3 – Intensive Care Coordination and Tier 2 – Moderate Care Coordination; and
 3. All other claim types (excluding MRSS and CME claims for Tier 3 – Intensive Care Coordination and Tier 2 – Moderate Care Coordination).

c. Application

- i. The OhioRISE Plan must comply with the prompt pay requirement for both electronic and paper claims and for both network and out of network providers.

d. Reporting

- i. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must submit quarterly prompt pay reports (Prompt Pay Report) to ODM.

7. Physician Incentive Plan Requirements

- a. If the OhioRISE Plan 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 OhioRISE Plan 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 OhioRISE Plan'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 OhioRISE Plan 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 OhioRISE Plan must provide assurance satisfactory to ODM that the requirements of 42 CFR 422.208 are met. In addition, the OhioRISE Plan 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 OhioRISE Plan must provide the following information to the member:

- i. Whether the OhioRISE Plan 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.

8. Third Party Liability Requirements

- a. The OhioRISE Plan must comply with OAC rule 5160-26-09.1 related to tort recovery, coordination of benefits, and reporting to ODM.
- b. Pursuant to OAC rule 5160-26-09.1, the OhioRISE Plan 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 OhioRISE Plan must use both the OhioRISE Plan's and ODM's TPL information, as specified by ODM.
- d. The OhioRISE Plan must comply with coordination of benefits requirements for members who are Medicare enrolled as directed by ODM;
- e. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must provide ODM with TPL information, including a change file based on reconciliation with ODM's data (Third Party Liability Data File).

9. Submission of Cost Reports

- a. As specified in Appendix P, Chart of Deliverables, the OhioRISE Plan must submit annual and quarterly 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 OhioRISE plan must use at any time.
- b. The OhioRISE Plan must complete the cost reports in accordance with this Agreement and the cost report instructions provided by ODM.
- c. The OhioRISE Plan must submit the cost reports in accordance with the timeframes specified by ODM in the cost report instructions.
- d. The OhioRISE Plan must revise its cost reports in accordance with the observation log prepared by ODM's actuary and/or ODM instructions. The OhioRISE Plan must address and submit responses to all comments from either ODM or ODM's actuary within the timeframe specified by ODM.

10. Sharing Data with ODM's Actuary

- a. Upon ODM's request, the OhioRISE Plan 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.

11. Notification of Regulatory Action

- a. If the OhioRISE Plan is notified by ODI of proposed or implemented regulatory action, the OhioRISE Plan 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 OhioRISE Plan must provide any additional information as necessary to ensure continued satisfaction of the requirements of this Agreement. The OhioRISE Plan 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 OAC rule 5160-26-10 and 42 CFR 438 Subpart I, ODM may impose the compliance actions described in this appendix against the OhioRISE Plan if ODM finds that the OhioRISE Plan 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; to conduct audits; or to 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, whether or not there is a pattern of repeated noncompliance, and the number of eligible individuals and members affected. ODM will consider evidence provided by the OhioRISE Plan 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 OhioRISE Plan subcontractor noncompliance to be beyond the OhioRISE Plan's control, unless the noncompliance was beyond the subcontractor's control.
- d. The OhioRISE Plan must take immediate action to correct noncompliance identified by the OhioRISE Plan or ODM. The OhioRISE Plan's responsibility to correct noncompliance is not dependent upon ODM's identification of noncompliance or compliance actions therefrom.
- e. The OhioRISE Plan must report to ODM upon becoming aware of any noncompliance that could impair a member's ability to obtain correct information regarding services, impair member rights, affect the ability of the OhioRISE Plan to deliver covered services, or affect a member's ability to access covered services.
- f. The OhioRISE Plan is singularly responsible for fully complying with all terms in this Agreement. The OhioRISE Plan is precluded from using ODM technical assistance to help the OhioRISE Plan achieve compliance with this Agreement as a defense for OhioRISE Plan noncompliance.
- g. ODM will issue notices of compliance actions in writing to the OhioRISE Plan contact identified in the Baseline Provider Agreement.

2. Administrative Actions

- a. Notice of Noncompliance
 - i. ODM may issue a written Notice of Noncompliance to the OhioRISE Plan when ODM identifies OhioRISE Plan noncompliance and does not require any other compliance

action (e.g., OhioRISE Plan developed corrective action plan, directed corrective action plan).

- ii. The OhioRISE Plan 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 OhioRISE Plan is not in compliance with one or more requirements in this Agreement, ODM may issue a Notice of Compliance Action, identifying the deficiency or deficiencies and the required OhioRISE Plan follow-up for each. The OhioRISE Plan follow-up may come in the form of an OhioRISE Plan-developed Corrective Action Plan (CAP) or a Directed CAP. ODM will also issue a Notice of Compliance Action when ODM determines that sanctions are necessary.
2. A CAP is a structured activity, process, or quality improvement initiative implemented by the OhioRISE Plan to address noncompliance. The OhioRISE Plan must submit all CAPs as specified by ODM. The OhioRISE Plan'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 OhioRISE Plan has provided evidence to ODM's satisfaction that the OhioRISE Plan has fulfilled the requirements of the CAP to achieve and sustain compliance. Failure of the OhioRISE Plan to achieve compliance within the timeframes established within the CAP, or to sustain compliance thereafter, may result in an escalation of compliance actions as provided in this appendix.

ii. OhioRISE Plan-Developed CAP

1. When directed by ODM, the OhioRISE Plan 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 OhioRISE Plan's proposed CAP is subject to ODM approval.

iii. Directed CAP

1. When directed by ODM in a Notice of Compliance Action, the OhioRISE Plan must comply with an ODM-developed or "directed" CAP when ODM has determined the specific action that the OhioRISE Plan must implement.

2. ODM may also issue a directed CAP if the OhioRISE Plan fails to submit a CAP.

3. Sanctions

a. Pre-Determined Financial Sanctions

- i. In addition to other compliance actions available to ODM, ODM may impose the following pre-determined financial sanctions in accordance with Table N.1 below.

Table N.1. Pre-Determined Financial Sanctions

	Noncompliance	Financial Sanction
1.	Failure to demonstrate readiness within the timeframe established by ODM as part of the OhioRISE Plan's readiness review as specified in Appendix A, General Requirements.	<ul style="list-style-type: none"> To Be Determined
2.	Failure to comply with staffing requirements as specified in Appendix A, General Requirements.	<ul style="list-style-type: none"> To Be Determined
3.	Failure to have appropriate OhioRISE Plan staff members attend meetings as requested by ODM as specified in Appendix A, General Requirements.	<ul style="list-style-type: none"> To Be Determined
4.	Failure to operate a toll-free member services call center with appropriately trained staff who understand the Ohio Medicaid structure as specified in Appendix A, General Requirements.	<ul style="list-style-type: none"> To Be Determined
5.	Failure to meet monthly call center metrics for member services or provider services call center as specified in Appendix A, General Requirements.	<ul style="list-style-type: none"> To Be Determined
6.	Failure to secure protected health information as defined by Health Insurance Portability and Accountability Act (HIPAA) as specified in Appendix A, General Requirements.	<ul style="list-style-type: none"> To Be Determined
7.	Failure to forward a grievance, appeal, or request for state hearing received in error by the OhioRISE Plan to the appropriate ODM-contracted managed care entity, as required by Appendix A, General Requirements.	<ul style="list-style-type: none"> To Be Determined

	Noncompliance	Financial Sanction
8.	Failure to resolve at least 98% of expedited appeals within required timelines, as specified in Appendix A, General Requirements.	<ul style="list-style-type: none"> To Be Determined
9.	Failure to resolve at least 95% of standard appeals within required timelines, as specified in Appendix A, General Requirements.	<ul style="list-style-type: none"> To Be Determined
10.	Failure to resolve at least 95% of member grievances within required timelines, as specified in Appendix A, General Requirements.	<ul style="list-style-type: none"> To Be Determined
11.	Failure to continue services during a pending appeal, external review or state hearing as specified in Appendix A, General Requirements.	<ul style="list-style-type: none"> To Be Determined
12.	Failure to authorize services after receiving a reversal of OhioRISE Plan decision resulting from an appeal or state hearing as specified in Appendix A, General Requirements.	<ul style="list-style-type: none"> To Be Determined
13.	Failure to ensure appropriate OhioRISE Plan representatives attend state hearings as scheduled as specified in Appendix A, General Requirements.	<ul style="list-style-type: none"> To Be Determined
14.	Failure to provide necessary witnesses or evidentiary materials for state hearings as specified in Appendix A, General Requirements.	<ul style="list-style-type: none"> To Be Determined
15.	Failure to comply with timeframes for at least 99% of expedited service authorization requests, as specified in Appendix B, Coverage and Services.	<ul style="list-style-type: none"> To Be Determined
16.	Failure to comply with timeframes for at least 99% of standard service authorization requests, as specified in Appendix B, Coverage and Services.	<ul style="list-style-type: none"> To Be Determined
17.	Failure to follow ODM or ODM-approved clinical coverage policies as specified in Appendix B, Coverage and Services.	<ul style="list-style-type: none"> To Be Determined

	Noncompliance	Financial Sanction
18.	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.	<ul style="list-style-type: none"> To Be Determined
19.	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.	<ul style="list-style-type: none"> To Be Determined
20.	Failure to provide feedback to a care management entity (CME) on the development of a child and family centered care plan within the timeframes specified in Appendix B, Coverage and Services.	<ul style="list-style-type: none"> To Be Determined
21.	Failure to provide a timely and content-compliant Notice of Action as required by OAC rule 5160-26-08.4 and Appendix B, Coverage and Services.	<ul style="list-style-type: none"> To Be Determined
22.	Failure to authorize and provide timely access to covered services as specified in Appendix B, Coverage and Services.	<ul style="list-style-type: none"> To Be Determined
23.	Failure to authorize and provide medically necessary early and periodic screening, diagnosis and treatment (EPSDT) services as specified in Appendix B, Coverage and Services.	<ul style="list-style-type: none"> To Be Determined
24.	Failure to cooperate with ODM's external quality review organization (EQRO) as specified in Appendix C, Population Health and Quality.	<ul style="list-style-type: none"> To Be Determined
25.	Failure to actively participate in quality improvement projects or performance improvement projects facilitated by ODM or the EQRO as specified in Appendix C, Population Health and Quality.	<ul style="list-style-type: none"> To Be Determined

	Noncompliance	Financial Sanction
26.	Failure to comply with transition of care requirements for members transitioning to the OhioRISE Plan from fee-for-service (FFS) or an ODM contracted MCO, as specified in Appendix D, Care Coordination.	<ul style="list-style-type: none"> To Be Determined
27.	Failure to comply with transition of care requirements for members transitioning between health care settings, as specified in Appendix D, Care Coordination.	<ul style="list-style-type: none"> To Be Determined
28.	Failure to comply with transition of care requirements for members transitioning from the OhioRISE Plan to an MCO due to improved assessment score or a member's request for disenrollment, as specified in Appendix D, Care Coordination.	<ul style="list-style-type: none"> To Be Determined
29.	Failure to comply with transition of care requirements for members transitioning from one CME to another CME, as specified in Appendix D, Care Coordination.	<ul style="list-style-type: none"> To Be Determined
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 and safety.	<ul style="list-style-type: none"> To Be Determined
31.	Failure to obtain ODM's approval prior to using member materials that require ODM's approval prior to distribution as specified in Appendix E, Marketing and Member Materials.	<ul style="list-style-type: none"> To Be Determined
32.	Failure to comply with the timeframes for providing member materials as specified in Appendix E, Marketing and Member Materials.	<ul style="list-style-type: none"> To Be Determined
33.	Failure to include and distribute ODM-approved new member materials, as specified in Appendix E, Marketing and Member Materials.	<ul style="list-style-type: none"> To Be Determined

	Noncompliance	Financial Sanction
34.	Failure to notify ODM and impacted members of provider termination of network provider within required timeframes as specified in Appendix F, Provider Network.	<ul style="list-style-type: none"> To Be Determined
35.	Failure to provide timely notification to ODM of network changes that impact 250 or more members or reduce the OhioRISE Plan's network by 10% or more as specified in Appendix F, Provider Network.	<ul style="list-style-type: none"> To Be Determined
36.	Failure to meet minimum provider capacity standards as specified in Appendix F, Provider Network. Provider capacity is measured on a quarterly basis.	<ul style="list-style-type: none"> To Be Determined
37.	Failure to meet access (time and distance) requirements as specified in Appendix F, Provider Network. Access compliance is measured on a quarterly basis.	<ul style="list-style-type: none"> To Be Determined
38.	Failure to meet provider network information performance standards, as specified in Appendix F, Provider Network.	<ul style="list-style-type: none"> To Be Determined
39.	Failure to respond to information or witness requests within specified timeframe as specified in Appendix G, Program Integrity.	<ul style="list-style-type: none"> To Be Determined
40.	Payment to a terminated or suspended provider as specified in Appendix G, Program Integrity.	<ul style="list-style-type: none"> To Be Determined
41.	Failure to report credible allegation of fraud, waste, or abuse as specified in Appendix G, Program Integrity.	<ul style="list-style-type: none"> To Be Determined
42.	Failure to report recoveries as specified in Appendix G, Program Integrity.	<ul style="list-style-type: none"> To Be Determined
43.	Failure to adjust claims/encounters to reflect recovery as specified in Appendix G, Program Integrity.	<ul style="list-style-type: none"> To Be Determined

	Noncompliance	Financial Sanction
44.	Failure to meet quality measure requirements in Table I.1 of Appendix I, Quality Measures.	<ul style="list-style-type: none"> To Be Determined
45.	Failure to submit data to the MCOs related to measures in Table I.2 of Appendix I, Quality Measures.	<ul style="list-style-type: none"> To Be Determined
46.	Failure to include guidance in policy or operational manuals with CMEs related to measure outcomes in Table I.3, as specified in Appendix I, Quality Measures.	<ul style="list-style-type: none"> To Be Determined
47.	Failure to meet requirements to adjudicate claims to final status and notify providers of the status of submitted claims as specified in Appendix K, Information Systems, Claims, and Data.	<ul style="list-style-type: none"> To Be Determined
48.	Failure to meet the encounter data volume standard for every service category in all quarters of the measurement period for each of the following populations: aged, blind, and disabled children and Covered Families and Children (CFC) children members, as specified in <i>the Encounter Data Quality Measures</i> document referenced in Appendix K, Information Systems, Claims, and Data.	<ul style="list-style-type: none"> To Be Determined
49.	Failure to meet the requirements for rejected encounters as specified in the <i>Encounter Data Quality Measures</i> document referenced in Appendix K, Information Systems, Claims, and Data.	<ul style="list-style-type: none"> To Be Determined
50.	Failure to meet acceptance rate requirement as specified in the <i>Encounter Data Quality Measures</i> document referenced in Appendix K, Information Systems, Claims, and Data.	<ul style="list-style-type: none"> To Be Determined
51.	Failure to meet payment accuracy measures for encounter data accuracy studies as specified in the <i>Encounter Data Quality Measures</i> document referenced in Appendix K, Information Systems, Claims, and Data.	<ul style="list-style-type: none"> To Be Determined

	Noncompliance	Financial Sanction
52.	Failure to meet the minimum record submittal rate for encounter data accuracy studies as specified in the <i>Encounter Data Quality Measures</i> document referenced in Appendix K, Information Systems, Claims, and Data.	<ul style="list-style-type: none"> To Be Determined
53.	Failure to meet standards for rendering provider data for all quarters of the measurement period as specified in the <i>Encounter Data Quality Measures</i> document referenced in Appendix K, Information Systems, Claims, and Data.	<ul style="list-style-type: none"> To Be Determined
54.	Failure to meet standards for National Provider Identifier (NPI) provider number usage as specified in the <i>Encounter Data Quality Measures</i> document referenced in Appendix K, Information Systems, Claims, and Data.	<ul style="list-style-type: none"> To Be Determined
55.	Failure to meet encounter submission requirements as specified in the <i>Encounter Data Quality Measures</i> document referenced in Appendix K, Information Systems, Claims, and Data.	<ul style="list-style-type: none"> To Be Determined
56.	Failure to meet encounter timeliness standards as specified in Appendix K, Information Systems, Claims, and Data, and the <i>Encounter Data Quality Measures</i> document referenced in Appendix K, Information Systems, Claims, and Data.	<ul style="list-style-type: none"> To Be Determined
57.	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.	<ul style="list-style-type: none"> To Be Determined

	Noncompliance	Financial Sanction
58.	<p>Failure to comply with any of the following reinsurance requirements as specified in Appendix L, Payment and Financial Performance:</p> <ul style="list-style-type: none"> • 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 covers less than 80% of inpatient costs in excess of the deductible incurred by one member for one year. 	<ul style="list-style-type: none"> • To Be Determined
59.	Failure to comply with prompt pay requirements as specified in Appendix L, Payment and Financial Performance.	<ul style="list-style-type: none"> • To Be Determined
60.	Failure to submit a deliverable or respond to ODM's requests within the required timeframe under this Agreement.	<ul style="list-style-type: none"> • To Be Determined
61.	Failure to complete or comply with a CAP as described in this appendix.	<ul style="list-style-type: none"> • To Be Determined

b. Pre-Determined Non-Financial Sanctions

- i. In addition to other compliance actions available to ODM, ODM may impose the following pre-determined non-financial sanctions in accordance with Table N.2 below.

Table N.2. Pre-Determined Non-Financial Sanctions

	Noncompliance	Non-Financial Sanction
1.	Failure to maintain required accreditation status with the National Committee for Quality Assurance (NCQA) as specified in Appendix A, General Requirements.	<ul style="list-style-type: none"> • If the OhioRISE Plan receives a Provisional accreditation status, the OhioRISE Plan must complete a second survey within 12 months of the accreditation decision. If the new survey results are in a Provisional or Denied status, ODM will consider this a

	Noncompliance	Non-Financial Sanction
		<p>material breach of this Agreement and may terminate this Agreement.</p> <ul style="list-style-type: none"> If the OhioRISE Plan receives a Denied accreditation status, ODM will consider this a material breach of this Agreement and may terminate this Agreement.
2.	Failure to submit quarterly Financial Statements to ODM as specified in Appendix L, Payment and Financial Performance.	<ul style="list-style-type: none"> ODM may require the OhioRISE Plan to complete a CAP. To the extent that the OhioRISE Plan does not demonstrate compliance with the CAP, the OhioRISE Plan will be subject to the financial penalty in Table N.1.
3.	Failure to submit annual Financial Statements to ODM as specified in Appendix L, Payment and Financial Performance.	<ul style="list-style-type: none"> ODM may require the OhioRISE Plan to complete a CAP. To the extent that the OhioRISE Plan does not demonstrate compliance with the CAP, the OhioRISE Plan will be subject to the financial penalty in Table N.1.
4.	Failure to meet financial performance requirements as specified in Appendix L, Payment and Financial Performance.	<ul style="list-style-type: none"> ODM may require the OhioRISE Plan to complete a CAP. To the extent that the OhioRISE Plan does not demonstrate compliance with the CAP, the OhioRISE Plan will be subject to the financial penalty in Table N.1.
5.	Failure to notify ODM within one business day after the receipt of a proposed or implemented regulatory action by Ohio Department of Insurance (ODI) as Appendix L, Payment and Financial Performance.	<ul style="list-style-type: none"> To Be Determined

c. Financial Sanctionsi. 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 OhioRISE Plan's 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 OhioRISE Plan 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 that staff performing care coordination functions are operating within their professional scope of practice or that they are complying with the state's licensure/credentialing requirements;
 - b. Failure to update the family and child centered care plan in a timely manner when the needs of a 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 OhioRISE Plan'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 OhioRISE Plan's noncompliance:
 - a. Noncompliance that is associated with a poor health outcome for the member;

- b. Failure to provide medically necessary services that the OhioRISE Plan must provide under the terms of this Agreement to its enrolled members, such as:
 - i. Failure to assist a member in accessing needed services in a timely manner after receiving a request from the member;
 - ii. Failure to meet requirements related to discharge planning;
 - iii. Failure to provide services specified in the member's discharge plan;
 - iv. Failure to ensure staff performing care coordination functions are appropriately responding to a member's care coordination needs; and
 - v. Failure to complete a care gap analysis that identifies gaps between recommended care and care received by a member.
 - c. Misrepresentation or falsification of information furnished to an eligible individual, member, or provider; and
 - d. Failure to comply with physician incentive plan requirements.
- iv. Level 3 Sanctions
- 1. ODM may impose a Level 3 sanction up to a maximum of \$100,000 per occurrence of the OhioRISE Plan'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 OhioRISE Plan noncompliance:
 - a. Discrimination among members on the basis of their health status or need for health care services (this includes any practice that would reasonably be expected to encourage termination or discourage selection of members or eligible individuals whose medical condition indicates probable need for substantial future medical services); and
 - b. Misrepresentation or falsification of information provided to ODM or Centers for Medicare and Medicaid Services (CMS).
- v. Financial Sanction Calculation
- 1. ODM will evaluate OhioRISE Plan 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 OhioRISE Plan promptly identified, reported, and remediated the noncompliance;
- e. OhioRISE Plan enrollment size relative to the amount of the financial sanction;
- f. Financial implications to providers; and
- g. Financial harm and risk to the State.

d. Compounded Financial Sanctions

- i. ODM will compound pre-determined and financial sanctions if the OhioRISE Plan 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 two times the amount of the pre-determined or financial sanction, or the maximum amount for Level 1 financial sanctions, whichever is less, if:
 - a. The OhioRISE Plan fails to demonstrate compliance within the timeframe identified in the Notice of Compliance Action; or
 - b. The OhioRISE Plan 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 OhioRISE Plan from the net capitation paid to the OhioRISE Plan. ODM will specify on the invoice the date ODM will deduct the funds.
- ii. If ODM requests an Electronic Funds Transfer (EFT) from the OhioRISE Plan, the OhioRISE Plan must pay the pre-determined and financial sanction to ODM within 30 calendar days of the date of the invoice or as otherwise directed in writing by ODM. Pursuant to ORC section 131.02, ODM will certify to the Attorney General's (AG's) Office payments owed by the OhioRISE Plan to the State that are not received within 45 calendar days. The AG's Office will impose the appropriate collection fee for OhioRISE Plan payments certified to the AG's Office.

