OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
OHIO MEDICAL ASSISTANCE PROVIDER AGREEMENT
FOR MANAGED CARE PLAN

This provider agreement is entered into this first day of July, 2009, at Columbus, Franklin County, Ohio, between the State of Ohio, Department of Job and Family Services, (hereinafter referred to as ODJFS) whose principal offices are located in the City of Columbus, County of Franklin, State of Ohio, and [MCP NAME], Managed Care Plan (hereinafter referred to as MCP), an Ohio for-profit corporation, whose principal office is located in the city of [MCP CITY], County of [MCP COUNTY], State of Ohio.

MCP is licensed as a Health Insuring Corporation by the State of Ohio, Department of Insurance (hereinafter referred to as ODI), pursuant to Chapter 1751 of the Ohio Revised Code (ORC) and is organized and agrees to operate as prescribed by Chapter 5101:3-26 of the Ohio Administrative Code (OAC), and other applicable portions of the OAC as amended from time to time.

MCP is an entity eligible to enter into a provider agreement in accordance with 42 CFR (Code of Federal Regulations) 438.6 and is engaged in the business of providing prepaid comprehensive health care services as defined in 42 CFR 438.2 through the managed care program for the Medicaid eligible population described in OAC rule 5101:3-26-02(B) and Appendix B of this Agreement.

ODJFS, as the single state agency designated to administer the Medicaid program under Section 5111.02 of the ORC and Title XIX of the Social Security Act, desires to obtain MCP services for the benefit of certain Medicaid recipients. In so doing, MCP has provided and will continue to provide proof of MCP's capability to provide quality services, efficiently, effectively and economically during the term of this agreement.

This provider agreement is a contract between ODJFS and the undersigned MCP, provider of medical assistance, pursuant to the federal contracting provisions of 42 CFR 434.6 and 438.6 in which the MCP agrees to provide comprehensive medical services through the managed care program as provided in Chapter 5101:3-26 of the OAC, assuming the risk of loss, and complying with applicable state statutes, OAC, and Federal statutes, rules, regulations and other requirements, including but not limited to title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

ARTICLE I - GENERAL

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

B. MCP agrees to report to the Chief of the Bureau of Managed Care (hereinafter referred to as BMC) or his or her designee as necessary to assure understanding of the responsibilities and satisfactory compliance with this provider agreement.

C. MCP agrees to furnish its support staff and services as necessary for the satisfactory performance of the services as enumerated in this provider agreement.

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

E. If the MCP previously had a provider agreement with the ODJFS and the provider agreement terminated more than two years prior to the effective date of any new provider agreement, such MCP will be considered a new plan in its first year of operation with the Ohio Medicaid managed care program.

ARTICLE II - TIME OF PERFORMANCE

A. Upon approval by the Director of ODJFS this provider agreement shall be in effect from the date entered through June 30, 2010, unless this provider agreement is suspended or terminated pursuant to Article VIII prior to the termination date, or otherwise amended pursuant to Article IX.

B. It is expressly agreed by the parties that none of the rights, duties and obligations herein shall be binding on either party if award of this Agreement would be contrary to the terms of ORC Section 3517.13, ORC Section 127.16, or ORC Chapter 102.

ARTICLE III - REIMBURSEMENT

A. ODJFS will reimburse MCP in accordance with rule 5101:3-26-09 of the OAC and the appropriate appendices of this Agreement.

ARTICLE IV - RELATIONSHIP OF PARTIES

A. ODJFS and MCP agree that, during the term of this Agreement, MCP shall be engaged by ODJFS solely on an independent contractor basis, and neither MCP nor its personnel shall, at any time or for any purpose, be considered as agents, servants or employees of ODJFS or the state of Ohio. MCP shall therefore be responsible for all MCP's business expenses, including, but not limited to, employee's wages and salaries, insurance of every

type and description, and all business and personal taxes, including income and Social Security taxes and contributions for Workers' Compensation and Unemployment Compensation coverage, if any.

B. MCP agrees to comply with all applicable federal, state, and local laws in the conduct of the work hereunder.

C. While MCP shall be required to render services described hereunder for ODJFS during the term of this Agreement, nothing herein shall be construed to imply, by reason of MCP's engagement hereunder on an independent contractor basis, that ODJFS shall have or may exercise any right of control over MCP with regard to the manner or method of MCP's performance of services hereunder. The management of the work, including the exclusive right to control or direct the manner or means by which the work is performed, remains with MCP. ODJFS retains the right to ensure that MCP's work is in conformity with the terms and conditions of this Agreement.

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

ARTICLE V - CONFLICT OF INTEREST; ETHICS LAWS

A. In accordance with the safeguards specified in section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423) and other applicable federal requirements, no officer, member or employee of MCP, the Chief of BMC, or other ODJFS employee who exercises any functions or responsibilities in connection with the review or approval of this provider agreement or provision of services under this provider agreement shall, prior to the completion of such services or reimbursement, acquire any interest, personal or otherwise, direct or indirect, which is incompatible or in conflict with, or would compromise in any manner or degree the discharge and fulfillment of his or her functions and responsibilities with respect to the carrying out of such services. For purposes of this article, "members" does not include individuals whose sole connection with MCP is the receipt of services through a health care program offered by MCP.

B. MCP represents, warrants, and certifies that it and its employees engaged in the administration or performance of this Agreement are knowledgeable of and understand the Ohio Ethics and Conflicts of Interest laws and Executive Order 2007-01S. MCP further represents, warrants, and certifies that neither MCP nor any of its employees will do any act that is inconsistent with such laws and Executive Order. The Governor's Executive Orders may be found by accessing the following website: http://governor.ohio.gov/GovernorsOffice/ExecutiveOrdersDirectives/tabid/105/Default.aspx.

C. MCP hereby covenants that MCP, its officers, members and employees of the MCP, shall not, prior to the completion of the work under this Agreement, voluntarily acquire any interest, personal or otherwise, direct or indirect, which is incompatible or in conflict with

or would compromise in any manner of degree the discharge and fulfillment of his or her functions and responsibilities under this provider agreement. MCP shall periodically inquire of its officers, members and employees concerning such interests.