- iii. For pre-determined and financial sanctions calculated in accordance with this appendix, ODM will use the OhioRISE Plan'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 OhioRISE Plan.

f. Temporary Management

- i. Pursuant to OAC 5160-26-10 and 42 CFR 438.706, ODM may impose temporary management when the OhioRISE Plan has repeatedly failed to comply with the requirements in this Agreement.
- ii. The OhioRISE Plan must bear all costs incurred from the appointment of temporary management.
- iii. ODM's imposition of temporary management against the OhioRISE Plan will not be delayed to provide the OhioRISE Plan with an opportunity to request reconsideration. Temporary management will remain in place until ODM determines that the noncompliance will not reoccur.

g. Termination

- i. In accordance with 42 CFR 438.708, ODM may terminate this Agreement if ODM determines that the OhioRISE Plan has failed to carry out the substantive terms of this Agreement or failed to meet the applicable requirements in Sections 1932, 1903(m) or 1905(t) of the Social Security Act.
- ii. ODM may terminate or amend this Agreement if at any time ODM determines that continuation of this Agreement is not in the best interest of members or the state of Ohio, pursuant to OAC rule 5160-26-10.
- iii. Nothing in this appendix precludes ODM from terminating this Agreement pursuant to Article VIII of the Baseline Provider Agreement.

4. Request for Reconsideration

- a. Other than as specified below, pursuant to OAC rule 5160-26-10, the OhioRISE Plan may seek reconsideration of any compliance action in this appendix imposed by ODM.
 - i. The OhioRISE Plan may not seek reconsideration of a compliance action by ODM that results in the imposition of a Notice of Noncompliance, CAP, or directed CAP, as defined in this appendix.
- b. The OhioRISE Plan may only seek reconsideration of a CAP when a CAP is required for the first violation in a series of progressive compliance actions.
- c. The OhioRISE Plan must submit a request for reconsideration on the form required by ODM, in accordance with the following procedure:
 - i. The OhioRISE Plan must submit a request for reconsideration to ODM no later than ten business days after the date the OhioRISE Plan receives the Notice of Compliance Action from ODM.

- ii. The OhioRISE Plan's request for reconsideration must explain in detail why ODM should not impose the specified compliance action. At a minimum, the OhioRISE Plan's reconsideration request must include a statement of the proposed compliance action being contested, the basis for the OhioRISE Plan's request, and any supporting documentation. In considering the OhioRISE Plan's request for reconsideration, ODM will review only the written material submitted by the OhioRISE Plan.
- iii. ODM will take reasonable steps to issue a final written decision or request additional information within ten business days after receiving the OhioRISE Plan's request for reconsideration. If ODM requires additional time, ODM will notify the OhioRISE Plan in writing.
- iv. If ODM approves the OhioRISE Plan's reconsideration request in whole, ODM will rescind the associated compliance actions.
- v. If ODM approves the OhioRISE Plan's reconsideration request in part, ODM at its sole discretion may rescind or reduce the associated compliance actions.
- vi. If ODM denies the OhioRISE Plan's reconsideration request in whole, ODM will take the compliance actions outlined in the original notification of noncompliance.

APPENDIX O – PLAN TERMINATION AND NON-RENEWALS

1. General Requirements

- a. This Agreement may be terminated or not renewed as specified in Article VIII of the Baseline Provider Agreement.

- i. OhioRISE Plan-Initiated Terminations and Non-Renewal

1. When initiated by the OhioRISE Plan, the OhioRISE Plan must provide ODM written notice of the termination or non-renewal of this Agreement as required in Article VIII of the Baseline Provider Agreement.

- ii. ODM-Initiated Terminations for Cause Under OAC Rule 5160-26-10

1. If ODM initiates the proposed termination, non-renewal, or amendment of this Agreement pursuant to OAC rule 5160-26-10 by issuing a proposed adjudication order pursuant to ORC section 5164.38, and the OhioRISE Plan 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 OhioRISE Plan's appeal under ORC Chapter 119.
 2. Pursuant to OAC rule 5160-26-10, ODM may notify the OhioRISE Plan's members of the proposed action and inform the members of their right to immediately terminate their enrollment with the OhioRISE Plan 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 OhioRISE Plan's members. The OhioRISE Plan may request reconsideration of a proposed enrollment termination of members as follows:
 - a. ODM will notify the OhioRISE Plan of the proposed enrollment termination via certified or overnight mail to the OhioRISE Plan. The OhioRISE Plan will have three business days from the date of receipt to request reconsideration.
 - b. The OhioRISE Plan 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 OhioRISE Plan's receipt of the ODM notification of termination.
 - c. The OhioRISE Plan'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 OhioRISE Plan.
 - d. The ODM Director will issue a final decision or a request for additional information within five business days of receipt of the OhioRISE Plan's request for reconsideration. ODM will notify the

OhioRISE Plan in writing if the Director requires additional time in rendering the final reconsideration decision.

- e. The proposed OhioRISE Plan enrollment termination will not occur while the reconsideration is under review and pending the Director's decision. If the Director denies the reconsideration, the OhioRISE Plan enrollment termination will proceed at the first possible effective date.

iii. Termination due to ODM OhioRISE Program Procurement Process

- 1. In the event this Agreement terminates as a result of ODM's procurement of the OhioRISE Program pursuant to ORC section 5167.10, the OhioRISE Plan has no right to appeal under the authorities in ORC Chapter 119 pursuant to ORC section 5164.38.

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 OhioRISE Plan 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, the OhioRISE Plan must comply with the transition requirements as described in this appendix.
- c. The OhioRISE Plan will continue to be subject to compliance actions as specified in Appendix N, Compliance Actions, of this Agreement until ODM approves the OhioRISE Plan's final report as specified by ODM documenting that the OhioRISE Plan has fulfilled all outstanding obligations.

2. Transition Requirements

- a. Upon notice of the termination/non-renewal of this Agreement the OhioRISE Plan must comply with the following transition requirements:

i. Transition Plan

- 1. The OhioRISE Plan must submit a proposed Transition Plan within ten business days of the notice of termination/non-renewal of this Agreement for ODM approval. The OhioRISE Plan must revise the Transition Plan as necessary to obtain ODM's approval. The OhioRISE Plan's Transition Plan must include the following:
 - a. The OhioRISE Plan'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 OhioRISE Plan's Transition Coordinator, the OhioRISE Plan's single point of contact responsible for coordinating the OhioRISE Plan's transition activities;

- c. The proposed submission timeframes for all outstanding reports and deliverables as identified by ODM;
- d. The member outreach workflow identifying the approach and timing of outreach to members impacted by the termination/non-renewal of this Agreement;
- e. The OhioRISE Plan's communication plan, including the OhioRISE Plan's written notifications and proposed timeline to notify all subcontractors, providers, and members impacted by the termination/non-renewal of this Agreement. The OhioRISE Plan's communication plan must include the following notifications:
 - i. Provider Notification
 - 1. The OhioRISE Plan must notify contracted 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 of this Agreement. The provider notification must be approved by ODM prior to distribution.
 - ii. Member Notification
 - 1. Unless otherwise notified by ODM, the OhioRISE Plan 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 must be approved by ODM prior to distribution.
 - iii. MCO Notification
 - 1. The OhioRISE Plan must notify each member's MCO at least 55 calendar days prior to the effective date of the termination of this Agreement. The MCO notification must be approved by ODM prior to distribution.
 - iv. Prior Authorization Redirection Notification
 - 1. The OhioRISE Plan 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; this notice will direct members and providers to contact their MCO or other entity as directed by ODM. The second notice is for prior authorization requests for services to be provided before and after the effective date of termination. The OhioRISE Plan 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 OhioRISE Plan membership.

2. The OhioRISE Plan must utilize ODM model language to create the notices and receive approval by ODM prior to distribution. The OhioRISE Plan must mail notices to the provider and copy the member for all requests received during the last month of OhioRISE Plan enrollment.

- f. The OhioRISE Plan'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.

ii. Transition Plan Updates

1. The OhioRISE Plan must report Transition Plan updates to ODM detailing OhioRISE Plan progress toward completing OhioRISE Plan obligations under this Agreement and Transition Plan on a monthly basis, on the fifth day of the month following the month reported.

iii. Fulfill Existing Duties and Obligations

1. The OhioRISE Plan must fulfill all duties and obligations as required under OAC Chapter 5160-59 and this Agreement. OhioRISE Plan 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 but are not limited to the following:

a. Member Grievances and Appeals, Provider Complaints, and State Hearings

- i. The OhioRISE Plan must resolve all provider complaints and member grievances and appeals related to the OhioRISE Plan's decisions and responsibilities exercised under this Agreement. The OhioRISE Plan must also participate in state hearings related thereto. The OhioRISE Plan must provide a monthly report of:
 1. Member complaint, grievance, appeal, and state hearing information; and
 2. Provider complaint information, as outlined in the OhioRISE Plan's ODM-approved Transition Plan.

b. Claims Payment

- i. The OhioRISE Plan must pay all outstanding obligations for services and benefits rendered to members during the period of time when the OhioRISE Plan was under contract with ODM in accordance with the requirements in this Agreement and OAC rule 5160-26-09.1. This includes without limitation, the payment of funds owed as a result of the concurrent risk analysis process as well as the reporting, data integration, and payment requirements related to quality improvement strategies and value-based initiatives initiated by the OhioRISE Plan under this Agreement.

c. Encounter and Claims Data

- i. The OhioRISE Plan 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 OhioRISE Plan 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.

d. Population Health and Performance Data

- i. The OhioRISE Plan must provide population health, care coordination, and quality data files as specified in Appendix C, Population Health and Quality, Appendix D, Care Coordination; and Appendix I, Quality Measures, for all periods prior to the termination/non-renewal of this Agreement.

e. Financial Reports

- i. The OhioRISE Plan must provide financial reports as outlined in the OhioRISE Plan'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.

iv. Cooperation

1. The OhioRISE Plan must fully cooperate with ODM and ODM's designee(s) to support a seamless transition of members and administrative responsibilities under this Agreement to the satisfaction of ODM. The OhioRISE Plan must participate in any meetings, workgroups, or other activities as requested by ODM to support the transition.

v. Maintenance of Financial Requirements and Insurance

1. The OhioRISE Plan must comply with financial and insurance requirements until ODM provides the OhioRISE Plan written notice that all continuing OhioRISE Plan obligations under this Agreement have been fulfilled.

vi. Refundable Monetary Assurance

1. The OhioRISE Plan must submit a refundable monetary assurance upon the termination/non-renewal of this Agreement. This monetary assurance will be held by ODM and must be in an amount of 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 OhioRISE Plan must remit the monetary assurance in the specified amounts via separate electronic fund transfers payable to Treasurer of State, state of Ohio (ODM). The OhioRISE Plan 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 OhioRISE Plan 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 OhioRISE Plan's next month's capitation payment until such time that ODM receives documentation that the monetary assurance is received by the Treasurer of State.

4. Upon ODM's approval of the OhioRISE Plan's final report as specified by ODM, ODM will refund the monetary assurance to the OhioRISE Plan.
- vii. Quality Withhold
 1. Unreturned funds from the quality withhold program of this Agreement set forth in Appendix J, Quality Withholds, will be retained by ODM.
- viii. Final Accounting of Amounts Outstanding
 1. The OhioRISE Plan must submit to ODM a final accounting list of any outstanding monies owed by ODM 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 OhioRISE Plan to submit a list of outstanding items within the timeframe will be deemed a forfeiture of any additional compensation due to the OhioRISE Plan.
- ix. Member Transitions
 1. The OhioRISE Plan must conduct all member transition activities in accordance with the ODM-approved Transition Plan and in accordance with ODM member transition requirements. When transitioning members to ODM or ODM-contracted managed care entities, the OhioRISE Plan is responsible for providing the pertinent information related to the special needs of transitioning members to ODM and ODM-contracted managed care entities as directed by ODM. The OhioRISE Plan must transfer member data to ODM and/or ODM's designee- within the time period and in a file format as specified by ODM.
- x. Data Files
 1. In order to assist members with transition and continuity of care, the OhioRISE Plan must create data files to share with each newly enrolling ODM designee. The OhioRISE Plan 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, and prescribers. The timeline for the OhioRISE Plan providing these files will be at the discretion of ODM. At termination, the OhioRISE Plan will be responsible for all costs associated with data sharing and for ensuring the accuracy and data quality of the files.
- xi. OhioRISE Plan Release
 1. ODM will release the OhioRISE Plan from its responsibilities under the Transition Plan and this Agreement upon ODM's approval of the OhioRISE Plan's final report documenting that the OhioRISE Plan has fulfilled all outstanding obligations. Following ODM release, the OhioRISE Plan will retain ongoing responsibility for providing data to support audits related to the Medicaid population served by the OhioRISE Plan during the term of this Agreement.

APPENDIX P — CHART OF DELIVERABLES

1. General

- a. The OhioRISE Plan 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 OhioRISE Plan 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 OhioRISE Plan 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 OhioRISE Plan must receive written notice of review or approval from ODM prior to the deliverable taking effect.
- f. Unless otherwise specified by ODM, deliverables must be submitted to the email address provided by ODM.
- 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 OhioRISE Plan must review all deliverables prior to submission to ODM and ensure the OhioRISE Plan submits timely, accurate, and complete deliverables to ODM.
- i. The OhioRISE Plan'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 OhioRISE Plan must make the changes and resubmit the deliverable in the format and timeframe specified by ODM. ODM will determine the OhioRISE Plan's compliance with the requirement to submit timely, accurate, and complete deliverables based on the original submission.
- k. The OhioRISE Plan must review the content of deliverables to determine whether performance as documented in the deliverable complies with this Agreement. If the OhioRISE Plan identifies deficient performance, the OhioRISE Plan, 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 OhioRISE Plan to bring performance into compliance with this Agreement. The OhioRISE Plan'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 OhioRISE Plan's self-identification when determining the appropriate compliance action.

2. Ad Hoc Deliverables

- a. The OhioRISE Plan must submit notifications and other ad hoc deliverables (deliverables that are not scheduled, but the OhioRISE Plan must submit to ODM under specific circumstances) to ODM as specified in this Agreement or as otherwise directed by ODM.
- b. Unless otherwise specified by this Agreement or ODM, the OhioRISE Plan 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 applicable reference to this Agreement, the deliverable name, the frequency of the deliverable, the due date, and the name of any applicable reporting guidance document.
- b. The Chart of Scheduled Deliverables is presented here for convenience only and does not limit the OhioRISE Plan's responsibility to provide all deliverables required by ODM in the format and frequency specified by ODM.

4. Chart of Scheduled Deliverables

#	Provider Agreement Appendix	Deliverable Name	Frequency	Due Date
1.	Appendix A	Protected Health Information (PHI) Breach Report	Annual	<ul style="list-style-type: none"> January 31 for the year ending the previous December
2.	Appendix A	Member Services Call Center Report	Monthly Semi-Annual	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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
4.	Appendix A	Monthly Appeal and Grievance Activity Report	Monthly	<ul style="list-style-type: none"> 15th of the month
5.	Appendix A	Monthly Grievance and Appeal System Report	Monthly	<ul style="list-style-type: none"> 5th of the month

#	Provider Agreement Appendix	Deliverable Name	Frequency	Due Date
6.	Appendix A	Provider Call Center Report	Quarterly	<ul style="list-style-type: none"> 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
7.	Appendix A	Calendar of Provider and Subcontractor Required Training	Annual	<ul style="list-style-type: none"> September 30
8.	Appendix A	Provider Claim Dispute Resolution Report	Monthly	<ul style="list-style-type: none"> 15th of the month
9.	Appendix A	Provider Advisory Council Activity Report	Semi Annual	<ul style="list-style-type: none"> January 15 for the 6 month period ending December 31 July 15 for the 6 month period ending June 30
10.	Appendix A	OhioRISE Plan Organizational and Functional Chart	Annual	<ul style="list-style-type: none"> June 30 January 15 thereafter
11.	Appendix A	OhioRISE Plan Staff Training Plan	Annual	<ul style="list-style-type: none"> September 30
12.	Appendix A	FDR Oversight Report	Annual	<ul style="list-style-type: none"> January 15
13.	Appendix B	Value-Added Services Report	Quarterly	<ul style="list-style-type: none"> 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
14.	Appendix B	Service Authorization Report	Monthly	<ul style="list-style-type: none"> 15th of the month
15.	Appendix B	Mental Health Parity and Addiction Equity Act (MHPAEA) Compliance Analysis/ Attestation of Compliance	Annual	<ul style="list-style-type: none"> December 31
16.	Appendix C	Community Reinvestment Plan and Evaluation	Annual	<ul style="list-style-type: none"> October 15

#	Provider Agreement Appendix	Deliverable Name	Frequency	Due Date
17.	Appendix C	Evidence of QI Training Completion	Within 1 month of completion	<ul style="list-style-type: none"> Varies
18.	Appendix C	Documentation of Project Learning	Monthly	<ul style="list-style-type: none"> At least 2 business days prior to the monthly QI meeting
19.	Appendix D	Care Coordination Program Description	Annual	<ul style="list-style-type: none"> July 31
20.	Appendix D	Care Coordination Status Submission File	Quarterly	<ul style="list-style-type: none"> January 31 for the quarter ending December 31 April 30 for the quarter ending March 31 July 30 for the quarter ending June 30 October 31 for the quarter ending September 30
21.	Appendix F	Network Development and Management Plan	Annual	<ul style="list-style-type: none"> September 30 January 15 thereafter
22.	Appendix F	Quarterly Time and Distance Reports	Quarterly	<ul style="list-style-type: none"> 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
23.	Appendix F	Appointment Availability Report	Semi-Annual	<ul style="list-style-type: none"> January 15 July 15
24.	Appendix F	Report on the Number and Geographic Location of General and Child and Adolescent Psychiatrists and Psychiatric APRNs	Initially	<ul style="list-style-type: none"> January 30th for the quarter ending December 31
25.	Appendix F	Telehealth Report	Annual	<ul style="list-style-type: none"> January 15
26.	Appendix G	Compliance Plan	Annual	<ul style="list-style-type: none"> September 30
27.	Appendix G	Date of Explanation of Benefits Mailing	Annual	<ul style="list-style-type: none"> June 30
28.	Appendix G	Fraud, Waste, and Abuse Plan	Annual	<ul style="list-style-type: none"> October 1
29.	Appendix G	Fraud, Waste, and Abuse Report	Annual	<ul style="list-style-type: none"> February 26

#	Provider Agreement Appendix	Deliverable Name	Frequency	Due Date
30.	Appendix G	Fraud, Waste, and Abuse Inventory Report	Quarterly	<ul style="list-style-type: none"> January 31 April 30 July 31 October 31
31.	Appendix H	Proposal for Value Based Payment and Payment Reform Initiatives	Annual	<ul style="list-style-type: none"> June 30, 2022
32.	Appendix H	Report on Value Based Progress Reports	Semi-Annual	<ul style="list-style-type: none"> June 30 December 30
33.	Appendix I	Quarterly and Annual Data for Table I.1 Measures	Quarterly and Annual	<ul style="list-style-type: none"> September 1 in FY 2023 for quarter ending June 30 October 30 for the quarter ending September 30 January 30 for the quarter ending December 31 April 30 for the quarter ending March 31 July 30 for the quarter ending June 30
34.	Appendix I	Confirmation of Annual Data for Table I.2 Measures	Annual	<ul style="list-style-type: none"> January 31
35.	Appendix I	Confirmation of Annual Data for Table I.3 Measures	Annual	<ul style="list-style-type: none"> January 31
36.	Appendix I	Satisfaction Surveys of Families and Youth Receiving MRSS, Tier 2 and 3 Care Coordination, and IHIT	Annual	<ul style="list-style-type: none"> Initial due 7/31/2022 January 31 thereafter
37.	Appendix I	Satisfaction Survey of Providers	Annual	<ul style="list-style-type: none"> Initial due 7/31/2022 January 31 thereafter
38.	Appendix I	Self-Reported, Audited HEDIS Results	Annual	<ul style="list-style-type: none"> July 19
39.	Appendix I	HEDIS Final Audit Report (FAR) and HEDIS IDSS Data Certification Letter	Annual	<ul style="list-style-type: none"> July 19
40.	Appendix K	Summary of BC-DR Plan Test Results	Annual	<ul style="list-style-type: none"> Within 30 days of receiving results
41.	Appendix K	System Audit Results	Annual	<ul style="list-style-type: none"> Within 2 weeks of receiving results
42.	Appendix K	CPSE Report	Monthly	<ul style="list-style-type: none"> 15th of the month

#	Provider Agreement Appendix	Deliverable Name	Frequency	Due Date
43.	Appendix K	Network Provider EHR Adoption Report	Annual	<ul style="list-style-type: none"> June 30
44.	Appendix K	Network Provider HIE Participation Report	Annual	<ul style="list-style-type: none"> June 30
45.	Appendix K	EHR and HIE Provider Support Plan	Annual	<ul style="list-style-type: none"> January 15
46.	Appendix L	NAIC Annual Financial Statement	Annual	<ul style="list-style-type: none"> March 1
47.	Appendix L	NAIC Quarterly Financial Statements	Quarterly	<ul style="list-style-type: none"> May 15 August 15 November 15
48.	Appendix L	NAIC/Cost Report Reconciliation	Annual	<ul style="list-style-type: none"> April 30
49.	Appendix L	HIC Tax Report	Quarterly	<ul style="list-style-type: none"> March 1 May 15 August 15 November 15
50.	Appendix L	Related Party Profit and Loss Report	Annual	<ul style="list-style-type: none"> March 1
51.	Appendix L	MLR Reporting Tool and Documentation	Annual	<ul style="list-style-type: none"> For each MLR reporting year
52.	Appendix L	Prompt Pay Report	Quarterly	<ul style="list-style-type: none"> 15th of the first month of the calendar quarter
53.	Appendix L	Third Party Liability Data Files	Weekly	<ul style="list-style-type: none"> No later than 11:00 pm Eastern Time Thursday night
54.	Appendix L	Annual Cost Report	Annual	<ul style="list-style-type: none"> April 30
55.	Appendix L	Quarterly Cost Report	Quarterly	<ul style="list-style-type: none"> January 31 April 30 July 31 October 31

Attachment B: Letter of Transmittal Template

Attachment B: Letter of Transmittal Template

The Applicant's transmittal letter must be written on the Applicant's official business letterhead, must include the information specified in this attachment in the order given (re-stating each item), and must be signed by an individual authorized to commit the Applicant to the OhioRISE Plan Provider Agreement. Failure to respond to any item may result in disqualification of the Application:

1. RFA # and title
2. Proposal due date
3. Applicant's legal name and any doing business as (DBA)
4. Applicant's corporate address
5. Applicant's form of business (e.g., corporation, nonprofit corporation, partnership, limited liability company)
6. Applicant's federal and state taxpayer identification numbers
7. Person authorized by the Applicant to contractually obligate the Applicant (name, title, phone number, and email address)
8. Person to be contacted for clarifications (name, title, phone number, and email address)
9. Statement that Applicant has not submitted more than one Application from organizations under a common controlling entity
10. Whether the Applicant proposes to use FDR(s) in the performance of this provider agreement. If the Applicant proposes to use FDR(s), provide the name of each FDR and the general scope of work to be performed by the FDR, and the approximate percent of work to be completed by the Applicant and each FDR.
11. If the Applicant proposes to use FDR(s), provide, as an attachment to the transmittal letter, a letter from each proposed FDR, signed by a person authorized to legally bind the FDR, indicating the following:
 - a. FDR's legal status, federal tax ID number, and principal business address;
 - b. Name, phone number, and email address of a person who is authorized to legally bind the FDR to contractual obligations;
 - c. A description of the work the FDR will do;
 - d. A commitment to do the work, if the Applicant is selected;
 - e. FDR qualifications for the proposed work the FDR will do; and
 - f. A statement that the FDR has read and understands the RFA, the nature of the work, and the requirements of the RFA.
12. A statement regarding whether the Applicant or a proposed FDR has an objection to or is unwilling to comply with any of the requirements, terms, or conditions of the RFA, including any attachments, and has submitted a completed Attachment D, Exceptions. Whether the

Applicant does not have any objections and is willing to comply with all of the requirements, terms, and conditions of the RFA, including attachments, a statement to that effect.

13. A statement certifying that, as applicable, the Applicant is (a) licensed by the Ohio Department of Insurance (ODI) as a Health Insuring Corporation (HIC), or (b) has submitted an application to be licensed by ODI as a HIC, and provide evidence to support (a) or (b) as applicable. For example, a copy of the license or application for a license.
14. A statement regarding whether there is any service the Applicant would not cover because of moral or religious objections; and, if applicable, a description of the services the Applicant would not cover.
15. A statement describing any ongoing, active business transactions if the Applicant is in the process of selling or acquiring health care related businesses, and if these transactions are expected to be completed within 12 months from the date of the Application. The Applicant must include this information for the Applicant's parent organization, affiliates, and subsidiaries, as applicable.
16. In accordance with Section 5.12, Mandatory Contract Performance Disclosure, a statement that (a) neither the Applicant nor a proposed FDR has received a formal claim for breach of contract; or (b) the Applicant or a proposed FDR has received a formal claim for breach of contract. If (b), provide, as an attachment to the Transmittal Letter, a detailed explanation of any claims.
17. In accordance with Section 5.13, Mandatory Disclosures of Governmental Investigations, a statement that (a) neither the Applicant nor a proposed FDR has been the subject of an adverse regulatory or administrative governmental action with respect to performance of a government contract; or (b) the Applicant or a proposed FDR has been the subject of an adverse regulatory or administrative governmental action with respect to such performance. If (b), provide, as an attachment to the Transmittal Letter, a detailed explanation of any such governmental actions.
18. A statement of whether there is any pending or recent (within the past five years) litigation against the Applicant where the amount in controversy or the damages sought or awarded is \$1 million or more. This includes but is not limited to litigation involving the failure to provide timely, adequate, or quality health care services. If there is pending or recent litigation against the Applicant, the Applicant must describe the litigation and the damages being sought or awarded and the extent to which an adverse judgment is/would be covered by insurance or reserves set aside for that purpose. The Applicant must include an opinion of counsel as to the degree of risk presented by any pending litigation and whether the pending or recent litigation will impair the Applicant's performance under the provider agreement. If there has been a judgment against the Applicant, the Applicant must provide the details of the judgment and an opinion of counsel as to the degree of risk presented by the judgment and whether the judgment will affect the Applicant's solvency and/or impair the Applicant's ability to perform under the provider agreement. If applicable, the Applicant must include any Securities Exchange Commission (SEC) filings discussing any pending or recent litigation. The Applicant must include requested litigation information for the Applicant, its parent organization, affiliates, and subsidiaries. This information may be included as an attachment to the transmittal letter.
19. A statement affirming that the Applicant will comply with the requirement to maintain a complete affirmative action plan and will be in compliance with ORC section 125.111 prior to being awarded a provider agreement.

20. A statement affirming that any and all information in the Application is not confidential and/or trade secret information (as defined in the RFA) and that the Application may be posted in its entirety on the Internet for public viewing. Following submission to ODM, all Applications may become part of the public record. ODM reserves the right to disqualify any Applicant whose Application is found to contain prohibited personal information. The Applicant affirms that it shall be solely responsible for any and all information disclosed in the Application and any or all information released by ODM in a public records request(s).
21. A statement affirming that the Application accurately represents the capabilities and qualifications of the Applicant.
22. A statement identifying all addenda to this RFA issued by the State and received by the Applicant. If no addenda have been received, a statement to that effect.
23. A statement certifying that the person signing the letter is a person in the Applicant's organization authorized to commit the Applicant to the provider agreement.

Attachment C: Application Checklist

Attachment C: Application Checklist

ODM has provided below the template for the Application Checklist that is to be submitted with the Application. Applicants are expected to confirm compliance by entering “Yes” in the Applicant Check column. Upon receipt of Applications, ODM will confirm compliance by entering “Yes” in the ODM Check column.

Application Checklist

Applicant Name:				
#	REQUIREMENT	RFA Section #	Applicant Check (Y, N, NA)	ODM Check (Y, N, NA)
1.	The Application was submitted prior to the deadline (date and time) for submission of Applications specified in Section 2.1, Anticipated RFA Schedule.	2.8 and 4.2 #1		
2.	The Applicant included the number of paper and electronic copies specified in Section 3.1, Number of Applications.	3.1 and 4.2 #2		
3.	The paper copies of the Application meet the format requirements in Section 3.2.1, Paper Copies.	3.2.1 and 4.2 #3		
4.	The electronic copies of the Application meet the format requirements in Section 3.2.2, Electronic Copy.	3.2.2 and 4.2 #3		
5.	The Application contains the information specified in Section 3.4, Submission Requirements, and is organized as specified in Section 3.3, Application Organization.	3.3, 3.4, and 4.2 #4		
6.	The Applicant’s transmittal letter complies with the requirements in Attachment B, Transmittal Letter Template.	3.4.3, 4.2 #5, and Attachment B		
7.	The Applicant is (a) licensed by the Ohio Department of Insurance (ODI) as a Health Insuring Corporation (HIC), or (b) submitted an application to be licensed by ODI as a HIC, and has submitted evidence in support.	4.2 #6		
8.	The Applicant has not submitted more than one Application from organizations under a common controlling entity.	4.2 #7		

Applicant Name:				
#	REQUIREMENT	RFA Section #	Applicant Check (Y, N, NA)	ODM Check (Y, N, NA)
9.	The Application includes completed forms as specified in Section 3.4.6, Required Forms: <ul style="list-style-type: none"> • Exceptions • Conflict of Interest • Location of Business and Offshore Declaration • Affidavit of Non-Collusion • Certification of Compliance with Special Conditions 	3.4.6, 4.2 #8, and Attachments D-H		
10.	The Applicant's response to Attachment E demonstrates no conflict of interest or Applicant has provided an acceptable conflict of interest mitigation plan(s).	4.2 #9		

Attachment D: Exceptions

Attachment D: Exceptions

Applicants must closely read the Model OhioRISE Plan Provider Agreement as provided in Attachment A and the Certification of Compliance with Special Conditions as provided in Attachment H, and identify any exceptions to these documents. Any exception must include an explanation for the Applicant's inability to comply with such requirement and, if applicable, alternative language the Applicant would find acceptable. ODM has sole discretion whether to accept or reject any proposed exceptions. Any exceptions may, at the sole discretion of ODM, be grounds for disqualification from further consideration. Any exceptions accepted by ODM will be incorporated into the Model OhioRISE Plan Provider Agreement and executed by the OhioRISE Plan. ODM will not negotiate exceptions by the OhioRISE Plan.

If no changes are listed, the Applicant is indicating that no changes to these documents are proposed, and that the Applicant intends to accept the Model OhioRISE Plan Provider Agreement and Certification of Compliance as written if the Applicant's Application is selected for award. If an exception is not noted, but is raised during negotiations, ODM reserves the right to cancel the negotiation and disqualify the Applicant from consideration in the award of a provider agreement, at its sole discretion.

Item #	Attachment and Section Reference	Language from the Model OhioRISE Plan Provider Agreement or Certification of Compliance with Special Conditions	Applicant's Proposed Alternative Language (if Applicable)	Explanation of Exception

Attachment E: Conflict of Interest

Attachment E: Conflict of Interest

APPLICANT BUSINESS ETHICS, CONFLICT OF INTEREST AND COMPLIANCE PROGRAM REQUIREMENTS

Instructions to Applicant: Complete this form for the Applicant and each FDR, and provide all of the following information contained herein (A. through E., plus the Certification) with your Application and update during performance under the provider agreement, as required. Because all of the information to be submitted cannot be contained within this form, provide a table of contents with your submission(s). Please ensure that you follow this outline format in your submission(s), and include the appropriate sections (A. through E., and Certification) and page numbers for ease of reference.

Defined Terms:

Biased Ground Rules (BG): Occur when a person or entity is involved in drafting the solicitation, statement of work, specifications, evaluation criteria, or providing technical direction on a procurement that the person or entity and/or its affiliates intend to compete.

Conflict of Interest (COI): An unfair competitive advantage arising from activities or relationships with other persons or entities, in which a person or entity is unable or potentially unable to render impartial assistance or advice to the state, or the person or entity's objectivity in performing the contract/provider agreement work is or might otherwise be impaired.

Financial Interest/Relationships: A health care related direct or indirect ownership or investment interest (including an option or non-vested interest) in any entity that exists through equity, debt, or other means and includes any indirect ownership or investment interest no matter how many levels removed from a direct interest.

Impaired Objectivity (IO): Occurs when the nature of person or entity under one contract/provider agreement could provide the opportunity to give itself a benefit under another contract/provider agreement, including when it is performing duties that involve assessing or evaluating itself or a related entity, such that it has competing interests when giving advice, and its objectivity could be impaired.

Mitigation: Reduce or alleviate the impact of unavoidable conflicts of interest to an acceptable level of risk, so that the state's interests with regard to fair competition and contract/provider agreement performance are not prejudiced. This is facilitated in developing a conflict of interest mitigation plan.

Unequal Access (UA): Unfair access to non-public information, occurring when, as part of performance on one state contract/provider agreement, a person or entity has access to non-public information (including but not limited to proprietary information or source selection information) that may provide that person or entity with a competitive advantage in a competition for a different state contract/provider agreement.

APPLICANT/FDR:

DATE SUBMITTED:

SUBMISSION TYPE: ☐ Initial Submission ☐ Revised Submission

RFA #: ODMR-2021-0024

A. DESCRIPTION OF CORPORATE AND ORGANIZATIONAL STRUCTURE

Applicant must provide:

1. Directors, officers, and partners of the Applicant and any persons with a beneficial ownership of 5% or more in the Applicant;
2. Organizational charts that show the complete corporate organizational structure of the Applicant, to include parent and affiliated organizations, as applicable;
3. Internal organization chart of the entity performing the work; and
4. Narrative explanation of structure/ownership.

B. DESCRIPTION OF ALL ACTUAL, POTENTIAL, AND/OR APPARENT COIs AND FINANCIAL INTERESTS/RELATIONSHIPS

Applicant must provide the following:

1. **COI COMPLIANCE PROCESS:** Describe the Applicant's COI oversight process, including but not limited to how the Applicant identifies and resolves COIs.
2. **DISCLOSURE OF CONTRACTS THAT COULD POSE AN ACTUAL, POTENTIAL, AND/OR APPARENT COI:** Disclose all current/active and known future contracts that could give rise to an actual, potential, and/or apparent COI, for the Applicant, its parent(s) and affiliate(s), and potential FDRs, using the table below:

Applicant or FDR or other Relationship?	Name of Entity with which Applicant is under contract	Contract/ Provider Agreement #	Period of Performance	Total Contract Value	Description of Supplies/ Services	*COI Unequal Access, Biased Ground Rules and/or Impaired Objectivity	*COI Actual, Potential, or Apparent	Explanation: See #4 below

3. **FINANCIAL INTERESTS/RELATIONSHIPS:** Any organizational Financial Interest/Relationship that causes an actual, potential, and/or apparent UA, BG, and/or IO conflict of interest must be disclosed in sufficient detail for ODM's independent analysis.

Name of entity with which Applicant has a Financial Interest/ Relationship.	Description of Financial Interest or Relationship	COI (Yes/No) UA, BG, and/or IO	Explanation: If answer is "No," please provide explanation why it's not a conflict. If yes, see # 4 below.
---	---	--------------------------------	--

4. **CONFLICT OF INTEREST MITIGATION:** For each actual, potential, and apparent conflict of interest identified above in 2 and 3, provide details regarding the COI and propose a mitigation plan, including the procedures the Applicant will undertake to ensure independence, objectivity, and transparency to ODM. If accepted, the details regarding the COI and the mitigation plan will be incorporated into the provider agreement. The COI details and mitigation plan must include the following, at a minimum:
 - a. Description of the COI, including whether it is actual, potential, or potentially apparent conflict or issue;
 - b. Rationale for identification of the COI;
 - c. Mitigation strategy for COI, including:
 - a. Procedures ensuring that the Applicant will be independently managed and will not be influenced by the corporate relationship, and
 - b. Procedures ensuring the financial operations of the entities are separate and that decisions will not be made for the purpose of financially benefitting its corporate relation;
 - d. Timeframes for resolving the COI; and
 - e. Plan for monitoring COIs.

C. PERSONAL CONFLICTS OF INTEREST (PCI)

1. **PCI DISCLOSURES & ANALYSIS:** PCI Financial Disclosure information must be obtained by The Applicant. The Applicant must ensure that the organization's Compliance Officer has analyzed each PCI Financial Disclosure to determine whether actual, potential, and/or apparent PCIs exist. *Applicant/Contractor must not submit or disclose the information gathered to ODM.*
2. **MITIGATION PLAN:** Any required PCI mitigation strategies must be disclosed with the required COI Mitigation Plan described in B.4 above.

D. FIRST TIER, DOWNSTREAM, AND RELATED ENTITIES (FDRs)

- 1. PRE-AWARD DISCLOSURE INFORMATION:** The Applicant must obtain from all of its proposed FDRs “Contractor Business Ethics, Conflict of Interest, and Compliance Program Requirements” information identified herein.

Proprietary FDR Information Submissions: Due to proprietary concerns, in some circumstances an FDR may wish to withhold some of the information ordinarily contained in its response from the Applicant. In these events, the FDR may submit directly to ODM proprietary information that cannot be disclosed to the Applicant. The FDR must submit the entire COI submission to ODM and a redacted version to the Applicant. These circumstances must be extremely limited.

The Applicant must be responsible for conducting an analysis of each of its FDR’s COI submissions (except for the redacted information that may have been disclosed to ODM) in order to ensure that the FDR can perform services conflict-free. The Applicant must include each of its FDR’s analysis with its Application.

The Applicant’s analysis of each FDR’s COI submission must include:

- Whether the FDR responded to all of the COI submission criteria stated herein;
- A determination of whether an actual, potential, and/or apparent UA, BG, and/or IO COI has been, or must be, mitigated;
- An analysis of each FDR’s mitigation strategy; and
- If a COI must be mitigated, a recommendation to ODM of the acceptability of the mitigation strategy.

- 2. POST-AWARD DISCLOSURE INFORMATION:** The Applicant must obtain from its FDRs the required COI disclosures. The Applicant must conduct the same analysis of each of its FDR’s COI submissions as stated in D.1 above and disclose to ODM any adverse findings. The Applicant does not need to submit the underlying FDR disclosures to ODM, unless ODM determines otherwise.

E. INTEGRITY/MISCONDUCT

The Applicant must disclose any and all known violations and alleged acts, within the past ten years, related to itself, its parent and affiliated companies or FDRs, with regard to False Claims Act, Civil Monetary Penalties, Criminal investigations and/or indictments, and, *Qui tam* lawsuits or other administrative misconduct. The Applicant must also disclose in its Application whether it has been suspended, debarred, or proposed for suspension or debarment in the past ten years.

CERTIFICATION

I hereby certify that –

1. This submission is an ☐ Initial submission filed with our Application; or a ☐ Post-Award Revision.
2. To the best of my knowledge and belief, I represent, by submission of this disclosure, that the Applicant has disclosed all relevant information of which the Applicant is aware regarding all actual, potential, and/or apparent organizational/personal conflicts of interest;
3. I am authorized to bind this entity and attest that the information submitted herein is true, accurate, and complete as of this date;
4. Applicant has ☐ or will ☐ put in place a Final Code of Business Ethics and Conduct.
5. The requirements for Business Ethics, Conflict of Interest, and Compliance have been, or will be, incorporated in all FDR contracts/agreements.

Print Name/Title

Signature/Date

Attachment F: Location of Business and Offshore Declaration Form

Attachment F: Location of Business and Offshore Declaration Form

LOCATION OF BUSINESS AND OFFSHORE DECLARATION FORM

Location of Business Declaration: Applicant must certify that no public funds shall be spent on services provided/performed offshore by completing, signing, and returning this form.

FAILURE TO PROPERLY COMPLETE, SIGN, AND RETURN THIS FORM MAY RESULT IN DISQUALIFICATION OF THE APPLICANT FROM CONSIDERATION FOR AWARD.

Pursuant to Governor's Executive Order 2019-12D (<https://governor.ohio.gov/wps/portal/gov/governor/media/executive-orders/2019-12d>), no public funds shall be spent on services provided offshore. This form serves as a certification of compliance with this policy and required disclosures. Please answer the following questions about the project or service you are seeking to perform for the Ohio Department of Medicaid:

1. Principal location of business of Applicant:

(Address)

(City, State, Zip)

Name/Principal location of business of FDR(s):

(Name)

(Address, City, State, Zip)

(Name)

(Address, City, State, Zip)

2. Location where services will be performed by Applicant:

(Address)

(City, State, Zip)

Name/Location where services will be performed by FDR(s):

(Name)

(Address, City, State, Zip)

(Name)

(Address, City, State, Zip)

3. Location where state data will be stored, accessed, tested, maintained, or backed-up by Applicant:

(Address)

(Address, City, State, Zip)

Name/Location(s) where state data will be stored, accessed, tested, maintained, or backed-up by **FDR(s)**:

(Name)

(Address, City, State, Zip)

(Name)

(Address, City, State, Zip)

(Name)

(Address, City, State, Zip)

4. Location where services to be performed will be changed or shifted by Applicant:

(Address)

(Address, City, State, Zip)

Name/Location(s) where services will be changed or shifted to be performed by **FDR(s)**:

(Name)

(Address, City, State, Zip)

(Name)

(Address, City, State, Zip)

(Name)

(Address, City, State, Zip)

By signing below, I hereby certify and affirm that I have reviewed, understand, and will abide by the Governor’s Executive Order 2019-12D. I attest that no funds provided by ODM for this project or any other agreement will be used to purchase services provided outside the United States or to contract with an FDR who will use the funds to purchase services provided outside the United States. I will promptly notify ODM if there is a change in the location where any of the services relating to this project will be performed. If I am signing this on behalf of a company, business, or organization, I hereby acknowledge that I have the authority to make this certification on behalf of that entity.