D. Any such person who acquires an incompatible, compromising or conflicting personal or business interest, on or after the effective date of this Agreement, or who involuntarily acquires any such incompatible or conflicting personal interest, shall immediately disclose his or her interest to ODJFS in writing. Thereafter, he or she shall not participate in any action affecting the services under this provider agreement, unless ODJFS shall determine in its sole discretion that, in the light of the personal interest disclosed, his or her participation in any such action would not be contrary to the public interest. The written disclosure of such interest shall be made to: Chief, BMC, ODJFS.

E. No officer, member or employee of MCP shall promise or give to any ODJFS employee anything of value that is of such a character as to manifest a substantial and improper influence upon the employee with respect to his or her duties. No officer, member or employee of MCP shall solicit an ODJFS employee to violate any ODJFS rule or policy relating to the conduct of the parties to this agreement or to violate sections 102.03, 102.04, 2921.42 or 2921.43 of the ORC.

F. MCP hereby covenants that MCP, its officers, members and employees are in compliance with section 102.04 of the ORC and that if MCP is required to file a statement pursuant to 102.04(D)(2) of the ORC, such statement has been filed with the ODJFS in addition to any other required filings.

ARTICLE VI - NONDISCRIMINATION OF EMPLOYMENT

A. MCP agrees that in the performance of this provider agreement or in the hiring of any employees for the performance of services under this provider agreement, MCP shall not by reason of race, color, religion, gender, sexual orientation, age, disability, national origin, veteran's status, health status, or ancestry, discriminate against any citizen of this state in the employment of a person qualified and available to perform the services to which the provider agreement relates.

B. MCP agrees that it shall not, in any manner, discriminate against, intimidate, or retaliate against any employee hired for the performance or services under the provider agreement on account of race, color, religion, gender, sexual orientation, age, disability, national origin, veteran's status, health status, or ancestry.

C. In addition to requirements imposed upon subcontractors in accordance with OAC Chapter 5101:3-26, MCP agrees to hold all subcontractors and persons acting on behalf of MCP in the performance of services under this provider agreement responsible for adhering to the requirements of paragraphs (A) and (B) above and shall include the requirements of paragraphs (A) and (B) above in all subcontracts for services performed under this provider agreement, in accordance with OAC rule 5101:3-26-05.

ARTICLE VII - RECORDS, DOCUMENTS AND INFORMATION

A. MCP agrees that all records, documents, writings or other information produced by MCP under this provider agreement and all records, documents, writings or other information used by MCP in the performance of this provider agreement shall be treated in accordance with OAC rule 5101:3-26-06. MCP must maintain an appropriate record system for services provided to members. MCP must retain all records in accordance with 45 CFR Part 74.

B. All information provided by MCP to ODJFS that is proprietary shall be held to be strictly confidential by ODJFS. Proprietary information is information which, if made public, would put MCP at a disadvantage in the market place and trade of which MCP is a part [see ORC Section 1333.61(D)]. MCP is responsible for notifying ODJFS of the nature of the information prior to its release to ODJFS. Failure to provide such prior notification is deemed to be a waiver of the proprietary nature of the information, and a waiver of any right of MCP to proceed against ODJFS for violation of this agreement or of any proprietary or trade secret laws. Such failure shall also be deemed a waiver of trade secret protection in that the MCP will have failed to make efforts that are reasonable under the circumstances to maintain the information's secrecy. ODJFS reserves the right to require reasonable evidence of MCP's assertion of the proprietary nature of any information to be provided and ODJFS will make the final determination of whether any or all of the information identified by the MCP is proprietary or a trade secret. The provisions of this Article are not self-executing.

C. MCP shall not use any information, systems, or records made available to it for any purpose other than to fulfill the duties specified in this provider agreement. MCP agrees to be bound by the same standards of confidentiality that apply to the employees of the ODJFS and the state of Ohio. The terms of this section shall be included in any subcontracts executed by MCP for services under this provider agreement. MCP must implement procedures to ensure that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164.

ARTICLE VIII - SUSPENSION AND TERMINATION

A. This provider agreement may be suspended or terminated by the department or MCP upon written notice in accordance with the applicable rule(s) of the OAC, with termination to occur at the end of the last day of a month.

B. MCP, upon receipt of notice of suspension or termination, shall cease provision of services on the suspended or terminated activities under this provider agreement; suspend, or terminate all subcontracts relating to such suspended or terminated activities, take all necessary or appropriate steps to limit disbursements and minimize costs, and furnish a report, as of the date of receipt of notice of suspension or termination describing the status of all services under this provider agreement.

C. In the event of suspension or termination under this Article, MCP shall be entitled to reconciliation of reimbursements through the end of the month for which services were provided under this provider agreement, in accordance with the reimbursement provisions of this provider agreement. MCP agrees to waive any right to, and shall make no claim for, additional compensation against ODJFS by reason of such suspension or termination.

D. ODJFS may, in its judgment, suspend, terminate or fail to renew this provider agreement if the MCP or MCP's subcontractors violate or fail to comply with the provisions of this agreement or other provisions of law or regulation governing the Medicaid program. Where ODJFS proposes to suspend, terminate or refuse to enter into a provider agreement, the provisions of applicable sections of the OAC with respect to ODJFS' suspension, termination or refusal to enter into a provider agreement shall apply, including the MCP's right to request an adjudication hearing under Chapter 119 of the ORC.

E. When initiated by MCP on or before June 30, 2010, termination of or failure to renew the provider agreement requires written notice to be received by ODJFS at least 120 days in advance of the termination or renewal date, provided, however, that termination or non-renewal must be effective at the end of the last day of a calendar month. When initiated by the MCP after June 30, 2010, termination of or failure to renew the provider agreement requires written notice to be received by ODJFS at least 240 days in advance of the termination or renewal date, provided, however, that termination or non-renewal must be effective at the end of the last day of a calendar month. In the event of non-renewal of the provider agreement with ODJFS, if MCP is unable to provide the required number of days of notice to ODJFS prior to the date when the provider agreement expires, then the provider agreement shall be deemed extended to the last day of the month that is the required number of days from the date of the termination notice, and both parties shall, for that time, continue to fulfill their duties and obligations as set forth herein. If an MCP wishes to terminate or not renew their provider agreement for a specific region(s), ODJFS reserves the right to initiate a procurement process to select additional MCPs to serve Medicaid consumers in that region(s). ODJFS, at its discretion, may use an MCP’s termination or non-renewal of this provider agreement as a factor in any future procurement process.