Signature

Date

Entity Name

Address (Principal place of business)

Printed name of individual authorized
to sign on behalf of entity

City, State, Zip

Attachment G: Affidavit of Non-Collusion

Attachment G: Affidavit of Non-Collusion

AFFIDAVIT OF NON-COLLUSION

I state that I am _____ (title) of _____
(name of Applicant) and that I am authorized to make this affidavit on behalf of the Applicant,
and its owners, directors, and officers.

I state that:

- (1) The Application has been developed independently and without consultation, communication, or agreement with any other Applicant or potential Applicant.
- (2) Neither the Application nor the content of the Application has been disclosed to any other firm or person who is an Applicant or potential Applicant, and neither the Application nor any content of the Application will be disclosed before solicitation opening.
- (3) No attempt has been made or will be made to induce any firm or person to refrain from submitting an Application or to submit a complementary Application.
- (4) The Application is made in good faith and not pursuant to any agreement or discussion with, or inducement from, any firm or person to submit a complementary or other noncompetitive Application.
- (5) _____ (name of Applicant), its affiliates, subsidiaries, officers, directors, and employees are not currently under investigation by any governmental agency, and have not in the last four years been convicted of or found liable for any act prohibited by state or federal law in any jurisdiction, involving conspiracy or collusion with respect to bidding on any public contract, except as described in the attached appendix.

I state that _____ (name of Applicant)
understands and acknowledges that the above representations are material and important, and
will be relied on by the ODM in awarding the provider agreement(s) for which this
Application is submitted. I understand and my firm understands that any misstatement in this
affidavit is and shall be treated as fraudulent concealment from the ODM of the true facts
relating to the submission of this Application.

(Authorized Signature)

(Name of Company/Position)

Sworn to and subscribed before me this ____ day of _____, 20__.

Notary Public for State of _____

My Commission Expires: _____

Attachment H: Certification of Compliance with Special Conditions

Attachment H: Certification of Compliance with Special Conditions

CERTIFICATION OF COMPLIANCE WITH SPECIAL CONDITIONS

I state that I am _____ (title) of _____ (name of Applicant) and that I am authorized to make this certification on behalf of my firm, and its owners, directors, and officers. By signing this certification, I hereby affirm current and continued compliance at the time of this Application and for the duration of my firm's provider agreement with ODM with each condition listed below.

1. **Debarment Requirements.** I affirm that neither my firm nor any of its principals or FDRs, is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in transactions by any governmental agency. I also affirm that within three years preceding this certification neither my firm nor any of its principals:
 - a. Have been convicted of, or had a civil judgment rendered against them for commission of fraud or other criminal offense in connection with obtaining, attempting to obtain, or performing a federal, state, or local public transaction or contract under a public transaction; for violation of federal or state antitrust statutes; for commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements; or for receiving stolen property; or
 - b. Are presently indicted or otherwise criminally or civilly charged by a government entity (federal, state, or local) for the commission of any of the offenses listed in this paragraph and have not had any federal, state, or local public transactions terminated for cause or default.
2. **Qualifications to Conduct Business.** I affirm that my firm has or has applied for all of the approvals, licenses, or other qualifications needed to conduct business in the State of Ohio. If at any time during the agreement period my firm, for any reason, becomes disqualified from conducting business in the State of Ohio, my firm will immediately notify ODM in writing and will comply with the termination requirements in the provider agreement.
3. **Unfair Labor Practices.** I affirm that neither my firm nor its principals are on the most recent list established by the Ohio Secretary of State, pursuant to ORC section 121.23, which would identify my firm as having more than one unfair labor practice contempt of court finding.
4. **Finding for Recovery.** I affirm that neither my firm nor its principals is subject to a finding for recovery under ORC section 9.24, or it has taken the appropriate remedial steps required, or otherwise qualifies under ORC section 9.24 to contract with the state of Ohio.
5. **Civil Rights Laws.** I affirm that my firm and its FDRs are in 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.).

6. Ethics and Conflicts of Interest Laws.

- a. I affirm that I have reviewed, and understand the State of Ohio's ethics and conflict of interest laws.
- b. I affirm that no party who holds a position listed or described in ORC section 3517.13 (I) or (J), has made, while in their current position, one or more personal monetary contributions in excess of One Thousand and 00/100 Dollars (\$1,000.00) to the current Governor or to the Governor's campaign committee when he was a candidate for office within the previous two calendar years. ORC section 3517.13 does not apply to professional associations organized under ORC Chapter 1785.
- c. I affirm that my firm will refrain from promising or giving to any ODM employee anything of value that could be construed as having a substantial and improper influence upon the employee with respect to the employee's duties. I further agree that my firm will not solicit any ODM employee to violate ORC sections 102.03, 2921.42, or 2921.43.
- d. I affirm that my firm, its officers, employees, and members have not nor will they acquire any interest, whether personal, business, direct or indirect, that is incompatible, in conflict with, or would compromise the discharge and fulfillment of the firm's functions and responsibilities under this RFA. If my firm, its officers, employees, or members acquire any incompatible, conflicting, or compromising interest, I agree that my firm will immediately disclose the interest in writing to the ODM Chief Legal Counsel at 50 West Town Street, Columbus, Ohio 43215-3414. I further agree that the person with the conflicting interest will not participate in any deliverables until ODM determines that participation would not be contrary to public interest.

7. Lobbying Restrictions.

- a. I affirm that no federal funds paid to my firm by ODM through this agreement or any other agreement have been or will be used to lobby Congress or any federal agency in connection with a particular contract, grant, cooperative agreement, or loan. I affirm compliance with all federal lobbying restrictions, including 31 USC 1352. I affirm that, if required by federal regulations, my firm has executed and filed the Disclosure of Lobbying Activities standard form LLL.
- b. I affirm my firm's compliance with the Ohio executive agency lobbying restrictions contained in ORC sections 121.60 to 121.69.
- c. I affirm my firm's compliance with the Byrd Anti-Lobbying Amendment, which at a minimum, attests my firm will not and has not used federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any agency, a member of Congress, officer or employee of Congress, or an employee of a

member of Congress in connection with obtaining any federal contract, grant, or any other award covered by 31 USC Chapter 1352.

8. **Combatting Trafficking in Persons.** I affirm that my firm is in compliance with the Federal Acquisition Regulation (FAR) for Combatting Trafficking in Persons, 48 CFR Subpart 22.17, in which “the United States Government has adopted a zero tolerance policy regarding trafficking in persons.” The provisions found in 48 CFR Subpart 52.2, specifically Subpart 52.222-50 are hereby incorporated by reference.
9. **Boycott.** I acknowledge that, pursuant to ORC section 9.76, a state agency may not enter into or renew a contract or Provider Agreement for supplies, equipment, or services with a company that operates to earn a profit unless the company provides the following declaration. If applicable, I affirm that my firm is not boycotting any jurisdiction with whom the state of Ohio can enjoy open trade and will not do so during the Agreement period. My firm will notify ODM immediately if it boycotts a jurisdiction with whom the state of Ohio can enjoy open trade. ODM reserves the right to terminate this Agreement immediately upon discovery of such a boycott.
10. **Certification of Compliance.** I affirm that my firm is in compliance with all other applicable federal and state laws, regulations, and rules and will require the same certification from my firm’s FDRs.

Signature

Date

Firm Name

Address

Printed Name of individual authorized
to sign on behalf of firm

Attachment I: Draft OhioRISE Rules and Managed Care Rule



**RFA# ODMR-2021-0025 – ATTACHMENT I:
DRAFT OHIORISE AND MANAGED CARE RULES**

TABLE OF CONTENTS

1. Overview	3
1.1 OhioRISE and Managed Care Rules.....	3
2. 5160-59-01 OhioRISE: Definitions	4
3. 5160-59-01.1 OhioRISE: Application of general managed care rules	7
4. 5160-59-02 OhioRISE: Eligibility And Enrollment	9
5. 5160-59-03 OhioRISE: Covered Services	11
6. 5160-59-03.1 OhioRISE: Utilization Management	17
7. 5160-26-05 Managed Care: Provider Panel and Contracting Requirements.....	20
8. 5160-26-05.1 Managed Care: Provider Services	29
9. 5160-26-06 Managed Care: Program Integrity — Fraud, Waste and Abuse, Audits, Reporting, and Record Retention	32
10. 5160-26-08.3 Managed Health Care Programs: Member Rights	34
11. 5160-26-08.4 Managed Care: Appeal and Grievance System.....	37
12. 5160-26-09.1 Managed Care: Third Party Liability and Recovery.....	46
13. 5160-26-10 Managed Care: Sanctions and Provider Agreement Actions.....	50
14. 5160-26-11 Managed Care: Non-Contracting Providers.....	54
15. 5160-26-12 Managed Care: Member Co-payments.....	56

1. Overview

As a prepaid inpatient health plan (PIHP), which is a type of Medicaid managed care entity, the Contractor must comply with the federal and state Medicaid managed care requirements. This includes federal Medicaid managed care requirements in Title 42 of the Code of Federal Regulations (CFR), Part 438, Managed Care (42 CFR Part 438) that apply to PIHPs and the State managed care requirements in Ohio Administrative Code (OAC) rules. Attachment I outlines OhioRISE and managed care requirements the Contractor will have to follow that will be outlined in OAC rules upon OhioRISE implementation.

1.1 OhioRISE and Managed Care Rules

The proposed OhioRISE and managed care rules outlined in this attachment are in draft form. To implement the requirements contained in the sections below, Ohio Department of Medicaid (ODM) must adopt administrative rules. The Ohio Revised Code grants rule-making authority to ODM to adopt new rules. These rules, as amended or adopted, will have the same effect of law. The proposed rules, as outlined below, provide notification of the agency's plan to adopt new or updated rules. All proposed rules must go through a formal rule-making process and are subject to change based on public comments received by various constituents and stakeholders. The rule-making process is not expected to be complete by the time this RFA is published, therefore, the following draft rules are provided for informational purposes only to notify potential bidders of additional managed care requirements and are subject to change.

Prior to beginning the formal rule-making process, ODM intends to engage stakeholders in an informal review process to gather input and feedback on draft OhioRISE rules and the underlying policy used to develop them. This stakeholder input process will include an extensive review of the OhioRISE services described in draft rule 5160-59-03, included in this attachment. Following the stakeholder process, ODM anticipates revisions to these draft rules, development of additional new rules, and amendments to existing Medicaid rules as necessary to implement OhioRISE.

2. 5160-59-01 OhioRISE: Definitions

- (A) The definitions set forth in rule 5160-26-01 of the Administrative Code apply to the Ohio resilience through integrated systems and excellence (OhioRISE) rules set forth in Chapter 5160-59 of the Administrative Code.
- (B) In addition to the definitions set forth in rule 5160-26-01 of the Administrative Code, the following definitions apply to Chapter 5160-59 of the Administrative Code:
- (1) "Abuse (of a member)" has the same meaning as in rule 5160-44-05 of the Administrative Code.
 - (2) "Actuary" means 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 as defined in 42 CFR 438.2 (October 1, 2020).
 - (3) "Care coordination" means the strategy that will be deployed by OhioRISE program to deliberately organize and support children, youth, and their families by addressing needs to achieve better health outcomes. The OhioRISE program will use a three-tiered model of care coordination: intensive and moderate care coordination (tiers 3 and 2, respectively) delivered through care management entities based on a system of care approach and a wraparound philosophy, and tier 1 care coordination performed by OhioRISE plan care coordinators, or their contracted designees as approved by ODM, for members who need less intensive care coordination.
 - (4) "Care coordination entity (CCE)" is a local community agency other than a care management entity that provides care coordination to specific populations in the Medicaid program.
 - (5) "Care management entity (CME)" is a local community agency contracted with the OhioRISE plan that provides care coordination to OhioRISE plan enrolled members. The CME will serve as the "locus of accountability" for children with complex challenges and their families who are involved in navigating multiple state systems. The CME will be responsible for providing and/or coordinating the provision of intensive care coordination, community-based and in-home services, and other services and supports to improve health outcomes.
 - (6) "Child and adolescent needs and strengths (CANS)" is a multiple-purpose information integration tool developed for children's services to support decision-making including level of care and service planning, facilitate quality improvement initiatives and allow for the monitoring of outcomes of services. CANS is designed to be the output of a functional assessment process.
 - (7) "Electronic health record (EHR)" means 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.
 - (8) "External medical review" means the review process conducted by an ODM-identified, independent, external medical review entity that is initiated by a provider that disagrees with the OhioRISE plan's decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity.

- (9) "Family" means a child's family or caregiver and may include biological, adoptive, or foster parents, as well as extended family or non-biological adults who have a role in the care for and support of a child or youth.
- (10) "Incident" has the same meaning as in rule 5160-44-05 of the Administrative Code.
- (11) "Limited English proficiency (LEP)" means an 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.
- (12) "Managed care entities (MCEs)" means entities that include managed care organizations, statewide pharmacy benefits manager, and the OhioRISE plan.
- (13) "Neglect" has the same meaning as in rule 5160-44-05 of the Administrative Code.
- (14) "Network provider" means any provider, group of providers, or entity that has a network provider contract with the OhioRISE plan and receives Medicaid funding directly or indirectly to order, refer, or render covered services as a result of ODM's provider agreement with the OhioRISE plan. A network provider is not a subcontractor by virtue of the network provider contract as defined in 42 CFR 438.2 (October 1, 2020).
- (15) "Notice of action" has the same meaning as in rule 5160-26-08.4 of the Administrative Code, the written notice the OhioRISE plan must provide to members when an adverse benefit determination has occurred or will occur.
- (16) "OhioRISE plan" is a prepaid inpatient health plan (PIHP) and health insuring corporation (HIC) contracted to comprehensively manage Medicaid behavioral health benefits for enrolled members. OhioRISE plan eligibility and enrollment is determined by ODM.
- (17) "Prepaid inpatient health plan" has the same definition as in 42 CFR 438.2 (October 1, 2020).
- (18) "Provider claim dispute resolution" means the established process for OhioRISE plan network and out-of-network providers to challenge OhioRISE plan claim payments or denials.
- (19) "Social risk factors" means 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.
- (20) "State hearing" means the process set forth in 42 CFR Part 431, Subpart E (October 1, 2020), and has the same meaning as in rule 5101:6 of the Administrative Code.
- (21) "System of care" means a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them function better at home, in school, in the community, and throughout life.
- (22) "Telehealth" has the same meaning as in rule 5160-1-18 of the Administrative Code.
- (23) "Unexplained death" means a 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.

- (24) "Warm transfer" means the 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.

3. 5160-59-01.1 OhioRISE: Application of general managed care rules

(A) The Ohio resilience through integrated systems and excellence (OhioRISE) plan must comply with all of the requirements applicable to managed care organizations (MCOs) in the following rules:

- (1) Rule 5160-26-05 of the Administrative Code;
- (2) Rule 5160-26-05.1 of the Administrative Code;
- (3) Rule 5160-26-06 of the Administrative Code;
- (4) Rule 5160-26-08.3 of the Administrative Code;
- (5) Rule 5160-26-08.4 of the Administrative Code;
- (6) Rule 5160-26-09 of the Administrative Code;
- (7) Rule 5160-26-09.1 of the Administrative Code;
- (8) Rule 5160-26-10 of the Administrative Code;
- (9) Rule 5160-26-11 of the Administrative Code; and
- (10) Rule 5160-26-12 of the Administrative Code.

(B) For all rules listed in paragraph (A) of this rule, the following provisions apply to the OhioRISE program described in Chapter 5160-59 of the Administrative Code:

- (1) All cross-references to rule 5160-26-01 of the Administrative Code are replaced by cross-references to rule 5160-59-01 of the Administrative Code.
- (2) All cross-references to rule 5160-26-02 of the Administrative Code are replaced by cross-references to rule 5160-59-02 of the Administrative Code.
- (3) All cross-references to rule 5160-26-02.1 of the Administrative Code are replaced by cross-references to rule 5160-59-02 of the Administrative Code.
- (4) All cross-references to rule 5160-26-03 of the Administrative Code are replaced by cross-references to rule 5160-59-03 of the Administrative Code.
- (5) All cross-references to rule 5160-26-03.1 of the Administrative Code are replaced by cross-references to rule 5160-59-03.1 of the Administrative Code.

(C) The following rules in Chapter 5160-26 of the Administrative Code do not apply to OhioRISE, as they are replaced by corresponding rules in Chapter 5160-59 of the Administrative Code:

- (1) Rule 5160-26-02 of the Administrative Code;
- (2) Rule 5160-26-02.1 of the Administrative Code;
- (3) Rule 5160-26-03 of the Administrative Code; and

(4) Rule 5160-26-03.1 of the Administrative Code.

- (D) When the OhioRISE plan holds provider agreements with the Ohio Department of Medicaid (ODM) for the Ohio RISE program, as well as the MyCare Ohio or Medicaid managed care programs, ODM may apply all of the applicable provisions in Chapter 5160-26 of the Administrative Code separately to each of the contracts.

4. 5160-59-02 OhioRISE: Eligibility And Enrollment

- (A) Except as provided in paragraph (B) of this rule, to be eligible for enrollment in Ohio resilience through integrated systems and excellence (OhioRISE) an individual must meet the criteria in paragraphs (A)(1) through (A)(4) below:
- (1) Be age 20 or younger at the time of enrollment;
 - (2) Be determined eligible for Ohio Medicaid in accordance with Chapters 5160:1-1 to 5160:1-5 of the Administrative Code;
 - (3) Not be enrolled in a MyCare Ohio plan as described in chapter 5160-58 of the Administrative Code; and
 - (4) Meet a threshold score established for OhioRISE eligibility on the Ohio "Child and Adolescent Needs and Strengths" (CANS) assessment administered in an accordance with Ohio Department of Medicaid (ODM) guidelines.
- (B) An individual who meets the criteria in paragraphs (A)(1) through (A)(3) of this rule is eligible for OhioRISE enrollment under any of the following conditions and will remain in OhioRISE until he or she meets the criteria for disenrollment in paragraph (D) of this rule.
- (1) Be an inpatient in a hospital with a primary diagnosis of mental illness or substance use disorder as listed in the appendix to this rule;
 - (2) Be an inpatient in a psychiatric residential treatment facility (PRTF) as described in rule 5160-59-03 in Administrative Code; or
 - (3) Have an immediate need for OhioRISE services due to a behavioral health crisis or out-of-home placement.
- (C) Enrollment in OhioRISE.
- (1) Enrollment is mandatory for eligible individuals and begins the earlier of:
 - (a) The first day of the month following the determination that the individual meets the requirements in paragraphs (A)(1) through (A)(4) of this rule; or
 - (b) The date of admission to an inpatient hospital with a primary diagnosis of mental illness or substance use disorder as described in paragraph (B)(1) of this rule; or
 - (c) The date of admission to a PRTF as described in paragraph (B)(2) of this rule; or
 - (d) For individuals with an immediate need for OhioRISE services as described in paragraph (B)(3) of this rule, the date the behavioral health crisis services are initiated or the out-of-home placement began.
- (D) Disenrollment from OhioRISE occurs upon any of the following occurring:
- (1) The later of the last day of the month when the individual:

- (a) Turns age 21 except for as described in paragraph (D)(2) of this rule; or
 - (b) No longer meets the eligibility criteria described in paragraph (A)(2) through (A)(4) of this rule.
- (2) For an individual who resides in a PRTF, upon turning age 21, will remain enrolled in OhioRISE until he or she is discharged from the PRTF or upon turning age 22, whichever occurs first.
- (3) An individual begins enrollment in a MyCare Ohio plan, as described in chapter 5160-58 of the Administrative Code.
- (E) If an individual is denied enrollment in the program pursuant to paragraph (A) of this rule, or is disenrolled from the program pursuant to paragraph (D) of this rule, the individual will be afforded notice and hearing rights in accordance with division 5101:6 of the Administrative Code.

5. 5160-59-03 OhioRISE: Covered Services

- (A) The Ohio resilience through integrated systems and excellence (OhioRISE) plan must ensure members have access to the medically necessary services stated in paragraph (B) of this rule. The OhioRISE plan must ensure:
- (1) Services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished;
 - (2) The amount, duration, or scope of a required service is not arbitrarily denied or reduced solely because of the diagnosis, type of illness, or condition;
 - (3) Prior authorization is available for services on which an OhioRISE plan has placed an identified limitation to ensure the limitation may be exceeded when medically necessary, unless the OhioRISE plan's limitation is also a limitation for fee-for-service Medicaid coverage;
 - (4) Coverage decisions are based on the coverage and medical necessity criteria published in agency 5160 of the Administrative Code and practice guidelines specified in rule 5160-26-05.1 and 5160-59-01.1 of the Administrative Code; and
 - (5) If a member is unable to obtain medically necessary services described in this rule through an OhioRISE plan panel provider, the OhioRISE plan must adequately and timely cover the services out of panel, until the OhioRISE plan is able to provide the services from a panel provider.
- (B) An OhioRISE plan must ensure members have access to the following services:
- (1) Intensive care coordination using high fidelity wraparound. Intensive care coordination is a structured approach to service planning and care coordination for individuals with complex needs, which is built on key system of care values, including being family- and youth-driven, team-based, collaborative, individualized, and outcomes-based. This approach adheres to specified procedures for engagement, individualized care planning, identifying strengths, leveraging natural supports, and monitoring progress.
 - (2) Moderate care coordination using a wraparound-informed approach. Moderate care coordination is intended to meet the needs of youth and families with lesser complex needs who do not meet level of care criteria for intensive care coordination, but whose challenges exceed the resources of routine care coordination; and who will benefit from targeted care coordination to assist them in maintaining stability in the community. Moderate care coordination may also provide a transition of care option for youth and their families when improvements have been realized through delivery of the intensive care coordination service. Moderate care coordination is built on key system of care values, including being family- and youth-driven, team-based, collaborative, individualized, and outcomes-based. The service involves interagency collaboration; individualized strengths-based care; cultural competence; youth and family involvement; community-based services; and accountability.
 - (3) Mobile response and stabilization services (MRSS). MRSS is a mobile response stabilization service for young people who are experiencing significant behavioral or emotional challenges and their families. The service may be delivered through a face-to-face mobile response to the young person's home, school, a local emergency department (ED), or another location in the community, including a location preferred by the family. MRSS is available twenty-four hours a

day, 365 days a year. MRSS provides rapid community-based crisis assessment and stabilization to young people and their families and builds the skills needed to help maintain young people in their homes and communities whenever safe and possible. In addition to the direct provision of crisis intervention and stabilization services, MRSS providers link young people and their families to ongoing clinical and natural supports and services through a facilitated child and family team planning process.

- (4) Intensive home based treatment (IHBT) as described in Administrative Code rule 5160-27-05.
- (5) Respite services for members under the age of 21 with behavioral health needs in accordance with OAC rule 5160-26-03.
- (6) Inpatient hospital services provided in accordance with Chapter 5160-2 of the Administrative Code in a free-standing psychiatric hospital or a general acute care hospital that are:
 - (a) Inpatient psychiatric services; or
 - (b) Inpatient substance use disorder (SUD) services (including withdrawal management) provided in accordance with American Society of Addiction Medicine level of care 4.
- (7) Psychiatric residential treatment facility (PRTF) services. A PRTF is a non-hospital facility with a provider agreement with the Ohio Department of Medicaid (ODM) or another state Medicaid agency to provide the inpatient psychiatric services to Medicaid-eligible individuals under the age of 21. The facility must be accredited by the Joint Commission or another accrediting organization with comparable standards recognized by ODM. PRTFs must also meet the requirements in 42 C.F.R. 441.151 through 42 C.F.R. 441.184.
- (8) Opioid Treatment Program (OTP) services delivered by community SUD programs licensed by Ohio Department of Mental Health and Addiction Services as a methadone administration program and/or certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) as an OTP.
- (9) Behavioral health services provided in accordance with Chapter 5160-27 of the Administrative Code.
- (10) Behavioral health services provided in accordance with rule 5160-8-05 of the Administrative Code.
- (11) Behavioral health services rendered by psychiatrists in accordance with OAC Chapter 5160-4 or advanced practice registered nurses in accordance with OAC Chapter 5160-4-04.
- (12) Behavioral health services rendered by outpatient hospital providers in accordance with ODM guidance. Technical specifications for outpatient hospital behavioral health services covered by the OhioRISE plan, including a protocol for claims that include both behavioral health and medical services, will be developed by ODM.
- (13) Behavioral health services rendered by federally qualified health centers (FQHCs) and rural health centers (RHCs) in accordance with OAC Chapter 5160-28-01.
- (14) Physician administered drugs for the treatment of mental health and SUD conditions.
- (15) Limited customized goods and services included in a wraparound plan using flexible funding consistent with ODM guidance.

(16) Other services identified by ODM.

(C) The OhioRISE plan may place appropriate limits on a service:

- (1) On the basis of medical necessity for the member's condition or diagnosis; or
- (2) For the purposes of utilization control, provided the services furnished can be reasonably expected to achieve their purpose as specified in paragraph (A)(1) of this rule.

(D) The OhioRISE plan must ensure OhioRISE covered services described in paragraph (B) of this rule that are emergency services as defined in rule 5160-26-01 of the Administrative Code are provided and covered twenty-four hours a day, seven days a week. At a minimum, covered services described in paragraph (B) of this rule that are emergency services must be provided and reimbursed in accordance with the following:

- (1) The OhioRISE plan may not deny payment for treatment obtained when a member had an emergency condition as defined in rule 5160-26-01 of the Administrative Code.
- (2) The OhioRISE plan cannot limit what constitutes an emergency condition on the basis of diagnoses or symptoms.
- (3) The OhioRISE plan must cover all emergency services without requiring prior authorization.
- (4) The OhioRISE plan must cover OhioRISE plan services related to the member's emergency condition when the member is instructed to go to an emergency facility by a representative of the OhioRISE plan or the member's managed care plan including but not limited to the member's primary care provider (PCP) or the OhioRISE plan or managed care plan's 24-hour toll-free call-in-system.
- (5) The OhioRISE plan cannot deny payment of emergency services based on the treating provider, hospital, or fiscal representative not notifying the member's PCP of the visit.
- (6) For the purposes of this rule, "non-contracting provider of emergency services" means any person, institution, or entity who does not contract with the OhioRISE plan but provides OhioRISE covered services described in paragraph (B) of this rule that are emergency services to a plan member, regardless of whether that provider has a Medicaid provider agreement with ODM. The plan must cover OhioRISE covered services described in paragraph (B) of this rule that are emergency services as defined in rule 5160-26-01 of the Administrative Code when the services are delivered by a non-contracting provider of emergency services. Claims for these services cannot be denied regardless of whether the services meet an emergency medical condition as defined in rule 5160-26-01 of the Administrative Code. Such services must be reimbursed by the plan at the lesser of billed charges or 100% of the Ohio Medicaid program fee-for-service reimbursement rate (less any payments for indirect costs of medical education and direct costs of graduate medical education that is included in the Ohio Medicaid program fee-for-service reimbursement rate) in effect for the date of service. If an inpatient admission results, the plan is required to reimburse at this rate only until the member can be transferred to a provider designated by the plan.
- (7) The OhioRISE plan must cover OhioRISE covered services as described in paragraph (B) of this rule that are emergency services until the member is stabilized and can be safely discharged or transferred.

- (8) The OhioRISE plan must adhere to the judgment of the attending provider when the attending provider requests a member's transfer to another facility or discharge. The plan may establish arrangements with hospitals whereby the plan may designate one of its contracting providers to assume the attending provider's responsibilities to stabilize, treat and transfer the member.
- (9) A member who has had an emergency condition may not be held liable for payment of any subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.
- (E) The OhioRISE plan must establish, in writing, the process and procedures for the submission of claims for services delivered by non-contracting providers, including non-contracting providers of emergency services as described in paragraph (D)(6) of this rule. Such information must be made available upon request to non-contracting providers, including non-contracting providers of emergency services. An OhioRISE plan shall not establish claims filing and processing procedures for non-contracting providers, including non-contracting providers of emergency services, that are more stringent than those established for their contracting providers.
- (F) The OhioRISE plan must ensure any OhioRISE covered services described in paragraph (B) of this rule that are post-stabilization care services as defined in rule 5160-26-01 of the Administrative Code are provided and covered 24 hours a day, seven days a week.
 - (1) The OhioRISE plan must designate a telephone line to receive provider requests for coverage of post-stabilization care services. The line must be available 24 hours a day. The OhioRISE plan must document that the telephone number and process for obtaining authorization has been provided to each emergency facility in the service area. The OhioRISE plan must maintain a record of any request for coverage of post-stabilization care services that is denied including, at a minimum, the time of the provider's request and the time the OhioRISE plan communicated the decision in writing to the provider.
 - (2) At a minimum, OhioRISE covered services described in paragraph (B) of this rule that are post-stabilization care services must be provided and reimbursed in accordance with the following:
 - (a) The OhioRISE plan must cover services obtained within or outside the OhioRISE plan's panel that are pre-approved in writing to the requesting provider by a plan provider or other OhioRISE plan representative.
 - (b) The OhioRISE plan must cover services obtained within or outside the OhioRISE plan's panel that are not pre-approved by a plan provider or other OhioRISE plan representative but are administered to maintain the member's stabilized condition within one hour of a request to the OhioRISE plan for pre-approval of further post-stabilization care services.
 - (c) The OhioRISE plan must cover services obtained within or outside the OhioRISE plan's panel that are not pre-approved by a plan provider or other OhioRISE plan representative but are administered to maintain, improve or resolve the member's stabilized condition if:
 - (i) The OhioRISE plan fails to respond within one hour to a provider request for authorization to provide such services.
 - (ii) The OhioRISE plan cannot be contacted.
 - (iii) The OhioRISE plan's representative and treating provider cannot reach an agreement concerning the member's care and a plan provider is not available for consultation. In

this situation, the OhioRISE plan must give the treating provider the opportunity to consult with a plan provider and the treating provider may continue with care until a plan provider is reached or one of the criteria specified in paragraph (F)(3) of this rule is met.

- (3) The OhioRISE plan's financial responsibility for OhioRISE covered services described in paragraph (B) of this rule that are post-stabilization care services not pre-approved ends when:
 - (a) A plan provider with privileges at the treating hospital assumes responsibility for the member's care;
 - (b) A plan provider assumes responsibility for the member's care through transfer;
 - (c) An OhioRISE plan representative and the treating provider reach an agreement concerning the member's care; or
 - (d) The member is discharged.

(G) OhioRISE plan responsibilities for payment of other services.

- (1) ODM may approve an OhioRISE plan's member to be referred to certain OhioRISE plan's non-contracting hospitals, as specified in rule 5160-26-11 of the Administrative Code, for non-emergency hospital services that are OhioRISE covered services as described in paragraph (B) of this rule. When ODM permits such authorization, ODM will notify the OhioRISE plan and the OhioRISE plan's non-contracting hospital of the terms and conditions, including the duration of the approval and the OhioRISE plan must reimburse the OhioRISE plan's non-contracting hospital at 100% of the current Ohio Medicaid program fee-for-service reimbursement rate in effect for the date of service for all Medicaid-covered non-emergency hospital services delivered by the OhioRISE plan's non-contracting hospital. ODM will base its determination of when an OhioRISE plan's members can be referred to OhioRISE plan non-contracting hospitals pursuant to the following:
 - (a) The OhioRISE plan's submission of a written request to ODM for the approval to refer members to a hospital that has declined to contract with the OhioRISE plan. The request must document the OhioRISE plan's contracting efforts and why the OhioRISE plan believes it will be necessary for members to be referred to this particular hospital; and
 - (b) ODM consultation with the OhioRISE plan non-contracting hospital to determine the basis for the hospital's decision to decline to contract with the OhioRISE plan, including but not limited to whether the OhioRISE plan's contracting efforts were unreasonable and/or that contracting with the OhioRISE plan would have adversely impacted the hospital's business.
- (2) Paragraph (G)(1) of this rule is not applicable when an OhioRISE plan and an OhioRISE plan non-contracting hospital have mutually agreed to that hospital providing non-emergency OhioRISE covered hospital services to an OhioRISE plan's members. The OhioRISE plan must ensure that such arrangements comply with rule 5160-26-05 of the Administrative Code.
- (3) The OhioRISE plan is not responsible for payment of services provided through Medicaid school program (MSP) pursuant to Chapter 5160-35 of the Administrative Code. An OhioRISE plan must ensure access to OhioRISE-covered services for members who are unable to timely access services or unwilling to access services through MSP providers.

- (4) The OhioRISE plan is not required to cover services provided to members outside the United States.

6. 5160-59-03.1 OhioRISE: Utilization Management

The Ohio Resilience through Integrated Systems and Excellence (OhioRISE) plan must have a utilization management (UM) program with clearly defined structures and processes designed to maximize the effectiveness of the care provided to the member. The OhioRISE plan must ensure decisions rendered through the UM program are based on medical necessity.

(A) The UM program must be based on written policies and procedures that include, at a minimum:

- (1) The information sources used to make determinations of medical necessity;
- (2) The criteria, based on sound clinical evidence, to make UM decisions and the specific procedures for appropriately applying the criteria;
- (3) A specification that written UM criteria will be made available to both contracting and non-contracting providers; and
- (4) A description of how the OhioRISE plan will monitor the impact of the UM program to detect and correct potential under-and over-utilization.
- (5) The OhioRISE plan's UM program must also ensure and document the following:
 - (a) An annual review and update of the UM program;
 - (b) The involvement of a designated senior physician in the UM program;
 - (c) The use of appropriate qualified licensed health professionals to assess the clinical information used to support UM decisions;
 - (d) Review of the Child and Family Plan;
 - (e) The use of board-certified consultants to assist in making medical necessity determinations, as necessary;
 - (f) That UM decisions are consistent with clinical practice guidelines as specified in rule 5160-26-05.1 of the Administrative Code. The OhioRISE plan may not impose conditions around the coverage of a medically necessary-covered service unless they are supported by such clinical practice guidelines;
 - (g) The reason for each denial of a service, based on sound clinical evidence; and
 - (h) That compensation by the OhioRISE plan to individuals or entities that conduct UM activities does not offer incentives to deny, limit, or discontinue medically necessary services to any member.

(B) The OhioRISE plan must process requests for initial and continuing authorizations of services from their providers and members. The OhioRISE plan must have written policies and procedures to process requests and, upon request, the OhioRISE plan's policies and procedures must be made available for review by the Ohio Department of Medicaid (ODM). The OhioRISE plan's written policies and procedures for initial and continuing authorization of services must also be made

available to contracting and non-contracting providers upon request. The OhioRISE plan must ensure and document the following occurs when processing requests for initial and continuing authorizations of services:

- (1) Consistent application of review criteria for authorization decisions.
- (2) Consultation with the requesting provider, when necessary.
- (3) Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.
- (4) That a written notice will be sent to the member and the requesting provider of any decision to reduce, suspend, terminate, or deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the member must meet the requirements of division 5101:6 and rule 5160-26-08.4 of the Administrative Code.
- (5) For standard authorization decisions, the OhioRISE plan must provide notice to the provider and member as expeditiously as the member's health condition requires but no later than 10 calendar days following receipt of the request for service, except as specified in paragraph (B)(7) of this rule. If requested by the member, provider, or the OhioRISE plan, standard authorization decisions may be extended up to 14 additional calendar days. If requested by the OhioRISE plan, the OhioRISE plan must submit to ODM for prior-approval, documentation as to how the extension is in the member's interest. If ODM approves the OhioRISE plan's extension request, the OhioRISE plan must give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision. The OhioRISE plan must carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.
- (6) If a provider indicates or the OhioRISE plan determines that following the standard authorization time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the OhioRISE plan must make an expedited authorization decision and provide notice of the authorization decision as expeditiously as the member's health condition requires but no later than 48 hours after receipt of the request for service. If requested by the member or OhioRISE plan, expedited authorization decisions may be extended up to 14 additional calendar days. If requested by the OhioRISE plan, the OhioRISE plan must submit to ODM for prior-approval, documentation as to how the extension is in the member's interest. If ODM approves the OhioRISE plan's extension request, the OhioRISE plan must give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision. The OhioRISE plan must carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.
- (7) Service authorization decisions not reached within the time frames specified in paragraphs (B)(5) and (B)(6) of this rule constitute a denial, and the OhioRISE plan must give notice to the member as specified in rule 5160-26-08.4 of the Administrative Code.
- (8) The OhioRISE plan must maintain and submit as directed by ODM, a record of all authorization requests, including standard and expedited authorization requests and any extensions granted. The OhioRISE plan's records must include member-identifying information, service requested,

date initial request received, any extension requests, decision made, date of decision, date of member notice, and basis for denial, if applicable.

7. 5160-26-05 Managed Care: Provider Panel and Contracting Requirements

(A) Provider contracts.

- (1) The managed care organization (MCO) or single pharmacy benefit manager (SPBM) must provide or arrange for the delivery of covered health care services described in rule 5160-26-03 of the Administrative Code either through the use of employees or through contracts with network providers of health care services ("providers"). All provider contracts must be in writing and in accordance with paragraph (D) of this rule and 42 C.F.R. 434.6 and 438.6 (October 1, 2019). The MCO or SPBM's execution of a provider contract does not terminate the MCO or SPBM's legal responsibility to the Ohio Department of Medicaid (ODM) to ensure all of the MCO or SPBM's activities and obligations are performed in accordance with Chapter 5160-26 or Chapter 5160-58 of the Administrative Code, as applicable, the MCO provider agreement or SPBM contract, as applicable, and all applicable federal, state, and local regulations.
- (2) The MCO or SPBM shall make all provider contracts available to ODM upon request.
- (3) Provider contracts may not include language that conflicts with the specifications identified in paragraphs (C) and (D) of this rule.
- (4) When utilizing an out of panel provider, the MCO or SPBM must establish a mutually agreed upon compensation amount for the authorized service and notify the provider of the applicable provisions of paragraph (D) of this rule. For Medicaid-covered non-emergency hospital services outlined in rule 5160-26-03 of the Administrative Code, the compensation amount is identified in rule 5160-26-11 of the Administrative Code.

(B) Notification.

- (1) Notwithstanding paragraph (D)(13) of this rule, the MCO or SPBM must notify ODM of any addition to or deletion from its provider panel on an ongoing basis, and must follow the time restrictions contained in this paragraph unless the explanation of extenuating circumstances is accepted by ODM.
- (2) At the direction of ODM, the MCO or SPBM must submit evidence of the following:
 - (a) A copy of the provider's current licensure;
 - (b) Copies of written agreements with the provider, including but not limited to contracts, amendments, and the Medicaid addendum as specified in paragraph (D) of this rule;
 - (c) Notification to ODM of any hospital contract for which a date of termination is specified; and
 - (d) The provider's Medicaid provider number and provider reporting number, if applicable.
- (3) The MCO or SPBM shall notify ODM in writing of the expiration, nonrenewal, or termination of any provider contract at least 55 calendar days prior to the expiration, nonrenewal or termination of the provider contract in a manner and format directed by ODM. If the MCO or SPBM receives less than 55 calendar days' notice from the provider, the MCO or SPBM must

inform ODM in writing within one working day of becoming aware of this information. The MCO must also comply with the following:

- (a) If the provider contract is for a hospital:
 - (i) Forty-five calendar days prior to the effective date of the expiration, nonrenewal or termination of the hospital's provider contract, the MCO shall notify in writing all providers who have admitting privileges at the hospital of the impending expiration, nonrenewal, or termination of the provider contract and the last date the hospital will provide services to MCO members. If the MCO receives less than 45 calendar days' notice from the hospital, the MCO shall send the notice within one working day of becoming aware of the expiration, nonrenewal, or termination of the provider contract.
 - (ii) Forty-five calendar days prior to the effective date of the expiration, nonrenewal, or termination of the hospital's provider contract, the MCO shall notify in writing all members in the service area, or in an area authorized by ODM, of the impending expiration, nonrenewal, or termination of the hospital's provider contract. If the MCO receives less than 45 calendar days' notice from the hospital provider, the MCO shall send the notice within one working day of becoming aware of the expiration, nonrenewal, or termination of the provider contract.
 - (iii) The MCO shall submit a template for member and provider notifications to ODM along with the MCO's notification to ODM of the impending expiration, nonrenewal, or termination of the hospital's provider contract. The notifications shall comply with the following:
 - (A) The form and content of the member notice must be prior approved by ODM and contain an ODM designated toll-free telephone number members can call for information and assistance.
 - (B) The form and content of the provider notice must be prior approved by ODM.
 - (iv) ODM may require the MCO to notify additional members or providers if the impending expiration, nonrenewal, or termination of the hospital's provider contract adversely impacts additional members or providers.
- (b) If the provider contract is for a primary care provider (PCP):
 - (i) The MCO shall include the number of members that will be affected by the change in the notice to ODM; and
 - (ii) The MCO shall notify in writing all members who use or are assigned to the provider as a PCP at least 45 calendar days prior to the effective date of the change. If the MCO receives less than 45 calendar days prior notice from the PCP, the MCO shall issue the notification within one working day of the MCO becoming aware of the expiration, nonrenewal, or termination of PCP's provider contract. The form of the notice and its content must be prior-approved by ODM and must contain, at a minimum, all of the following information:
 - (A) The PCP's name and last date the PCP is available to provide care to the MCO's members;

- (B) Information regarding how members can select a different PCP; and
 - (C) An MCO telephone number members can call for further information or assistance.
- (4) ODM may require the MCO or SPBM to notify members or providers for the expiration, nonrenewal, or termination of certain other provider contracts that may adversely impact the MCO or SPBM's members.
 - (5) In order to ensure availability of services and qualifications of providers, ODM may require submission of documentation in accordance with paragraph (B) of this rule regardless of whether the MCO or SPBM contracts directly for services or does so through another entity.
 - (6) In the event that the MCO or SPBM's Medicaid managed care program participation in a service area is terminated, the MCO or SPBM must provide written notification to its affected contracted providers at least 45 calendar days prior to the termination date, unless otherwise specified by ODM.
- (C) Provider qualifications.
- (1) The MCO and SPBM must ensure that none of its employees or contracted providers are sanctioned or excluded from providing Medicaid or Medicare services. At a minimum, monthly, the MCO and SPBM shall use available resources for identifying sanctioned providers, including, but not limited to, the following:
 - (a) The federal Office of Inspector General provider exclusion list;
 - (b) The ODM excluded provider web page; and
 - (c) The discipline pages of the applicable state boards that license providers or an alternative data resource, such as the national practitioner databank, that is as complete and accurate as the discipline pages of the applicable state boards.
 - (2) The MCO and SPBM may not discriminate with regard to the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. If the MCO or SPBM declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reasons for its decision. This paragraph may not be construed to:
 - (a) Require the MCO or SPBM to contract with providers beyond the number necessary to meet the needs of its members;
 - (b) Preclude the MCO from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or
 - (c) Preclude the MCO or SPBM from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members.
 - (3) The MCO and SPBM must have written policies and procedures for the selection and retention of providers that prohibit discrimination against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

(D) Provider contract requirements.