ARTICLE IX - AMENDMENT AND RENEWAL

A. This writing constitutes the entire agreement between the parties with respect to all matters herein. This provider agreement may be amended only by a writing signed by both parties. Any written amendments to this provider agreement shall be prospective in nature.

B. This provider agreement may be renewed one or more times by in writing signed by both parties for a period of not more than twelve months for each renewal.

C. In the event that changes in state or federal law, regulations, an applicable waiver or state plan amendment, or the terms and conditions of any applicable federal waiver or state plan amendment, require ODJFS to modify this Agreement, ODJFS shall notify MCP regarding such changes and this agreement shall be automatically amended to conform to such changes without the necessity for executing written amendments pursuant to this Article of this Agreement.

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

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

ARTICLE X - LIMITATION OF LIABILITY

A. MCP agrees to indemnify and to hold ODJFS and the state of Ohio harmless and immune from any and all claims for injury or damages resulting from the actions or omissions of MCP or its subcontractors in the fulfillment of this provider agreement or arising from this Agreement which are attributable to the MCP's own actions or omissions of those of its trustees, officers, employees, subcontractors, suppliers, third parties utilized by MCP, or joint venturers while acting under this Agreement. Such claims shall include 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, and trademarks. MCP shall bear all costs associated with defending ODJFS and the state of Ohio against these claims.

B. MCP hereby agrees to be liable for any loss of federal funds suffered by ODJFS for enrollees resulting from specific, negligent acts or omissions of the MCP or its subcontractors during the term of this agreement, including but not limited to the nonperformance of the duties and obligations to which MCP has agreed under this agreement.

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

D. In no event shall either party be liable to the other party for indirect, consequential, incidental, special or punitive damages, or lost profits.

ARTICLE XI - ASSIGNMENT

A. ODJFS will not allow the transfer of Medicaid members by one MCP to another MCP unless this membership has been obtained as a result of an MCP selling their entire Ohio corporation to another health plan. MCP shall not assign any interest in this provider agreement and shall not transfer any interest in the same (whether by assignment or novation) without the prior written approval of ODJFS and subject to such conditions and provisions as ODJFS may deem necessary. Any such assignments shall be submitted for ODJFS' review 120 days prior to the desired effective date. No such approval by ODJFS of any assignment shall be deemed in any event or in any manner to provide for the incurrence of any obligation by ODJFS in addition to the total agreed-upon reimbursement in accordance with this agreement.

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

ARTICLE XII - CERTIFICATION MADE BY MCP

A. This agreement is conditioned upon the full disclosure by MCP to ODJFS of all information required for compliance with federal regulations as requested by ODJFS.

B. By executing this agreement, MCP certifies that no federal funds paid to MCP through this or any other agreement with ODJFS shall be or have been used to lobby Congress or any federal agency in connection with a particular contract, grant, cooperative agreement or loan. MCP further certifies compliance with the lobbying restrictions contained in Section 1352, Title 31 of the U.S. Code, Section 319 of Public Law 101-121 and federal regulations issued pursuant thereto and contained in 45 CFR Part 93, Federal Register, Vol. 55, No. 38, February 26, 1990, pages 6735-6756. If this Agreement exceeds $100,000, MCP has executed the Disclosure of Lobbying Activities, Standard Form LLL, if required by federal regulations. This certification is material representation of fact upon which reliance was placed when this provider agreement was entered into.

C. By executing this agreement, MCP certifies that neither MCP nor any principals of MCP (i.e., a director, officer, partner, or person with beneficial ownership of more than 5% of the MCP's equity) is presently debarred, suspended, proposed for debarment, declared ineligible, or otherwise excluded from participation in transactions by any Federal agency. The MCP also certifies that it is not debarred from consideration for contract awards by the Director of the Department of Administrative Services, pursuant to either ORC Section 153.02 or ORC Section 125.25. The MCP also certifies that the MCP has

no employment, consulting or any other arrangement with any such debarred or suspended person for the provision of items or services or services that are significant and material to the MCP's contractual obligation with ODJFS. This certification is a material representation of fact upon which reliance was placed when this provider agreement was entered into. Federal financial participation (FFP) is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP, except for emergency services. If it is ever determined that MCP knowingly executed this certification erroneously, then in addition to any other remedies, this provider agreement shall be terminated pursuant to Article VII, and ODJFS must advise the Secretary of the appropriate federal agency of the knowingly erroneous certification.

D. By executing this agreement, MCP certifies compliance with Article V as well as agreeing to future compliance with Article V. This certification is a material representation of fact upon which reliance was placed when this contract was entered into.

E. By executing this agreement, MCP certifies compliance with the executive agency lobbying requirements of sections 121.60 to 121.69 of the ORC. This certification is a material representation of fact upon which reliance was placed when this provider agreement was entered into.

F. By executing this agreement, MCP certifies that MCP is not on the most recent list established by the Secretary of State, pursuant to section 121.23 of the ORC, which identifies MCP as having more than one unfair labor practice contempt of court finding. This certification is a material representation of fact upon which reliance was placed when this provider agreement was entered into.

G. By executing this agreement MCP agrees not to discriminate against individuals who have or are participating in any work program administered by a county Department of Job and Family Services (CDJFS) under Chapters 5101 or 5107 of the ORC.

H. By executing this agreement, MCP certifies and affirms that, as applicable to MCP, that no party listed or described in Division (I) or (J) of Section 3517.13 of the ORC who was actually in a listed position at the time of the contribution, has made as an individual, within the two previous calendar years, one or more contributions in excess of one thousand and 00/100 ($1,000.00) to the present governor or to the governor's campaign committees during any time he/she was a candidate for office. This certification is a material representation of fact upon which reliance was placed when this provider agreement was entered into. If it is ever determined that MCP's certification of this requirement is false or misleading, and not withstanding any criminal or civil liabilities imposed by law, MCP shall return to ODJFS all monies paid to MCP under this provider agreement. The provisions of this section shall survive the expiration or termination of this provider agreement.