All provider contracts, including single case agreements, must include a Medicaid addendum that has been approved by ODM. The Medicaid addendum must include the following elements, appropriate to the service being rendered, as specified by ODM:

- (1) An agreement by the provider to comply with the applicable provisions for record keeping and auditing in accordance with Chapter 5160-26 of the Administrative Code.
- (2) Specification of the Medicaid population and service areas, pursuant to the MCO's provider agreement or the SPBM's contract with ODM.
- (3) Specification of the health care services to be provided.
- (4) Specification that the provider contract is governed by, and construed in accordance with all applicable laws, regulations, and contractual obligations of the MCO or SPBM and:
 - (a) ODM shall notify the MCO and/or the SPBM and the MCO or SPBM shall notify the provider of any changes in applicable state or federal law, regulations, waiver, or contractual obligation of the MCO or SPBM;
 - (b) The provider contract shall be automatically amended to conform to such changes without the necessity for written execution; and
 - (c) The MCO or SPBM shall notify the provider of all applicable contractual obligations.
- (5) Specification of the beginning date and expiration date of the provider contract, or an automatic renewal clause, as well as the applicable methods of extension, renegotiation, and termination.
- (6) Specification of the procedures to be employed upon the ending, nonrenewal, or termination of the provider contract, including an agreement by the provider to promptly supply all records necessary for the settlement of outstanding medical claims.
- (7) Full disclosure of the method and amount of compensation or other consideration to be received by the provider from the MCO or SPBM.
- (8) An agreement not to discriminate in the delivery of services based on the member's race, color, religion, gender, gender identity, genetic information, sexual orientation, age, disability, national origin, military status, ancestry, health status, or need for health services.
- (9) An agreement by the provider to not hold ODM or members liable in the event that the MCO or SPBM cannot or will not pay for services performed by the provider pursuant to the provider contract with the exception that:
 - (a) Federally qualified health centers (FQHCs) and rural health clinics (RHCs) may be reimbursed by ODM in the event of MCO insolvency.
 - (b) The provider may bill the member when the MCO or SPBM has denied prior authorization or referral for services and the following conditions are met:
 - (i) The member was notified by the provider of the financial liability in advance of service delivery.

- (ii) The notification by the provider was in writing, specific to the service being rendered, and clearly states that the member is financially responsible for the specific service. A general patient liability statement signed by all patients is not sufficient for this purpose.
 - (iii) The notification is dated and signed by the member.
- (10) An agreement by the provider that with the exception of any member co-payments, the MCO or SPBM's payment constitutes payment in full for any covered service and the provider will not charge the member or ODM any co-payment, cost sharing, down payment, or similar charge, refundable or otherwise. This agreement does not prohibit nursing facilities or home- and community-based services waiver providers from collecting patient liability payments from members as specified in rules 5160:1-6-07 and 5160:1-6-07.1 of the Administrative Code or FQHCs and RHCs from submitting claims for supplemental payments to ODM as specified in Chapter 5160-28 of the Administrative Code. Additionally, the MCO or SPBM and the provider agree to the following:
 - (a) The MCO or SPBM shall notify the provider whether the MCO or SPBM has elected to implement any member co-payments and if, applicable, the circumstances in which member co-payment amounts will be imposed in accordance with rule 5160-26-12 of the Administrative Code; and
 - (b) The provider agrees that member notifications regarding any applicable co-payment amounts must be carried out in accordance with rule 5160-26-12 of the Administrative Code.
- (11) A specification that the provider and all employees of the provider are duly registered, licensed or certified under applicable state and federal statutes and regulations to provide the health care services that are the subject of the provider contract, and that provider and all employees of the provider have not been excluded from participating in federally funded health care programs.
- (12) An agreement that MyCare Ohio waiver providers are currently enrolled as ODM providers with an active status in accordance with 5160-58-04 of the Administrative Code, and all other providers are either currently enrolled as ODM providers and meet the qualifications specified in paragraph (C) of this rule, or they are in the process of enrolling as ODM providers;
- (13) A stipulation that the MCO or SPBM will give the provider at least 60-days' prior notice in writing for the nonrenewal or termination of the provider contract except in cases where an adverse finding by a regulatory agency or health or safety risks dictate that the provider contract be terminated sooner or when the provider contract is temporary in accordance with 42 C.F.R. 438.602 (October 1, 2019) and the provider fails to enroll as an ODM provider within 120 days.
- (14) A stipulation that the provider may nonrenew or terminate the provider contract if one of the following occurs:
 - (a) The provider gives the MCO or SPBM at least 60 days prior notice in writing for the nonrenewal or termination of the provider contract, or the termination of any services for which the provider is contracted. The effective date for any nonrenewal or termination of the provider contract, or termination of any contracted service must be the last day of the month.

- (b) ODM has proposed action to terminate, nonrenew, deny or amend the MCO's provider agreement or the SPBM's contract in accordance with rule 5160-26-10 of the Administrative Code, regardless of whether this action is appealed. The provider's termination or nonrenewal written notice must be received by the MCO or SPBM within 15 working days prior to the end of the month in which the provider is proposing termination or nonrenewal. If the notice is not received by this date, the provider must agree to extend the termination or nonrenewal date to the last day of the subsequent month.
- (15) The provider's agreement to serve members through the last day the provider contract is in effect.
- (16) The provider's agreement to make the medical records for Medicaid eligible individuals available for transfer to new providers at no cost to the individual.
- (17) A specification that all laboratory testing sites providing services to members must have either a current clinical laboratory improvement amendments (CLIA) certificate of waiver, certificate of accreditation, certificate of compliance, or certificate of registration along with a CLIA identification number.
- (18) A requirement securing cooperation with the MCO or SPBM's quality assessment and performance improvement (QAPI) program in all its provider contracts and employment agreements for physician and non-physician providers.
- (19) An agreement by the provider and MCO or SPBM that:
 - (a) The MCO or SPBM shall disseminate written policies in accordance with the requirements of 42 U.S.C. 1396a(a)(68) (as in effect July 1, 2020) and section 5162.15 of the Revised Code, regarding the reporting of false claims and whistleblower protections for employees who make such a report, and including the MCO or SPBM's policies and procedures for detecting and preventing fraud, waste, and abuse; and
 - (b) The provider agrees to abide by the MCO or SPBM's written policies related to the requirements of 42 U.S.C. 1396a(a)(68) (as in effect July 1, 2020) and section 5162.15 of the Revised Code, including the MCO or SPBM's policies and procedures for detecting and preventing fraud, waste, and abuse.
- (20) A specification that hospitals and other providers must allow the MCO or SPBM access to all member medical records for a period of not less than eight years from the date of service or until any audit initiated within the eight-year period is completed and allow access to all record-keeping, audits, financial records, and medical records to ODM or its designee or other entities as specified in rule 5160-26-06 of the Administrative Code.
- (21) A specification, appearing above the signature(s) on the signature page in all PCP subcontracts, stating the maximum number of MCO members that each PCP can serve at each practice site for that MCO.
- (22) A specification that the provider must cooperate with the ODM external quality reviews required by 42 C.F.R. 438.358 (October 1, 2019) and on-site audits as deemed necessary based on ODM's periodic analysis of financial, utilization, provider panel and other information.
- (23) A specification that the provider must be bound by the same standards of confidentiality that apply to ODM and the State of Ohio as described in rule 5160-1-32 of the Administrative Code,

including standards for unauthorized uses of or disclosures of protected health information (PHI).

- (24) A specification that any third party administrator (TPA) must include the elements of paragraph (D) of this rule in its subcontracts and ensure that its contracted providers will forward information to ODM as requested.
- (25) A specification that home health providers must meet the eligible provider requirements specified in Chapter 5160-12 of the Administrative Code and comply with the requirements for home care dependent adults as specified in section 121.36 of the Revised Code.
- (26) A specification that PCPs must participate in the care coordination requirements outlined in rule 5160-26-03.1 of the Administrative Code.
- (27) A specification that the provider in providing health care services to members must identify and where necessary arrange, pursuant to the mutually agreed upon policies and procedures between the MCO and provider, for the following at no cost to the member;
 - (a) Sign language services; and
 - (b) Oral interpretation and oral translation services.
- (28) A specification that the MCO or SPBM agrees to fulfill the provider's responsibility to mail or personally deliver notice of the member's right to request a state hearing whenever the provider bills a member due to the MCO or SPBM's denial of payment of a service, as specified in rules 5160-26-08.4 and 5160-58-08.4 of the Administrative Code, utilizing the procedures and forms as specified in Chapter 5160:6-2 of the Administrative Code.
- (29) The provider's agreement to contact the 24-hour post-stabilization services phone line designated by the MCO or SPBM to request authorization to provide post-stabilization services in accordance with rule 5160-26-03 of the Administrative Code.
- (30) A specification that the MCO or SPBM may not prohibit or otherwise restrict a provider, acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient for the following:
 - (a) The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
 - (b) Any information the member needs in order to decide among all relevant treatment options;
 - (c) The risks, benefits, and consequences of treatment versus non-treatment; and
 - (d) The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- (31) A stipulation that the provider must not identify the addressee as a Medicaid recipient on the outside of the envelope when contacting members by mail.
- (32) An agreement by the provider that members will not be billed for missed appointments.

- (33) An agreement that in the performance of the provider contract or in the hiring of any employees for the performance of services under the provider contract, the provider shall not by reason of race, color, religion, gender, gender identity, genetic information, sexual orientation, age, disability, national origin, military status, health status, or ancestry, discriminate against any citizen of Ohio in the employment of a person qualified and available to perform the services to which the provider contract relates.
 - (34) An agreement by the provider that it shall not in any manner, discriminate against, intimidate, or retaliate against any employee hired for the performance of services under the provider contract on account of race, color, religion, gender, gender identity, genetic information, sexual orientation, age, disability, national origin, military status, health status, or ancestry.
 - (35) Notwithstanding paragraphs (D)(13) and (D)(14) of this rule, in the event of a hospital's proposed nonrenewal or termination of a hospital provider contract, an agreement by the contracted hospital to notify in writing all providers who have admitting privileges at the hospital of the impending nonrenewal or termination of the provider contract and the last date the hospital will provide services to members. The contracted hospital must send this notice to the providers with admitting privileges at least 45 calendar days prior to the effective date of the nonrenewal or termination of the hospital provider contract. If the contracted hospital issues less than 45 days prior notice to the MCO, the notice to providers with admitting privileges must be sent within one working day of the contracted hospital issuing notice of nonrenewal or termination of the provider contract.
 - (36) An agreement by the provider to supply, upon request, the business transaction information required under 42 C.F.R. 455.105 (October 1, 2019).
 - (37) An agreement by the provider to release to the MCO or SPBM, ODM, or ODM designee any information necessary for the MCO or SPBM to perform any of its obligations under the ODM provider agreement or contract, as applicable, including but not limited to compliance with reporting and quality assurance requirements.
 - (38) An agreement by the provider that its applicable facilities and records will be open to inspection by the MCO or SPBM, ODM or its designee, or other entities as specified in rule 5160-26-06 of the Administrative Code.
- (E) In lieu of including a Medicaid addendum as required by paragraph (D) of this rule, the MCO may permit a benefit manager that assists in the administration of health care services including dental, vision and behavioral health services on behalf of the MCO's members, to include elements in paragraphs (D)(1) to (D)(38) of this rule in subcontracts with entities that provide for the direct provision of health care services to MCO members. The MCO must receive written evidence that the benefit manager complied with this paragraph and has informed the entities of the obligation to provide health care services to the MCO's members.

8. 5160-26-05.1 Managed Care: Provider Services

(A) Managed care organizations (MCOs) and the single pharmacy benefit manager (SPBM) must provide the following written information to their contracting providers:

- (1) The MCO or SPBM's grievance, appeal and state fair hearing procedures and timeframes, including:
 - (a) The member's right to file grievances and appeals and the requirements and timeframes for filing;
 - (b) The MCO or SPBM's toll-free telephone number to file oral grievances and appeals;
 - (c) The member's right to a state fair hearing, the requirements and time frames for requesting a hearing, and representation rules at a hearing;
 - (d) The availability of assistance from the MCO or SPBM in filing any of these actions;
 - (e) The member's right to request continuation of benefits during an appeal or a state hearing and specification that at the discretion of ODM the member may be liable for the cost of any such continued benefits; and
 - (f) The provider's rights to participate in these processes on behalf of the provider's patients and to challenge the failure of the MCO or SPBM to cover a specific service.
- (2) The MCO or SPBM's requirements regarding the submission and processing of prior authorization requests including:
 - (a) A list of the benefits, if any, that require prior authorization approval from the MCO or SPBM;
 - (b) The process and format to be used in submitting such requests;
 - (c) The timeframes in which the MCO or SPBM must respond to such requests;
 - (d) Pursuant to the provisions of paragraph (A)(1) of this rule, how the provider will be notified of the MCO or SPBM's decision regarding such requests; and
 - (e) Pursuant to the provisions of paragraph (A)(1) of this rule, the procedures to be followed in appealing the MCO or SPBM's denial of a prior authorization request.
- (3) The MCO or SPBM's documentation, legibility, confidentiality, maintenance and access standards for member medical records; including a member's right to amend or correct his or her medical record as specified in 45 C.F.R. 164.526 (October 1, 2019).
- (4) The MCO or SPBM's process and requirements for the submission of claims and the appeal of denied claims.

- (5) The MCO or SPBM's policies and procedures regarding what action the MCO or SPBM may take in response to occurrences of undelivered, inappropriate or substandard health care services, including the reporting of serious deficiencies to the appropriate authorities.
 - (6) The mutually agreed upon policies and procedures between the MCO or SPBM and the provider that explain the provider's obligation to provide oral translation, oral interpretation, and sign language services to the MCO or SPBM's members including:
 - (a) The provider's responsibility to identify those members who may require such assistance;
 - (b) The process the provider is to follow in arranging for such services to be provided;
 - (c) Information that members will not be liable for the costs of such services; and
 - (d) Specification of whether the MCO, SPBM, or the provider will be financially responsible for the costs of providing these services.
 - (7) The procedures that providers are to follow in notifying the MCO or SPBM of changes in their practice, including at a minimum:
 - (a) Address and phone numbers;
 - (b) Providers included in the practice;
 - (c) Acceptance of new patients; and
 - (d) Standard office hours.
 - (8) Specification of what service utilization and provider performance data the MCO or SPBM will make available to providers.
 - (9) Specification of the healthchek components to be provided to eligible members as specified in Chapter 5160-14 of the Administrative Code.
- (B) In addition to the requirements in paragraph (A) of this rule, the MCO must provide the following written information to providers:
- (1) The MCO's requirements and expectations for PCPs, including triage requirements.
 - (2) A description of the MCO's care coordination and care management programs, and the role of the provider in those programs, including:
 - (a) The MCO's criteria for determining which members might benefit from care management;
 - (b) The provider's responsibility in identifying members who may meet the MCO's care management criteria; and
 - (c) The process for the provider to follow in notifying the MCO when such members are identified.
 - (3) The MCO's requirements regarding the submission and processing of requests for specialist referrals including:
 - (a) A list of the provider types, if any, that require prior authorization approval from the MCO;

- (b) The process and format to be used in submitting such requests;
 - (c) How the provider will be notified of the MCO's decision regarding such requests; and
 - (d) The procedures to be followed in appealing the MCO's denial of such requests.
- (C) The MCO must adopt practice guidelines and disseminate the guidelines to all affected providers, and upon request to members and pending members. These guidelines must:
- (1) Be based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
 - (2) Consider the needs of the MCO's members;
 - (3) Be adopted in consultation with contracting health care professionals; and
 - (4) Be reviewed and updated periodically, as appropriate.
- (D) The MCO and the SPBM must have staff specifically responsible for resolving individual provider issues, including, but not limited to, problems with claims payment, prior authorizations and referrals. The MCO or SPBM must provide written information to their contracting providers detailing how to contact these designated staff.

9. 5160-26-06 Managed Care: Program Integrity — Fraud, Waste and Abuse, Audits, Reporting, and Record Retention

- (A) Managed care organizations (MCOs) and the single pharmacy benefit manager (SPBM) must have administrative and management arrangements or procedures, including a mandatory compliance plan, to guard against fraud, waste and abuse as required in the MCO provider agreement and SPBM contract located at <http://medicaid.ohio.gov/>.
- (1) These arrangements or procedures must be made available to the Ohio Department of Medicaid (ODM) upon request.
 - (2) The MCO and SPBM must annually submit to ODM a report that summarizes the MCO or SPBM's fraud, waste and abuse activities for the previous year and identifies any proposed changes to the MCO or SPBM's fraud, waste and abuse program for the coming year.
- (B) ODM or its designee, the state auditor's office, the state attorney general's office, and the U.S. Department of Health and Human Services may evaluate or audit a contracting MCO or SPBM's performance for the purpose of determining compliance with the requirements of Chapter 5160-26 of the Administrative Code, fraud, waste and abuse statutes, applicable state and federal regulations or requirements under federal waiver authority.
- (C) ODM or its designee may conduct on-site audits and reviews as deemed necessary based on periodic analysis of financial, utilization, provider panel, and other information.
- (D) The MCO or SPBM must submit required reports and additional information, as requested by ODM, as related to its duties and obligations and where needed to ensure operation in accordance with all state and federal regulations or requirements.
- (E) If the MCO fails to submit any ODM-requested materials, as specified in paragraph (D) of this rule, without cause as determined by ODM, on or before the due date, ODM may impose any or all of the sanctions listed in rule 5160-26-10 of the Administrative Code.
- (F) Record retention.

The MCO or SPBM and its subcontractors shall retain and safeguard all hard copy or electronic records originated or prepared in connection with the MCO or SPBM's performance of its obligations under the provider agreement or contract, as applicable, including but not limited to working papers or information related to the preparation of reports, medical records, progress notes, charges, journals, ledgers, and fiscal reports, in accordance with applicable sections of the federal regulations, the Revised Code, and the Administrative Code. Records stored electronically must be produced at the MCO or SPBM's expense, upon request, in the format specified by state or federal authorities. As specified in 42 C.F.R. 438.3 (October 1, 2018), such records must be maintained for a minimum of 10 years from the renewal, amendment or termination date of the provider agreement. In the event the MCO or SPBM has been notified that state or federal authorities have commenced an audit or investigation of the provider agreement or contract, as applicable, records must be maintained until such time as the matter under audit or investigation has been resolved. For the initial three years of the retention period, the MCO or SPBM and its subcontractors must store the records in a manner and place that provides readily available access.

10. 5160-26-08.3 Managed Health Care Programs: Member Rights

(A) Managed care organizations (MCOs) and the single pharmacy benefit manager (SPBM) must develop and implement written policies in accordance with 42 C.F.R. 438.100 (October 1, 2017), as applicable, to ensure each member has and is informed of his or her right to:

- (1) Receive all services the MCO or SPBM is required to provide pursuant to the terms of their provider agreement or contract, as applicable, with the Ohio Department of Medicaid (ODM).
- (2) Be treated with respect and with due consideration for their dignity and privacy.
- (3) Be ensured of confidential handling of information concerning their diagnoses, treatments, prognoses, and medical and social history.
- (4) Be provided information about their health. Such information should also be made available to the individual legally authorized by the member to have such information or the person to be notified in the event of an emergency when concern for a member's health makes it inadvisable to give him/her such information.
- (5) Be given the opportunity to participate in decisions involving their health care.
- (6) Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- (7) Maintain auditory and visual privacy during all health care examinations or treatment visits.
- (8) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- (9) Request and receive a copy of their medical records, and to be able to request that their medical records be amended or corrected.
- (10) Be afforded the opportunity to approve or refuse the release of information except when release is required by law.
- (11) Be afforded the opportunity to refuse treatment or therapy. Members who refuse treatment or therapy will be counseled relative to the consequences of their decision and documentation will be entered into the medical record accordingly.
- (12) Be afforded the opportunity to file grievances, appeals, or state hearings pursuant to the provisions of rule 5160-26-08.4 of the Administrative Code.
- (13) Be provided written member information from the MCO or SPBM:
 - (a) At no cost to the member,
 - (b) In the prevalent non-English languages of members specified by ODM, and
 - (c) In alternative formats and in an appropriate manner that takes into consideration the special needs of members.