I. MCP agrees to refrain from promising or giving to any ODJFS employee anything of value that is of such a character as to manifest a substantial and improper influence upon the employee with respect to his or her duties. MCP also agrees that it will not solicit an ODJFS employee to violate any ODJFS rule or policy relating to the conduct of contracting parties or to violate sections 102.03, 102.04, 2921.42 or 2921.43 of the ORC.

J. By executing this agreement, MCP certifies and affirms that HHS, US Comptroller General or representatives will have access to books, documents, etc. of MCP.

K. By executing this agreement, MCP agrees to comply with the false claims recovery requirements of Section 6032 of The Deficit Reduction Act of 2005 (also see Section 5111.101 of the ORC).

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

M. MCP hereby represents and warrants to ODJFS that it has not provided any material assistance, as that term is defined in ORC Section 2909.33(C), to any organization identified by and included on the United States Department of State Terrorist Exclusion List and that it has truthfully answered "no" to every question on the "Declaration Regarding Material Assistance/Non-assistance to a Terrorist Organization." MCP further represents and warrants that it has provided or will provide such to ODJFS prior to execution of this Agreement. If these representations and warranties are found to be false, this Agreement is void *ab initio* and MCP shall immediately repay to ODJFS any funds paid under this Agreement.

N. By executing this agreement, MCP certifies and confirms that any performance of experimental, developmental, or research work shall provide for the rights of the Federal Government and the recipient in any resulting invention.

O. By executing this agreement, MCP certifies and confirms that it agrees to comply with all applicable standards orders or regulations of the Clean Air Act and Federal Water Pollution Control Act.

ARTICLE XIII - CONSTRUCTION

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

ARTICLE XIV - INCORPORATION BY REFERENCE

A. OAC Chapter 5101:3-26 (Appendix A) is hereby incorporated by reference as part of this provider agreement having the full force and effect as if specifically restated herein.

B. Appendices B through P and any additional appendices are hereby incorporated by reference as part of this provider agreement having the full force and effect as if specifically restated herein.

C. In the event of inconsistence or ambiguity between the provisions of OAC Chapter 5101:3-26 and this Agreement, the provisions of OAC Chapter 5101:3-26 shall be determinative of the obligations of the parties unless such inconsistency or ambiguity is the result of changes in federal or state law, as provided in Article IX of this provider agreement, in which case such federal or state law shall be determinative of the obligations of the parties. In the event OAC 5101:3-26 is silent with respect to any ambiguity or inconsistency, the Agreement (including Appendices B through P and any additional appendices), shall be determinative of the obligations of the parties. In the event that a dispute arises which is not addressed in any of the aforementioned documents, the parties agree to make every reasonable effort to resolve the dispute, in keeping with the objectives of the provider agreement and the budgetary and statutory constraints of ODJFS.

ARTICLE XV – NOTICES

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

ARTICLE XVI – HEADINGS

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

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

MANAGED CARE PLAN:

BY: _____ DATE: _____
MANAGED CARE PLAN PRESIDENT/CEO

OHIO DEPARTMENT OF JOB AND FAMILY SERVICES:

BY: _____ DATE: _____
DOUGLAS E. LUMPKIN, DIRECTOR

Ohio Department of Job and Family Services
Medical Assistance Provider Agreement
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July 1, 2009

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APPENDIX A

OAC RULES 5101:3-26

The managed care program rules can be accessed electronically through the BMHC page of the ODJFS website.

APPENDIX B

SERVICE AREA SPECIFICATIONS

MCP : [NAME]

The MCP agrees to provide services to Aged, Blind or Disabled (ABD) members and/or Covered Families and Children (CFC) members residing in the following service area(s):

Service Area	ABD Eligible Population	CFC Eligible Population
Central Region	☐ ABD	☐ CFC
East Central Region	☐ ABD	☐ CFC
Northeast Region	☐ ABD	☐ CFC
Northeast Central Region	☐ ABD	☐ CFC
Northwest Region	☐ ABD	☐ CFC
Southeast Region	☐ ABD	☐ CFC
Southwest Region	☐ ABD	☐ CFC
West Central Region	☐ ABD	☐ CFC

*The ABD and CFC categories of assistance are described in OAC rule 5101:3-26-02(B).

*MCPs must serve all counties in any region they agree to serve. See the next page for a list of counties in each region.

OHIO MCP REGIONS

Counties in the Central Region

Crawford	Knox	Perry
Delaware	Licking	Pickaway
Fairfield	Logan	Pike
Fayette	Madison	Ross
Franklin	Marion	Scioto
Hocking	Morrow	Union

Counties in the East Central Region

Ashland	Portage	Summit
Carroll	Richland	Tuscarawas
Holmes	Stark	Wayne

Counties in the Northeast Region

Ashtabula	Geauga	Lorain
Cuyahoga	Huron	Medina
Erie	Lake	

Counties in the Northeast Central Region

Columbiana	Mahoning	Trumbull

Counties in the Northwest Region

Allen	Henry	Sandusky
Auglaize	Lucas	Seneca
Defiance	Mercer	Van Wert
Fulton	Ottawa	Williams
Hancock	Paulding	Wood
Hardin	Putnam	Wyandot

Counties in the Southeast Region

Athens	Jackson	Muskingum
Belmont	Jefferson	Noble
Coshocton	Lawrence	Vinton
Gallia	Meigs	Washington
Guernsey	Monroe	
Harrison	Morgan	

Counties in the Southwest Region

Adams	Clermont	Highland
Brown	Clinton	Warren
Butler	Hamilton	

Counties in the West Central Region

Champaign	Greene	Preble
Clark	Miami	Shelby
Darke	Montgomery	

APPENDIX C

MCP RESPONSIBILITIES

The MCP must meet on an ongoing basis, all program requirements specified in Appendix A, Ohio Administrative Code (OAC) Rules 5101:3-26 and the Ohio Department of Job and Family Services (ODJFS) - MCP Provider Agreement. The following are MCP responsibilities that are not otherwise specifically stated in OAC rule provisions or elsewhere in the MCP provider agreement, but are required by ODJFS.

General Provisions

1. The MCP agrees to implement program modifications as soon as reasonably possible or no later than the required effective date, in response to changes in applicable state and federal laws and regulations.

2. The MCP must submit a current copy of their Certificate of Authority (COA) to ODJFS within 30 days of issuance by the Ohio Department of Insurance (ODI).

3. The MCP must designate the following:

   a. A primary contact person (the Medicaid Coordinator) who will dedicate a majority of their time to the Medicaid product line and coordinate overall communication between ODJFS and the MCP. ODJFS may also require the MCP to designate contact staff for specific program areas. The Medicaid Coordinator will be responsible for ensuring the timeliness, accuracy, completeness and responsiveness of all MCP submissions to ODJFS.

   b. A provider relations representative for each service area included in their ODJFS provider agreement. This provider relations representative can serve in this capacity for only one service area (as specified in Appendix H).

4. All MCP employees are to direct all day-to-day submissions and communications to their ODJFS-designated Contract Administrator unless otherwise notified by ODJFS.

5. The MCP must be represented at all meetings and events designated by ODJFS as requiring mandatory attendance.

6. The MCP must have an administrative office located in Ohio.

7. Upon request by ODJFS, the MCP must submit information on the current status of their company's operations not specifically covered under this Agreement (for example, other product lines, Medicaid contracts in other states, National Committee for Quality Assurance [NCQA] accreditation, etc.) unless otherwise excluded by law.

8. The MCP must have all new employees trained on applicable program requirements, and represent, warrant and certify to ODJFS that such training occurs, or has occurred.

9. If an MCP determines that it does not wish to provide, reimburse, or cover a counseling service or referral service due to an objection to the service on moral or religious grounds, it must immediately notify ODJFS to coordinate the implementation of this change. MCPs will be required to notify their members of this change at least thirty (30) days prior to the effective date. The MCP's member handbook and provider directory, as well as all marketing materials, will need to include information specifying any such services that the MCP will not provide.

10. For any data and/or documentation that MCPs are required to maintain, ODJFS may request that MCPs provide analysis of this data and/or documentation to ODJFS in an aggregate format, such format to be solely determined by ODJFS.

11. The MCP is responsible for determining medical necessity for services and supplies requested for their members as specified in OAC rule 5101:3-26-03. Notwithstanding such responsibility, ODJFS retains the right to make the final determination on medical necessity in specific member situations.

12. In addition to the timely submission of medical records at no cost for the annual external quality review as specified in OAC rule 5101:3-26-07, the MCP may be required for other purposes to submit medical records at no cost to ODJFS and/or designee upon request.

13. In addition to the provisions in OAC 5101:3-26-05(B), the MCP must notify the BMC within 1 working day of becoming aware of the termination of an MCP panel provider if that provider is designated as the primary care provider (PCP) for either 100 or more of the MCP's ABD members or 500 or more of the MCP's CFC members, or a combined total of 500 or more of the MCP's members if the provider is serving both the ABD and CFC populations.

14. Upon request by ODJFS, MCPs may be required to provide written notice to members of any significant change(s) affecting contractual requirements, member services or access to providers.

15. MCPs may elect to provide services that are in addition to those covered under the Ohio Medicaid fee-for-service (FFS) program. Before MCPs notify potential or current members of the availability of these services, they must first notify ODJFS and advise ODJFS of such planned services availability. If an MCP elects to provide additional services, the MCP must ensure to the satisfaction of ODJFS that the services are readily available and accessible to members who are eligible to receive them. Additional benefits must be made available to members for at least six (6) calendar months from date approved by ODJFS.

a. MCPs are **required** to make transportation available to any member requesting transportation when they **must** travel thirty (30) miles or more from their home to receive a medically-necessary Medicaid-covered service. If the MCP offers transportation to their members as an additional benefit and this transportation benefit only covers a limited number of trips, the required transportation listed above may not be counted toward this trip limit.

b. Additional benefits may not vary by county within a region except out of necessity for transportation arrangements (e.g., bus versus cab). MCPs approved to serve consumers in more than one region may vary additional benefits between regions.

c. MCPs must give ODJFS and members ninety (90) days prior notice when decreasing or ceasing any additional benefit(s). When it is beyond the control of the MCP, as demonstrated to ODJFS' satisfaction, ODJFS must be notified within one (1) working day.

16. MCPs must comply with any applicable federal and state laws that pertain to member rights and ensure that its staff adheres to such laws when furnishing services to its members. MCPs shall include a requirement in its contracts with affiliated providers that such providers also adhere to applicable Federal and State laws when providing services to members.

17. MCPs must comply with any other applicable Federal and State laws (such as Title VI of the Civil rights Act of 1964, etc.) and other laws regarding privacy and confidentiality, as such may be applicable to this Agreement.

18. Upon request, the MCP will provide members and potential members with a copy of their practice guidelines.

19. The MCP is responsible for promoting the delivery of services in a culturally competent manner, as solely determined by ODJFS, to all members, including those with limited English proficiency (LEP) and diverse cultural and ethnic backgrounds.