- (14) Receive necessary oral interpretation and oral translation services at no cost.
- (15) Receive necessary services of sign language assistance at no cost.
- (16) Be informed of specific student practitioner roles and the right to refuse student care.
- (17) Refuse to participate in experimental research.
- (18) Formulate advance directives and to file any complaints concerning noncompliance with advance directives with the Ohio Department of Health.
- (19) Change primary care providers (PCPs) no less often than monthly. The MCO must mail written confirmation to the member of his or her new PCP selection prior to or on the effective date of the change.
- (20) Appeal to or file 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.
- (21) Appeal to or file directly with the ODM office of civil rights any complaints of discrimination on the basis of race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, genetic information, ancestry, health status or need for health services in the receipt of health services.
- (22) Be free to exercise their rights and to be assured that exercising their rights does not adversely affect the way the MCO or SPBM, the MCO or SPBM's providers, or ODM treats the member.
- (23) Be assured the MCO or SPBM must comply with all applicable federal and state laws and other laws regarding privacy and confidentiality.
- (24) Choose his or her health professional to the extent possible and appropriate.
- (25) For female members, to obtain direct access to a woman's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to a member's designated PCP if the PCP is not a woman's health specialist.
- (26) Be provided a second opinion from a qualified health care professional within the MCO's panel. If such a qualified health care professional is not available within the MCO's panel, the MCO must arrange for a second opinion outside the network, at no cost to the member.
- (27) Receive information on their MCO or SPBM.

- (B) The MCO and SPBM must advise members via the member handbook of the member rights specified in paragraph (A) of this rule.

11. 5160-26-08.4 Managed Care: Appeal and Grievance System

This rule does not apply to MyCare Ohio plans as defined in rule 5160-58-01 of the Administrative Code. Provisions regarding appeals and grievances for MyCare Ohio are described in Chapter 5160-58 of the Administrative Code.

(A) Definitions.

- (1) "Adverse benefit determination" is a managed care organization (MCO) or single pharmacy benefit manager (SPBM)'s:
 - (a) Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
 - (b) Reduction, suspension, or termination of services prior to the member receiving the services previously authorized by the MCO or SPBM;
 - (c) Denial, in whole or part, of payment for a service;
 - (d) Failure to provide services in a timely manner as specified in rule 5160-26-03.1 of the Administrative Code;
 - (e) Failure to act within the resolution time frames specified in this rule; or
 - (f) Denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other member financial liabilities, if applicable.
- (2) "Appeal" is the member's request for the MCO or SPBM to review an adverse benefit determination.
- (3) "Grievance" is the member's expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the MCO or SPBM to make an authorization decision.
- (4) "Notice of action (NOA)" is the written notice the MCO or SPBM must provide to members when adverse benefit determination has occurred or will occur.

(B) NOAs.

- (1) When an adverse benefit determination has occurred or will occur, the MCO or SPBM shall provide the affected member with a NOA.
- (2) The language and format of the NOA shall comply with the requirements listed in 42 CFR 438.10 (October 1, 2017), and the NOA shall explain:

- (a) The adverse benefit determination the MCO or SPBM has taken or intends to take;
 - (b) The reasons for the adverse benefit determination, including the right of the member to be provided, upon request and free of charge, reasonable access to copies of all documents, records, and other relevant determination information;
 - (c) The member's right to file an appeal to the MCO or SPBM;
 - (d) Information related to exhausting the MCO or SPBM appeal;
 - (e) The member's right to request a state hearing through the State's hearing system upon exhausting the MCO or SPBM appeal;
 - (f) Procedures for exercising the member's rights to appeal the adverse benefit determination;
 - (g) Circumstances under which expedited resolution is available and how to request it;
 - (h) If applicable, the member's right to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay for the cost of these services; and
 - (i) The date the notice is issued.
- (3) The MCO or SPBM shall issue each NOA within the following time frames:
- (a) For a decision to deny or limit authorization of a requested service the MCO or SPBM shall issue a NOA simultaneously with the MCO or SPBM's decision.
 - (b) For reduction, suspension, or termination of services prior to the member receiving the services previously authorized by the MCO or SPBM, the MCO or SPBM shall give notice at least 15 calendar days before the effective date of the adverse benefit determination except:
 - (i) If probable recipient fraud has been verified, the MCO or SPBM shall give notice five calendar days before the effective date of the adverse benefit determination.
 - (ii) Under the circumstances set forth in 42 CFR 431.213 (October 1, 2017), the MCO or SPBM shall give notice on or before the effective date of the adverse benefit determination.
 - (c) For denial of payment for a non-covered service, the MCO or SPBM shall give notice simultaneously with the MCO or SPBM's determination to deny the claim, in whole or part, for a service not covered by Medicaid, including a service determined through the MCO or SPBM's prior authorization process as not medically necessary.
 - (d) For untimely prior authorization, appeal, or grievance resolution, the MCO or SPBM shall give notice simultaneously with the MCO or SPBM becoming aware of the untimely resolution. Service authorization decisions not reached within the time frames specified in rule 5160-26-03.1 of the Administrative Code constitutes a denial and is thus considered to be an adverse benefit determination. Notice shall be given on the date the authorization decision time frame expires.

(C) Grievances.

- (1) A member may file a grievance with the MCO or SPBM orally or in writing at any time. An authorized representative must have the member's written consent to file a grievance on the member's behalf.
- (2) The MCO or SPBM shall acknowledge the receipt of each grievance to the member filing the grievance. Oral acknowledgment by the MCO or SPBM is acceptable. If the grievance is filed in writing, written acknowledgment shall be made within three business days of receipt of the grievance.
- (3) The MCO or SPBM shall review and resolve all grievances as expeditiously as the member's health condition requires. Grievance resolutions, including member notification, shall meet the following timeframes:
 - (a) Within two business days of receipt if the grievance is regarding access to services.
 - (b) Within 30 calendar days of receipt for non-claims-related grievances except as specified in paragraph (C)(3)(a) of this rule.
 - (c) Within 60 calendar days of receipt for claims-related grievances.
- (4) At a minimum, the MCO or SPBM shall provide oral notification to the member of a grievance resolution. If the MCO or SPBM is unable to speak directly with the member, or the resolution includes information that must be confirmed in writing, the resolution shall be provided in writing simultaneously with the MCO or SPBM's resolution.
- (5) If the MCO or SPBM's resolution to a grievance is to uphold the denial, reduction, suspension, or termination of a service or billing of a member due to the MCO's denial of payment for that service, the MCO shall notify the member of his or her right to request a state hearing as specified in paragraph (G) of this rule, if the member has not previously been notified.

(D) Standard appeals.

- (1) A member, a member's authorized representative, or a provider may file an appeal orally or in writing within 60 calendar days from the date that the NOA was issued. An oral appeal filing must be followed with a written appeal. The MCO or SPBM shall:
 - (a) Immediately convert an oral appeal filing to a written appeal on behalf of the member; and
 - (b) Consider the date of the oral appeal filing as the filing date.
- (2) Any provider acting on the member's behalf shall have the member's written consent to file an appeal. The MCO or SPBM shall begin processing the appeal upon receipt of the written consent.
- (3) The MCO or SPBM shall acknowledge receipt of each appeal to the member filing the appeal. At a minimum, acknowledgment shall be made in the same manner the appeal was filed. If an appeal is filed in writing, written acknowledgment shall be made by the MCO or SPBM within three business days of receipt of the appeal.
- (4) The MCO or SPBM shall provide the member reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing, and inform the member of this opportunity sufficiently in advance of the resolution timeframe. Upon request, the member and/or member's authorized representative shall be provided, free of charge and sufficiently in

advance of the resolution timeframe, the case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon or generated by the MCO or SPBM, or at the direction of the MCO or SPBM, in connection with the appeal of the adverse benefit determination.

- (5) The MCO or SPBM shall consider the member, the member's authorized representative, or an estate representative of a deceased member as parties to the appeal.
 - (6) The MCO or SPBM shall review and resolve each appeal as expeditiously as the member's health condition requires, but the resolution timeframe shall not exceed 15 calendar days from the receipt of the appeal unless the resolution time frame is extended as outlined in paragraph (F) of this rule.
 - (7) The MCO or SPBM shall provide written notice of the appeal's resolution to the member, and to the member's authorized representative if applicable. At a minimum, the written notice shall include the resolution decision and date of the resolution.
 - (8) For appeal resolutions not resolved wholly in the member's favor, the written notice to the member shall also include the following information:
 - (a) The right to request a state hearing through the State's hearing system;
 - (b) How to request a state hearing; and if applicable:
 - (i) The right to continue to receive benefits pending a state hearing;
 - (ii) How to request the continuation of benefits; and
 - (iii) If the adverse benefit determination is upheld at the state hearing, the member may be liable for the cost of any continued benefit.
 - (c) Oral interpretation is available for any language;
 - (d) Written translation is available in prevalent non-English languages as applicable;
 - (e) Written alternative formats may be available as needed; and
 - (f) How to access interpretation and translation services as well as alternative formats that can be provided by the MCO or SPBM.
 - (9) For appeal resolutions decided in favor of the member, the MCO or SPBM shall:
 - (a) Authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires, but no later than 72 hours from the appeal resolution date, if the services were not furnished while the appeal was pending.
 - (b) Pay for the disputed services if the member received the services while the appeal was pending.
- (E) Expedited appeals.
- (1) The MCO or SPBM shall establish and maintain an expedited review process to resolve appeals when the member requests and the MCO or SPBM determines, or the provider indicates in making the request on the member's behalf or supporting the member's request, that the

standard resolution timeframe could seriously jeopardize the member's life, physical or mental health or ability to attain, maintain, or regain maximum function.

- (2) In utilizing an expedited appeal process, the MCO or SPBM shall comply with the standard appeal process specified in paragraph (D) of this rule, except the MCO or SPBM shall:
 - (a) Determine within one business day of the appeal request whether to expedite the appeal resolution;
 - (b) Make reasonable efforts to provide prompt oral notification to the member of the decision to expedite or not expedite the appeal resolution;
 - (c) Inform the member of the limited time available for the member to present evidence and allegations of fact or law in person or in writing;
 - (d) Resolve the appeal as expeditiously as the member's health condition requires, but the resolution timeframe shall not exceed 72 hours from the date the MCO or SPBM received the appeal unless the resolution timeframe is extended as outlined in paragraph (F) of this rule;
 - (e) Make reasonable efforts to provide oral notice of the appeal resolution in addition to the required written notification;
 - (f) Ensure punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal; and
 - (g) Notify ODM within one business day of any appeal that meets the criteria for expedited resolution as specified by ODM.
- (3) If the MCO or SPBM denies a member's request for expedited resolution of an appeal, the MCO or SPBM shall:
 - (a) Transfer the appeal to the standard resolution time frame of 15 calendar days from the date the appeal was received unless the resolution time frame is extended as outlined in paragraph (F) of this rule;
 - (b) Make reasonable efforts to provide the member prompt oral notification of the decision not to expedite, and within two calendar days of the receipt of the appeal, provide the member written notice of the reason for the denial, including information that the member can grieve the decision.

(F) Grievance and appeal resolution extensions.

- (1) A member may request the time frame for the MCO or SPBM to resolve a grievance or a standard or expedited appeal be extended up to 14 calendar days.
- (2) The MCO or SPBM may request the time frame to resolve a grievance or a standard or expedited appeal be extended up to 14 calendar days. The following requirements apply:
 - (a) The MCO or SPBM shall seek such an extension from ODM prior to the expiration of the standard or expedited appeal or grievance resolution time frame;
 - (b) The MCO or SPBM request shall be supported by documentation of the need for additional information and that the extension is in the member's best interest; and

- (c) If ODM approves the extension, the MCO or SPBM shall make reasonable efforts to provide the member prompt oral notification of the extension and, within two calendar days, provide the member written notice of the reason for the extension and the date by which a decision shall be made.
 - (3) The MCO or SPBM shall maintain documentation of any extension request.
- (G) Access to state's hearing system.
- (1) Except as set forth in paragraph (G)(2) of this rule, and in accordance with 42 CFR 438.402 (October 1, 2017), members may request a state hearing only after exhausting the MCO or SPBM's appeal process. If the MCO or SPBM fails to adhere to the notice and timing requirements for appeals set forth in this rule, the member is deemed to have exhausted the appeal process and may request a state hearing.
 - (2) In accordance with rule 5160-20-01 of the Administrative Code, members proposed for enrollment or currently enrolled in the coordinated services program (CSP) are afforded state hearing rights in accordance with division 5101:6 of the Administrative Code and are not subject to the requirement of first appealing to the MCO.
 - (3) When required by paragraph (D)(8) of this rule, and in accordance with division 5101:6 of the Administrative Code, the MCO or SPBM shall notify members, and any authorized representatives on file with the MCO or SPBM, of the right to a state hearing subject to the following requirements:
 - (a) If an appeal resolution upholds the denial of a request for the authorization of a service, in whole or in part, the MCO or SPBM shall simultaneously issue the "Notice of Denial of Medical Services by Your Managed Care Plan" (ODM 04043, 1/2018).
 - (b) If an appeal resolution upholds the decision to reduce, suspend, or terminate services prior to the member receiving the services as previously authorized by the MCO or SPBM, the MCO or SPBM shall issue the "Notice of Reduction, Suspension or Termination of Medical Services By Your Managed Care Plan" (ODM 04066, 1/2018).
 - (c) If the MCO or SPBM learns a member has been billed for services received by the member due to the MCO or SPBM's denial of payment, and the MCO or SPBM upholds the denial of payment, the MCO or SPBM shall immediately issue the "Notice of Denial of Payment for Medical Services By Your Managed Care Plan" (ODM 04046, 1/2018).
 - (4) The member or member's authorized representative may request a state hearing within 120 days from the date of an adverse appeal resolution by contacting the Ohio Department of Job and Family Services bureau of state hearings or local County Department of Job and Family Services (CDJFS).
 - (5) There are no state hearing rights for a member terminated from an MCO pursuant to an MCO-initiated membership termination as permitted in rule 5160-26-02.1 of the Administrative Code.
 - (6) Following the bureau of state hearing's notification to the MCO or SPBM that a member has requested a state hearing, the MCO or SPBM shall:

- (a) Complete the "Appeal Summary for Managed Care Plans" (ODM 01959, 7/2014) with appropriate supporting attachments, and file it with the bureau of state hearings at least three business days prior to the scheduled hearing date. The appeal summary shall include all facts and documents relevant to the issue, in accordance with rule 5160-26-03.1 of the Administrative Code, and be sufficient to demonstrate the basis for the MCO or SPBM's adverse benefit determination;
 - (b) Send a copy of the completed ODM 01959 to the member and the member's authorized representative, if applicable, the CDJFS, and the designated ODM contact; and
 - (c) If benefits were continued through the appeal process in accordance with paragraph (H)(1) of this rule, continue or reinstate the benefit(s) if the MCO or SPBM is notified that the member's state hearing request was received within 15 days from the date of the appeal resolution.
- (7) The MCO or SPBM shall participate in the state hearing, in person or by telephone, on the date indicated on the "Notice to Appear for a Scheduled Hearing" (JFS 04002, 01/2015) sent by the bureau of state hearings.
- (8) The MCO or SPBM shall comply with the state hearing decision provided via the "State Hearing Decision" (JFS 04005, 01/2015). If the state hearing decision sustains the member's appeal, the MCO or SPBM shall submit the information required by the "Order of Compliance" (JFS 04068, 01/2015) to the bureau of state hearings. The information, including applicable supporting documentation, is due to the bureau of state hearings and the designated ODM contact by no later than the compliance date specified in the hearing decision. If applicable, the MCO or SPBM shall:
 - (a) Authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires, but no later than 72 hours from the date it receives notice reversing the adverse benefit determination if services were not furnished while the appeal was pending.
 - (b) Pay for the disputed services if the member received the services while the appeal was pending.
- (H) Continuation of benefits while an appeal or state hearing is pending.
 - (1) Unless a member requests that previously authorized benefits not be continued, the MCO or SPBM shall continue a member's benefits when all the following conditions are met:
 - (a) The member requests an appeal within 15 days of the MCO or SPBM issuing the NOA;
 - (b) The appeal involves the termination, suspension, or reduction of services prior to the member receiving the previously authorized services;
 - (c) The services were ordered by an authorized provider; and
 - (d) The authorization period has not expired.
 - (2) If the MCO or SPBM continues or reinstates the member's benefits while the appeal or state hearing is pending, the benefits shall be continued until one of the following occurs:
 - (a) The member withdraws the appeal or the state hearing request;

- (b) The member fails to request a state hearing within 15 days after the MCO or SPBM issues an adverse appeal resolution; or
 - (c) The bureau of state hearings issues a state hearing decision upholding the reduction, suspension or termination of services.
 - (3) If the final resolution of the appeal or state hearing upholds the MCO or SPBM's original adverse benefit determination, at the discretion of ODM, the MCO or SPBM may recover the cost of the services furnished to the member while the appeal and/or state hearing was pending.
- (I) Other duties of the MCO or SPBM regarding appeals and grievances.
- (1) The MCO or SPBM shall give members all reasonable assistance filing a grievance, an appeal, or a state hearing request including but not limited to:
 - (a) Explaining the MCO or SPBM's process to be followed in resolving the member's appeal or grievance;
 - (b) Completing forms and taking other procedural steps as outlined in this rule; and
 - (c) Providing oral interpretation and oral translation services, sign language assistance, and access to the appeals and grievance system through a toll-free number with text telephone yoke (TTY) and interpreter capability.
 - (2) The MCO or SPBM shall ensure the individuals who make decisions on appeals and grievances are individuals who:
 - (a) Were neither involved in any previous level of review or decision-making nor a subordinate of any such individual; and
 - (b) Are health care professionals who have the appropriate clinical expertise in treating the member's condition or disease if deciding any of the following:
 - (i) An appeal of a denial based on lack of medical necessity;
 - (ii) A grievance regarding the denial of an expedited resolution of an appeal; or
 - (iii) An appeal or grievance involving clinical issues.
 - (3) In reaching an appeal resolution, the MCO or SPBM shall take into account all comments, documents, records, and other information submitted by the member or their authorized representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

12. 5160-26-09.1 Managed Care: Third Party Liability and Recovery

(A) Tort.

- (1) Pursuant to sections 5160.37 and 5160.38 of the Revised Code, the Ohio Department of Medicaid (ODM) maintains all rights of recovery (tort) against the liability of any third party payer (TPP) for the cost of medical services.
- (2) The managed care organization (MCO) and the single pharmacy benefit manager (SPBM) are prohibited from accepting any settlement, compromise, judgment, award, or recovery of any action or claim by the member.
- (3) The MCO or SPBM must notify ODM and/or its designated entity within 14 calendar days of all requests for the release of financial and medical records to a member or the member's representative pursuant to the filing of a tort action. Notification must be made via the "Notification of Third Party (tort) Request For Release" form (ODM 03245, rev. 7/2014) or a method determined by the ODM designated entity, provided ODM approved the designated entity's method and notified the MCO or SPBM.
- (4) The MCO or SPBM must submit a summary of financial information to ODM and/or its designated entity within 30 calendar days of receiving an original authorization to release a financial claim statement letter from ODM pursuant to a tort action. The MCO or SPBM must use the "Tort Summary Statement" form (ODM 03246, rev. 7/2014) or a method determined by the ODM designated entity, provided ODM has approved the designated entity's method and notified the MCO or SPBM. Upon request, the MCO or SPBM must provide ODM and/or its designated entity with true copies of medical claims.

(B) Fraud, waste, and abuse recovery. ODM assigns to the MCO its rights of recovery against any TPP for costs due to provider fraud, waste, or abuse as defined in rule 5160-26-01 of the Administrative Code related to each member during periods of enrollment in the MCO. In instances when the MCO fails to properly report suspected fraud, waste, or abuse, before the suspected fraud, waste, or abuse is identified by the State of Ohio, any portion of the fraud, waste, or abuse recovered by the State shall be retained by the State.

(C) Coordination of benefits.

- (1) ODM assigns its right to third party resources (coordination of benefits) to the MCO for services rendered to each member during periods of enrollment. ODM reserves the right to identify, pursue, and retain any recovery of third party resources assigned to the MCO but not collected by the MCO after one year from date of claim payment.
- (2) The MCO or SPBM must act to provide coordination of benefits if a member has third party resources available for the payment of medical expenses for medically necessary Medicaid-covered services. Such expenses will be paid in accordance with this rule and sections 5160.37 and 5160.38 of the Revised Code.
- (3) The MCO or SPBM is the payer of last resort when a member has third party resources available for payment of medical expenses for Medicaid-covered services, except:

- (a) The MCO or SPBM pays after any TPP including Medicare but before:
 - (i) Resources provided through the children with medical handicaps program under sections 3701.021 to 3701.0210 of the Revised Code.
 - (ii) Resources that are exempt from primary payer status under federal Medicaid law, 42 U.S.C. 1396 (as in effect July 1, 2018).
 - (iii) Resources provided through the state-sponsored program awarding reparations to victims of crime, as set forth in sections 2743.51 to 2743.72 of the Revised Code.
 - (b) The MCO pays first for preventive pediatric services before seeking reimbursement from any liable third party.
- (4) The MCO or SPBM will take reasonable measures to ascertain and verify any third party resources available to a member. When the MCO or SPBM denies a claim due to third party liability (TPL), the MCO or SPBM must timely share, on the explanation of payment sent to providers, available information regarding the third party resources for the purposes of coordination of benefits, including:
- (a) Insurance company name;
 - (b) Insurance company billing address for claims;
 - (c) Member's group number;
 - (d) Member's policy number; and
 - (e) Policyholder name.
- (5) The MCO or SPBM must require providers who are submitting TPL claims to the MCO or SPBM to request information regarding third party benefits from the member or his/her authorized representative. If the member or the member's authorized representative specifies that the member has no third party benefits, or the provider is unable to determine that the member has third party benefits, the MCO or SPBM must permit the provider to submit a claim to the MCO or SPBM. If, as a result of requesting the information, the provider determines that third party liability exists, the MCO or SPBM must allow the provider to submit a claim for reimbursement if he/she first takes reasonable measures to obtain third party payment as set forth in paragraph (C)(6) of this rule.
- (6) The MCO or SPBM must require providers to take reasonable measures to obtain all third party payments and file claims with all TPPs prior to billing the MCO or SPBM. The MCO or SPBM must permit providers who have taken reasonable measures to obtain all third party payments, but who have not received payment from a TPP or received partial payment, to submit a claim to the MCO or SPBM requesting reimbursement for rendered services.
- (a) The MCO or SPBM must process claims when the provider has complied with one or more of the following reasonable measures:
 - (i) The provider first submits a claim to the TPP for the rendered services and does not receive a remittance advice or other communication from the TPP within 90 days after the submission date. The MCO or SPBM may require providers to document the claim and date of the claim submission to the TPP.