All MCPs must comply with the requirements specified in OAC rules 5101:3-26-03.1, 5101:3-26-05(D), 5101:3-26-05.1(A), 5101:3-26-08 and 5101:3-26-08.2 for providing assistance to LEP members and eligible individuals. In addition, MCPs must provide written translations of certain MCP materials in the prevalent non-English languages of members and eligible individuals in accordance with the following:

a. When 10% or more of the eligible individuals in the MCP's service area have a common primary language other than English, the MCP must translate all ODJFS-approved marketing materials into the primary language of that group. The MCP must monitor changes in the eligible population on an ongoing basis and conduct an assessment no less often than annually to determine which, if any, primary language groups meet the 10% threshold for the eligible individuals in each service area. When the 10% threshold is

met, the MCP must report this information to ODJFS, in a format as requested by ODJFS, translate their marketing materials, and make these marketing materials available to eligible individuals. MCPs must submit to ODJFS, upon request, their prevalent non-English language analysis of eligible individuals and the results of this analysis.

b. When 10% or more of an MCP's members in the MCP's service area have a common primary language other than English, the MCP must translate all ODJFS-approved member materials into the primary language of that group. The MCP must monitor their membership and conduct a quarterly assessment to determine which, if any**,** primary language groups meet the 10% threshold. When the 10% threshold is met, the MCP must report this information to ODJFS, in a format as requested by ODJFS, translate their member materials, and make these materials available to their members. MCPs must submit to ODJFS, upon request, their prevalent non-English language member analysis and the results of this analysis.

20. The MCP must utilize a centralized database which records the special communication needs of all MCP members (i.e., those with LEP, limited reading proficiency [LRP], visual impairment, and hearing impairment) and the provision of related services (i.e., MCP materials in alternate format, oral interpretation, oral translation services, written translations of MCP materials, and sign language services). This database must include all MCP member primary language information (PLI) as well as all other special communication needs information for MCP members, as indicated above, when identified by any source including but not limited to ODJFS, the Managed Care Enrollment Center (MCEC), MCP staff, providers, and members. This centralized database must be readily available to MCP staff and be used in coordinating communication and services to members, including the selection of a PCP who speaks the primary language of an LEP member, when such a provider is available. MCPs must share specific communication needs information with their providers [e.g., PCPs, Pharmacy Benefit Managers (PBMs), and Third Party Administrators (TPAs)], as applicable. MCPs must submit to ODJFS, upon request, detailed information regarding the MCP's members with special communication needs, which could include individual member names, their specific communication need, and any provision of special services to members (i.e., those special services arranged by the MCP as well as those services reported to the MCP which were arranged by the provider).

Additional requirements specific to providing assistance to hearing-impaired, vision-impaired, LRP, and LEP members and eligible individuals are found in OAC rules 5101:3-26-03.1, 5101:3-26-05(D), 5101:3-26-05.1(A), 5101:3-26-08, and 5101-3-26-08.2.

21. The MCP is responsible for ensuring that all member materials use easily understood language and format. The determination of whether materials comply with this requirement is in the sole discretion of ODJFS.

22. Pursuant to OAC rules 5101:3-26-08 and 5101:3-26-08.2, the MCP is responsible for

ensuring that all MCP marketing and member materials are prior approved by ODJFS before being used or shared with members. Member materials must be available in written format, but can be provided to the member in alternative formats (e.g., CD-rom) if specifically requested by the member, except as specified in OAC rule 5101:3-26-08.4. Marketing and member materials are defined as follows:

a. Marketing materials are those items produced in any medium, by or on behalf of an MCP, including gifts of nominal value (i.e., items worth no more than $15.00), which can reasonably be interpreted as intended to market to eligible individuals.

b. Member materials are those items developed, by or on behalf of an MCP, to fulfill MCP program requirements or to communicate to all members or a group of members. Member health education materials that are produced by a source other than the MCP and which do not include any reference to the MCP are not considered to be member materials.

c. All MCP marketing and member materials must represent the MCP in an honest and forthright manner and must not make statements which are inaccurate, misleading, confusing, or otherwise misrepresentative, or which defraud eligible individuals or ODJFS.

d. All MCP marketing cannot contain any assertion or statement (whether written or oral) that the MCP is endorsed by the Centers for Medicare and Medicaid Services (CMS), the Federal or State government or similar entity.

e. MCPs must establish positive working relationships with the County Department of Job and Family Services (CDJFS) offices and must not aggressively solicit from local Directors, MCP County Coordinators, or other staff. Furthermore, MCPs are prohibited from offering gifts of nominal value (i.e. clipboards, pens, coffee mugs, etc.) to CDJFS offices or MCEC staff, as these may influence an individual's decision to select a particular MCP.

f. MCP marketing representatives and other MCP staff are prohibited from offering eligible individuals the use of a portable device (laptop computer, cellular phone, etc.) to assist with the completion of an online application to select and/or change MCPs, as all enrollment activities must be completed by the MCEC.

23. Advance Directives - All MCPs must comply with the requirements specified in 42 CFR 422.128. At a minimum, the MCP must:

a. Maintain written policies and procedures that meet the requirements for advance directives, as set forth in 42 CFR Subpart I of part 489.

b. Maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care by or through the MCP to ensure that the MCP:

i. Provides written information to all adult members concerning:

a. The member's rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. In meeting this requirement, MCPs must utilize the current version of form JFS 08095 entitled *You Have the Right*, or include the text from JFS 08095 in their ODJFS-approved member handbook.

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

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

d. The right to file complaints concerning noncompliance with the advance directive requirements with the Ohio Department of Health.

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

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

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

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

24. New Member Materials - Pursuant to OAC rule 5101:3-26-08.2(B)(3), MCPs must provide to each member or assistance group, as applicable, an MCP identification (ID) card, a new member letter, a member handbook, a provider directory, and information on advance directives, as specified by ODJFS.

a. MCPs must use the model language specified by ODJFS for the new member letter.

b. The ID card and new member letter must be mailed together to the member via a method that will ensure their receipt prior to the member's effective date of coverage.

c. The member handbook, provider directory, and advance directives information may be mailed to the member separately from the ID card and new member letter. MCPs will meet the timely receipt requirement for these materials if they are mailed to the member within twenty-four (24) hours of the MCP receiving the ODJFS produced membership roster (MR). This is provided the materials are mailed via a method with an expected delivery date of no more than five (5) days. If the member handbook, provider directory, and advance directives information are mailed separately from the ID card and new member letter and the MCP is unable to mail the materials within twenty-four (24) hours, the member handbook, provider directory, and advance directives information must be mailed via a method that will ensure receipt by no later than the effective date of coverage. If the MCP mails the ID card and new member letter with the other materials (e.g., member handbook, provider directory, and advance directives), the MCP must ensure that <u>all</u> materials are mailed via a method that will ensure their receipt <u>prior</u> to the member's effective date of coverage.

d. MCPs must designate two (2) MCP staff members to receive a copy of the new member materials on a monthly basis in order to monitor the timely receipt of these materials. At least one of the staff members must receive the materials at their home address.

25. <u>Call Center Standards</u> - The MCP must provide assistance to members through a member services toll-free call-in system pursuant to OAC rule 5101:3-26-08.2(A)(1). MCP member services staff must be available nationwide to provide assistance to members through the toll-free call-in system every Monday through Friday, at all times during the hours of 7:00 am to 7:00 pm Eastern Time, except for the following major holidays:

- New Year's Day
- Martin Luther King's Birthday
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Day
- 2 optional closure days: These days can be used independently or in combination with any of the major holiday closures, but cannot both be used within the same closure period. Before announcing any optional closure dates to members and/or staff, MCPs must receive ODJFS prior-approval which verifies that the optional closure days meet the specified criteria.

If a major holiday falls on a Saturday, the MCP member services line may be closed on the preceding Friday. If a major holiday falls on a Sunday, the member services line may be closed on the following Monday. MCP member services closure days must be

specified in the MCP's member handbook, member newsletter, or other some general issuance to the MCP's members at least thirty (30) days in advance of the closure.

The MCP must also provide access to medical advice and direction through a centralized twenty-four-hour, seven day (24/7), toll-free call-in system, available nationwide, pursuant to OAC rule 5101:3-26-03.1(A)(6). The 24/7 call-in system must be staffed by appropriately trained medical personnel. For the purposes of meeting this requirement, trained medical professionals are defined as physicians, physician assistants, licensed practical nurses (LPNs), and registered nurses (RNs).

MCPs must meet the current American Accreditation HealthCare Commission/URAC-designed Health Call Center Standards (HCC) for call center abandonment rate, blockage rate and average speed of answer. By the 10th of each month, MCPs must self-report their prior month performance in these three areas for their member services and 24/7 hour toll-free call-in systems to ODJFS. If an MCP has separate telephone lines for different Medicaid populations, the MCP must report performance for each individual line separately. ODJFS will inform the MCPs of any changes/updates to these URAC call center standards.

MCPs are not permitted to delegate grievance/appeal functions [OAC rule 5101:3-26-08.4(A)(9)]. Therefore, the member services call center requirement may not be met through the execution of a Medicaid Delegation Subcontract Addendum or Medicaid Combined Services Subcontract Addendum.

26. Notification of Optional MCP Membership - In order to comply with the terms of the ODJFS State Plan Amendment for the managed care program (i.e., 42 CFR 438.50), MCPs in mandatory membership service areas must inform new members that MCP membership is optional for certain populations.

Specifically, MCPs must inform any applicable ABD or CFC pending member or member that the following population is not required to select an MCP in order to receive their Medicaid healthcare benefit and what steps they need to take if they do not wish to be a member of an MCP:

- Indians who are members of federally-recognized tribes, except as permitted under 42 C.F.R 438.50(d)(21).

Additionally, MCPs must inform any applicable CFC pending member or member that the following populations are not required to select an MCP in order to receive their Medicaid healthcare benefit and what steps they need to take if they do not wish to become a member of an MCP:

- Children under 19 years of age who are:
    - Eligible for Supplemental Security Income under title XVI;
    - In foster care or other out-of-home placement;
    - Receiving foster care or adoption assistance;
    - Receiving services through the Ohio Department of Health's Bureau for

Children with Medical Handicaps (BCMH) or any other family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V, and is defined by the state in terms of either program participation or special health care needs.

27. HIPAA Privacy Compliance Requirements - The Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations at 45 CFR.164.502(e) and 164.504(e) require ODJFS to have agreements with MCPs as a means of obtaining satisfactory assurance that the MCPs will appropriately safeguard all personal identified health information. Protected Health Information (PHI) (45 C.F.R. 160.103). is information received from or on behalf of ODJFS that meets the definition of PHI as defined by HIPAA and the regulations promulgated by the United States Department of Health and Human Services, specifically 45 CFR 164.501 and any amendments thereto. MCP is a business associate of the Office of Ohio Health Plans, ODJFS and agrees to the following:

a. The MCP shall not use or disclose PHI other than is permitted by this Agreement or as otherwise required under HIPAA regulations or other applicable law.

b. The MCP shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI that it creates, receives, maintains, or transmits on behalf the BMC.

c. The MCP shall report to ODJFS any unauthorized use or disclosure of PHI of which it becomes aware. Any breach by the MCP or its representatives of PHI standards shall be immediately reported to the State HIPAA compliance officer through the Bureau of Managed Care (BMC). MCPs must provide documentation of the breach and complete all actions ordered by the HIPAA compliance officer. The MCP shall mitigate any adverse effects of such a breach of confidentiality to the greatest extent possible.

d. The MCP shall ensure that all its agents and subcontractors agree to these same PHI conditions and restrictions that apply to the MCP with respect to the use or disclosure of PHI.

e. The MCP shall make available to ODJFS such information as ODJFS may require to fulfill its obligations to provide access to, provide a copy of, and account for disclosures with respect to PHI pursuant to HIPAA and regulations promulgated by the United States Department of Health and Human Services, including, but not limited to, 45 C.F.R. 164.524 and 164.528 and any amendments thereto.

f. The MCP shall make PHI available to ODJFS so that ODJFS may fulfill its obligations pursuant to HIPAA to amend the information. As directed by ODJFS, the MCP shall also incorporate any amendments into the information held by the MCP and shall ensure incorporation of any such amendments into information held by the MCP's agents or subcontractors.

g. The MCP shall make PHI disclosure information available for accounting as required by law.

h. The MCP shall make available to ODJFS and to the Secretary of the U.S. Department of Health and Human Services (HHS) any and all internal practices, documentation, books, and records related to the use and disclosure of PHI received from ODJFS, or created or received by the MCP on behalf of ODJFS. Such access is for the purpose of determining ODJFS' compliance with HIPAA, regulations promulgated by the United States Department of Health and Human Services, and any amendment thereto.

i. Upon termination of their agreement with ODJFS, the MCPs, at ODJFS' option, shall return to ODJFS, or destroy, all PHI in its possession, and keep no copies of the information, except as requested by ODJFS or required by law. If the MCP, its agent(s), or subcontractor(s) destroy any PHI, then the MCP will provide to ODJFS documentation evidencing such destruction. Any PHI retained by the MCP shall continue to be extended the same protections set forth in this Section and HIPAA regulations for as long as it is maintained.

j. In the event of material breach of the MCP's obligations under this article, ODJFS may immediately terminate this Agreement as set forth in Article VIII. Termination of this Agreement shall not affect any provision of this Agreement which, by its wording or its nature, is intended to remain effective and to continue to operate after termination.