- (ii) The provider has retained and/or submitted one of the following types of documentation indicating a valid reason for non-payment for the services not related to provider error:
 - (A) Documentation from the TPP;
 - (B) Documentation from the TPP's automated eligibility and claim verification system;
 - (C) Documentation from the TPP's member benefits reference guide/manual; or
 - (D) Any other documentation from the TPP showing there is no third party benefit coverage for the rendered services.
 - (iii) The provider submitted a claim to the TPP and received a partial payment along with a remittance advice documenting the allocation of the charges.
- (b) Valid reasons for non-payment from a TPP to the provider for a third party benefit claim include, but are not limited to:
- (i) The service is not covered under the member's third party benefits.
 - (ii) The member does not have third party benefits through the TPP for the date of service.
 - (iii) All of the provider's billed charges or the TPP's approved rate was applied, in whole or in part, to the member's third party benefit deductible amount, coinsurance and/or co-payment for the TPP. The provider may then submit a secondary claim to the MCO or SPBM showing the appropriate amount received from the TPP.
 - (iv) The member has not met any required waiting periods, or residency requirements for his/her third party benefits or was non-compliant with the TPP's requirements in order to maintain coverage.
 - (v) The member is a dependent of the individual with third party benefits, but the benefits do not cover the individual's dependents.
 - (vi) The member has reached the lifetime benefit maximum for the medical service or third party benefits being billed to the TPP.
 - (vii) The TPP is disputing or contesting its liability to pay the claim or cover the service.
- (7) If the provider receives payment from the TPP after the MCO or SPBM has made payment, the MCO or SPBM must require the provider to repay the MCO or SPBM any amount overpaid by the MCO or SPBM. The MCO or SPBM must not allow the provider to reimburse any overpaid amounts to the member.
- (8) The MCO or SPBM must make available to providers information on how to submit a claim that will have a zero paid amount in the third party field on the claim.
- (9) The MCO or SPBM payment for third party claims will not exceed the MCO or SPBM allowed amount for the service, less all third party payments for the service.

- (10) The MCO or SPBM's timely filing limits for provider claims shall be at least 90 days from the date of the remittance advice that indicates adjudication or adjustment of the third party claim by the TPP.
 - (11) The MCO or SPBM must ensure that providers do not hold liable or bill members in the event that the MCO or SPBM cannot or will not pay for covered services unless all of the specifications set forth in rule 5160-26-05 and rule 5160-26-11 of the Administrative Code are met. The provider may not collect and/or bill the member for any difference between the MCO or SPBM's payment and the provider's charge or request the member to share in the cost through a deductible, coinsurance, co-payment, or other similar charge, other than MCO or SPBM co-payments.
- (D) The MCO and SPBM are required to submit information regarding members with third party coverage as directed by ODM.

13. 5160-26-10 Managed Care: Sanctions and Provider Agreement Actions.

This rule does not apply to the single pharmacy benefit manager as defined in rule 5160-26-01 of the Administrative Code.

(A) If the managed care organization (MCO) fails to fulfill its duties and obligations under 42 C.F.R. Part 438 (October 1, 2013), 42 U.S.C. 1396b(m) (as in effect January 1, 2015), 42 U.S.C. 1396u-2 (as in effect January 1, 2015), Chapter 5160-26 or 5160-58 of the Administrative Code, or the MCO provider agreement, the Ohio Department of Medicaid (ODM) will provide timely written notification to the MCO identifying the violations or deficiencies, and may impose corrective actions or any of the following sanctions in addition to or instead of any actions or sanctions specified in the provider agreement:

- (1) ODM may require corrective action plans (CAPs) in accordance with the following:
 - (a) If requested by ODM, the MCO must submit, within the specified time frame, a proposed CAP for each cited violation or deficiency.
 - (b) The CAP must contain the proposed correction date, describe the manner in which each violation or deficiency will be resolved, and address all items specified in the ODM notification.
 - (c) The CAP must be reviewed and approved by ODM.
 - (d) Following the approval of the CAP, ODM will monitor the correction process until all violations or deficiencies are corrected to the satisfaction of ODM.
 - (e) If the MCO fails to submit an approvable CAP within the ODM-specified time frames, ODM may impose an ODM-developed CAP, sanctions, or both.
 - (f) If ODM has already determined the specific action that must be implemented by the MCO, ODM may require the MCO to comply with an ODM-developed or directed CAP.
 - (g) Failure by the MCO to successfully complete the correction process and correct the violations or deficiencies to the satisfaction of ODM may lead to the imposition of any or all of the sanctions listed in paragraph (A)(2) of this rule.
- (2) Sanctions that may be imposed on MCOs by ODM include but are not limited to the following:
 - (a) Suspension of the enrollment of MCO members.
 - (b) Disenrollment of the MCO's members.
 - (c) Prohibition or reduction of the MCO's voluntary assignments.
 - (d) Prohibition or reduction of the MCO's involuntary assignments.
 - (e) Granting MCO members the right to terminate without cause and notifying the affected members of their right to disenroll.

- (f) Retention by ODM of the MCO's premium payments or a portion thereof until the violations or deficiencies are corrected.
 - (g) Imposition of financial sanctions.
- (B) ODM will select sanction(s) specified in paragraph (A)(2) of this rule based on a pattern of repeated violations or deficiencies, the severity of the cited violations or deficiencies, the failure of the MCO to meet the requirements of an approved CAP, or all these factors.
- (C) The sanctions in paragraph (A)(2) of this rule are subject to reconsideration by ODM as specified in Chapter 5160-70 of the Administrative Code, with the exception that the involuntary assignments referenced in paragraph (A)(2)(d) of this rule are not subject to reconsideration.
- (D) Regardless of any other sanction that may be imposed, ODM may impose temporary management on any MCO that has repeatedly failed to meet substantive requirements in 42 U.S.C. 1396b(m) (as in effect January 1, 2015), 42 U.S.C. 1396 u-2 (as in effect January 1, 2015) or 42 C.F.R. Part 438 subpart I (October 1, 2013). Such temporary management shall be imposed in accordance with the following:
- (1) The MCO must pay the costs of a temporary manager for performing the duties of a temporary manager as determined by ODM.
 - (2) The MCO is solely responsible for any costs or liabilities incurred on behalf of the MCO when temporary management is imposed by ODM.
 - (3) The imposition of temporary management is not subject to the appeals process provided under Chapter 119 of the Revised Code; however, the MCO may request that the director for the Medicaid program reconsider this action. ODM will not delay imposition of temporary management to provide reconsideration prior to imposing this sanction.
 - (4) Unless the director for the Medicaid program determines through the reconsideration process that temporary management should not have been imposed, the temporary management will remain in place until such time as ODM determines that the MCO can ensure that the sanctioned behavior will not recur.
 - (5) Regardless of the imposition of temporary management, the MCO retains the right to appeal any proposed termination or nonrenewal of its provider agreement under Chapter 119 of the Revised Code. The MCO also retains the right to initiate the sale of the MCO or its assets.
 - (6) If temporary management is imposed, ODM will notify the MCO's members that such action has occurred and inform them that they therefore have the right to terminate their membership in the MCO without cause. Termination of the MCO's membership without cause is not subject to the appeals process provided under Chapter 119 of the Revised Code; however, the MCO may request that the director for the Medicaid program reconsider this action. ODM will not delay the notification to the MCO's membership to provide reconsideration prior to imposing this sanction.
- (E) ODM will provide an MCO with written notice before imposing any sanction. The notice will describe any reconsideration or appeal rights that are available to the MCO.
- (F) Regardless of whether ODM imposes a sanction, MCOs shall initiate corrective action for any MCO program violations or deficiencies as soon as they are identified by either the MCO or ODM.

- (G) The following provisions apply in the event ODM decides to terminate, nonrenew, deny or amend the MCO's provider agreement.
- (1) ODM may terminate, nonrenew, deny or amend the MCO's provider agreement if at any time ODM determines that continuation or assumption of a provider agreement is not in the best interest of recipients or the State of Ohio. For the purposes of this rule, an amendment to an MCO's provider agreement is defined as and limited to the elimination of one or more service areas included in that MCO's current agreement. The phrase "not in the best interest" includes, but is not limited to, the following:
 - (a) The MCO's delivery system does not assure adequate access to services for its members.
 - (b) The MCO's delivery system does not assure the availability of all services covered under the provider agreement.
 - (c) The MCO fails to provide all medically necessary covered services.
 - (d) The MCO fails to provide proper assurances of financial solvency.
 - (e) The number of members enrolled by the MCO in a service area is not sufficient to ensure the effective or efficient delivery of services to members.
 - (f) The MCO fails to comply with any of the following:
 - (i) Chapter 5160-26 or 5160-58 of the Administrative Code or both;
 - (ii) The provider agreement;
 - (iii) The applicable requirements in 42 U.S.C. 1396b(m) (as in effect January 1, 2015) or 42 U.S.C. 1396u-2 (as in effect January 1, 2015); and
 - (iv) 42 C.F.R. Part 438 (October 1, 2013).
 - (2) If ODM has proposed termination, nonrenewal, denial, or amendment of a provider agreement, ODM may notify the MCO's members of this proposed action and inform the members of their right to immediately disenroll from the MCO without cause.
 - (3) If ODM determines that the termination, nonrenewal, or denial of a provider agreement is warranted:
 - (a) ODM will provide notice, at a minimum, 45 days prior to the effective date of the proposed action;
 - (b) The action will be in accordance with and subject to Chapter 5160-70 of the Administrative Code; and
 - (c) The action will be effective at the end of the last day of a calendar month.
 - (4) If ODM determines that the amendment of a provider agreement is warranted, the proposed action is subject to reconsideration pursuant to Chapter 5160-70 of the Administrative Code.
 - (5) Notwithstanding the preceding paragraphs of this rule, ODM may terminate an MCO's provider agreement effective on the last day of the calendar month in which any of the following occur:

- (a) The determination by ODM that the loss or reduction of federal or state funding has reduced funding to a level which is insufficient to maintain the activities or services agreed to in the provider agreement;
 - (b) The exclusion from participation of the MCO in a program administered under Title XVIII, XIX, or XX of the Social Security Act due to criminal conviction or the imposition of civil monetary penalties in accordance with 42 C.F.R. Part 455 subpart B (October 1, 2013), 42 C.F.R. Part 1002 subpart A (October 1, 2013), and rule 5160-1-17.3 of the Administrative Code;
 - (c) The suspension, revocation or nonrenewal of ODM's authority to operate the program under the state plan or waivers of certain federal regulations granted by CMS or congress;
 - (d) The suspension, revocation or nonrenewal of the MCO's certificate of authority or license.
 - (e) The exclusion of the MCO from participation in accordance with 42 C.F.R. 438.808 (October 1, 2013).
- (6) MCOs whose provider agreements are amended, terminated, denied or nonrenewed are required to fulfill all duties and obligations under Chapter 5160-26 or 5160-58 or both of the Administrative Code and the provider agreement.

14. 5160-26-11 Managed Care: Non-Contracting Providers.

(A) For the purposes of this rule, the following terms are defined as follows:

- (1) "Non-contracting provider" means any managed care organization (MCO) or single pharmacy benefit manager (SPBM) provider with an Ohio Department of Medicaid (ODM) provider agreement who does not contract with the MCO or SPBM but delivers health care services to the MCO or SPBM's members.
- (2) "Non-contracting provider of emergency services" means any person, institution, or entity that does not contract with the MCO but provides emergency services to the MCO's members, regardless of whether that provider has an ODM provider agreement.

(B) MCO non-contracting providers of emergency services must accept as payment in full from the MCO the lesser of billed charges or 100% of the Ohio Medicaid program reimbursement rate (less any payments for indirect costs of medical education and direct costs of graduate medical education that is included in the Ohio Medicaid program reimbursement rate) in effect for the date of service. Pursuant to section 5167.10 of the Revised Code, the MCO shall not compensate a hospital for inpatient capital costs in an amount that exceeds the maximum rate established by ODM.

(C) When ODM has approved an MCO's members to be referred to an MCO non-contracting hospital pursuant to rule 5160-26-03 of the Administrative Code, the MCO non-contracting hospital must provide the service for which the referral was authorized and must accept as payment in full from the MCO 100% of the current Ohio Medicaid program reimbursement rate in effect for the date of service. Pursuant to section 5167.10 of the Revised Code, the MCO shall not compensate a hospital for inpatient capital costs in an amount that exceeds the maximum rate established by ODM. MCO non-contracting hospitals are exempted from this provision when:

- (1) The hospital is located in a county in which eligible individuals were required to enroll in an MCO prior to January 1, 2006;
- (2) The hospital is contracted with at least one MCO serving the eligible individuals specified in paragraph (C)(1) of this rule prior to January 1, 2006; and
- (3) The hospital remains contracted with at least one MCO serving eligible individuals who are required to enroll in an MCO in the service area where the hospital is located.

(D) MCO non-contracting qualified family planning providers (QFPPs) must accept as payment in full from the MCO the lesser of 100% of the Ohio Medicaid program reimbursement rate or billed charges, in effect for the date of service.

(E) An MCO or SPBM non-contracting provider may not bill the MCO or SPBM member unless all of the following conditions are met:

- (1) The member was notified by the provider of the financial liability in advance of service delivery.
- (2) The notification by the provider was in writing, specific to the service being rendered, and clearly states that the recipient is financially responsible for the specific service. A general patient liability statement signed by all patients is not sufficient for this purpose.

- (3) The notification is dated and signed by the member.
- (4) The reason the service is not covered by the MCO or SPBM is specified and is one of the following:
 - (a) The service is a benefit exclusion;
 - (b) The provider is not contracted with the MCO or SPBM and the MCO or SPBM has denied approval for the provider to provide the service because the service is available from a contracted provider, at no cost to the member; or
 - (c) The provider is not contracted with the MCO or SPBM and has not requested approval to provide the service.
- (F) An MCO non-contracting provider may not bill an MCO member for a missed appointment.
- (G) MCO non-contracting providers, including non-contracting providers of emergency services, must contact the 24-hour post-stabilization services phone line designated by the MCO to request authorization to provide post-stabilization services in accordance with rule 5160-26-03 of the Administrative Code.
- (H) Non-contracting providers, including non-contracting providers of emergency services, must allow the MCO or SPBM, ODM, and ODM's designee access to all member medical records for a period not less than 10 years from the date of service or until any audit initiated within the 10-year period is completed. Access must include copies of the medical records at no cost for the purpose of activities related to the annual external quality review specified by 42.C.F.R. 438.358 (October 1, 2017).
- (I) When the MCO or SPBM elects to impose member co-payments, applicable co-payments shall also apply to services rendered by MCO or SPBM non-contracting providers. When the MCO or SPBM has not elected to impose co-payments, MCO or SPBM non-contracting providers are not permitted to impose co-payments on MCO or SPBM members.

15. 5160-26-12 Managed Care: Member Co-payments.

This rule does not apply to "MyCare Ohio" plans pursuant to Chapter 5160-58 of the Administrative Code.

- (A) Managed care organizations (MCOs) may elect to implement a member co-payment program pursuant to section 5162.20 of the Revised Code for dental services, vision services, or non-emergency emergency department services as provided for in this rule. The MCO must receive prior approval from the Ohio Department of Medicaid (ODM) before notifying members that a co-payment program will be implemented.
- (B) The single pharmacy benefit manager (SPBM) may only elect to implement a member co-payment program pursuant to section 5162.20 of the Revised Code for prescriptions drugs as provided for in this rule if directed to by ODM.
- (C) If the MCO or SPBM implements a member co-payment program, the MCO or SPBM must:
 - (1) Exclude the populations and services set forth in paragraph (C) of this rule;
 - (2) Not deny services to members as specified in paragraph (D) of this rule;
 - (3) Not impose co-payment amounts in excess of the maximum amounts specified in 42 C.F.R. 447.54 (October 1, 2015);
 - (4) Specify in provider contracts governed by rule 5160-26-05 of the Administrative Code the circumstances under which member co-payment amounts can be requested. If the MCO or SPBM implements a co-payment program, no provider can waive a member's obligation to pay the provider a co-payment except as described in paragraph (G) of this rule;
 - (5) Ensure that the member is not billed for any difference between the MCO or SPBM's payment and the provider's charge or request that the member share in the cost through co-payment or other similar charge, other than Medicaid co-payments as defined in this rule;
 - (6) Ensure that member co-payment amounts are requested by providers in accordance with this rule; and
 - (7) Ensure that no provider or drug manufacturer, including the manufacturer's representative, employee, independent contractor, or agent shall pay any co-payment on behalf of the member.
- (D) Exclusions to the member co-payment program for dental, vision, non-emergency emergency department services, and prescription medications include the following:
 - (1) Children. Members who are under the age of 21 are excluded from Medicaid co-payment obligations.
 - (2) Pregnant women. With the exception of routine eye examinations and the dispensation of eyeglasses during a member's pregnancy or post-partum period, all services provided to pregnant women during their pregnancy and the post-partum period are excluded from a

Medicaid co-payment obligation. The post-partum period is the period that begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends.

- (3) Institutionalized members. Services or medications provided to members who reside in a nursing facility (NF) or intermediate care facility for individuals with intellectual disabilities (ICF/IID) are excluded from Medicaid co-payment obligations.
 - (4) Emergency. The MCO shall not impose a co-payment obligation for emergency services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily part or organ.
 - (5) Family planning (pregnancy prevention or contraceptive management). The MCO or SPBM shall not impose a Medicaid co-payment obligation on any service identified by ODM as a pregnancy prevention/contraceptive management service in accordance with rule 5160-21-02 of the Administrative Code and the appendix to rule 5160-9-12 of the Administrative Code and provided to an individual of childbearing age.
 - (6) Hospice. Members receiving services for hospice care are excluded from Medicaid co-payment obligation.
 - (7) Medicare crossover claims. Medicare crossover claims defined in accordance with rule 5160-1-05 of the Administrative Code will not be subject to Medicaid co-payment obligations.
 - (8) Medications administered to a member during a medical encounter provided in a hospital, clinic, office or other facility, when the medication is part of the evaluation and treatment of the condition, are not subject to a member co-payment.
- (E) No provider may deny services to a member who is eligible for services due to the member's inability to pay the member co-payment. Members who are unable to pay their member co-payment may declare their inability to pay for services or medication and receive their services or medications without paying their member co-payment amount. This provision does not relieve the member from the obligation to pay a member co-payment or prohibit the provider from attempting to collect an unpaid member co-payment. If it is the routine business practice of the provider to refuse service to any individual who owes an outstanding debt to the provider, the provider may consider an unpaid Medicaid co-payment as an outstanding debt and may refuse service to a member who owes the provider an outstanding debt. If the provider intends to refuse service to a member who owes the provider an outstanding debt, the provider shall notify the individual of the provider's intent to refuse services. In such situations, the MCO or SPBM must still ensure that the member has access to needed services.
- (F) The MCO or SPBM may impose member co-payments as follows:
- (1) For dental services, the member co-payment amount may not exceed the amount set forth in Chapter 5160-5 of the Administrative Code. Services provided to a member on the same date of service by the same provider are subject to only one co-payment.
 - (2) For non-emergency emergency department services, the member co-payment amount must not exceed the amount set forth in Chapter 5160-2 of the Administrative Code. For purposes of

this rule, the hospital provider shall determine if services rendered are non-emergency emergency department services and will report, through claim submission, the applicable co-payment to the MCO in accordance with Medicaid hospital billing instructions.

- (3) For vision services, the member co-payment amounts must not exceed the amounts set forth in Chapter 5160-6 of the Administrative Code.
 - (4) For pharmacy services, the member co-payment amounts must not exceed the amounts set forth in Chapter 5160-9 of the Administrative Code.
- (G) Prescriptions for medications are subject to the applicable member co-payment for medications if they are given to a member during a medical encounter provided in the emergency department or other hospital setting, clinic, office, or other facility as a result of the evaluation and treatment of the condition, regardless of whether they are filled at a pharmacy located at the facility or at an outside location.
- (H) If the MCO has implemented a member co-payment program for non-emergency emergency department services, as described in paragraph (E)(2) of this rule, a hospital may take action to collect a co-payment by providing, at the time services are rendered to a managed care member, notice that a co-payment may be owed. If the hospital provides the notice and chooses not to take further action to pursue collection of the co-payment, the prohibition against waiving co-payments, as described in paragraph (B)(4) of this rule, does not apply.
- (I) If the MCO or SPBM does not to impose a co-payment amount for dental services, vision services, non-emergency emergency department services or prescription drugs and the MCO or SPBM reimburses contracting or non-contracting providers for these services using the Medicaid provider reimbursement rate, the MCO or SPBM must not reduce its provider payments by the applicable co-payment amount set forth in this rule.