28. Electronic Communications – MCPs are required to purchase/utilize Transport Layer Security (TLS) for all e-mail communication between ODJFS and the MCP. The MCP's e-mail gateway must be able to support the sending and receiving of e-mail using TLS and the MCP's gateway must be able to enforce the sending and receiving of email via TLS.

29. MCP Membership Acceptance, Documentation and Reconciliation

a. Managed Care Enrollment Center (MCEC) Contractor - The MCP shall provide to the MCEC ODJFS prior-approved MCP materials and directories for distribution to eligible individuals who request additional information about the MCP.

b. Monthly Reconciliation of Membership and Premiums - The MCP shall reconcile member data as reported on the MCEC produced consumer contact record (CCR) with the MR and report to the ODJFS any difficulties in interpreting or reconciling information received. Membership reconciliation questions must be identified and reported to the ODJFS prior to the first of the next month. The MCP shall reconcile membership with premium payments reported on the monthly remittance advice (RA).

The MCP shall work directly with the ODJFS, or other ODJFS-identified entity, resolve any difficulties in interpreting or reconciling premium information. Premium reconciliation questions must be identified within thirty (30) days of receipt of the RA

unless the reconciliation concerns a newborn. Newborn related reconciliation questions must be identified within 460 days from the newborn's date of birth. Monthly reconciliation data must be submitted in the format specified by ODJFS.

c. Monthly Premiums and Delivery Payments - The MCP must be able to receive monthly premiums and delivery payments in a method specified by ODJFS.

d. Hospital/Inpatient Facility Deferment - When an MCP learns of a currently hospitalized member's intent to disenroll through the CCR or the 834, the disenrolling MCP must notify the hospital/inpatient facility and treating providers as well as the enrolling MCP of the change in enrollment. The disenrolling MCP must notify the inpatient facility that it will remain responsible for the inpatient facility charges through the date of discharge; and must notify the treating providers that it will remain responsible for provider charges through the date of disenrollment. The disenrolling MCP shall not request and/or require that a disenrolled member be discharged from the inpatient facility for transfer to another inpatient facility. Should a discharge and transfer to another inpatient facility be medically necessary, the disenrolling MCP must notify the treating providers to work with the enrolling MCP to facilitate the discharge, transfer and authorization of services as needed.

When the enrolling MCP learns through the disenrolling MCP, through ODJFS or other means, that a new member who was previously enrolled with another MCP was admitted prior to the effective date of enrollment and remains an inpatient on the effective date of enrollment, the enrolling MCP shall contact the hospital/ inpatient facility. The enrolling MCP shall verify that it is responsible for all medically necessary Medicaid covered services from the effective date of MCP membership, including treating provider services related to the inpatient stay; the enrolling MCP must reiterate that the admitting/disenrolling MCP remains responsible for the hospital/inpatient facility charges through the date of discharge. The enrolling MCP shall work with the hospital/inpatient facility to facilitate discharge planning and authorize services as needed.

When an MCP learns that a new member who was previously on Medicaid fee-for-service was admitted prior to the effective date of enrollment and remains an inpatient on the effective date of enrollment, the enrolling MCP shall notify the hospital/ inpatient facility and treating providers that the MCP may not be the payer. The MCP shall work with hospital/inpatient facility, treating providers and the ODJFS to assure that discharge planning assures continuity of care and accurate payment. When the enrolling MCP learns of a deferment-eligible hospitalization, the MCP shall notify the ODJFS **and** request the deferment (6) months of the member's effective date.

e. Just Cause Requests - As specified by ODJFS, the MCP shall assist in resolving member-initiated requests affecting membership.

f. Newborn Notifications –Newborns, whose mothers are eligible for CFC and enrolled in an MCP on the date of birth, are eligible for MCP membership from their date of birth as

long as they don't meet any of the exclusions or exemptions from membership that is described in rule 5101:3-26-02. MCP membership for the newborn will be in accordance with rule 5101:3-26-02 or limited to the date of birth through the last day of the month in which the newborn reaches ninety days of age as specified in 5101:3-26-02(C)(6)(c).

In order to encourage the timely addition and authorization for Medicaid and enrollment in the MCP, the MCP must provide notification of the birth to the CDJFS and the ODJFS and advise the mother of the importance of contacting her CDJFS caseworker. The MCP may provide additional notification or newborn information to the CDJFS or mother as appropriate.

The MCP must notify the CDJFS and provide at a minimum the mother's name, social security number, 10 digit CRIS-E case number, 12 digit recipient ID, county and the newborn's name, gender, and date of birth, unless the CDJFS and MCP have agreed to a different minimum set of information to be transmitted for the CDJFS newborn notification. This information must be sent within five working days of the birth, or immediately upon learning of the birth. The information must be sent again at sixty days from the date of birth if the MCP has not received confirmation by ODJFS of a newborn's MCP membership via the membership roster(s).

The MCP must inform the newborn's mother about the need to contact the CDJFS as soon as possible following the birth. This information must be sent in writing unless the MCP has a standard process for a face to face or verbal contact with the mother. Whether it's verbal or in writing, this information must be relayed within five working days of the birth, or immediately upon learning of the birth and must be documented.

If the MCP has not received confirmation from ODJFS of a newborn's MCP membership via the membership roster(s) within sixty days of the date of birth, the MCP must again inform the newborn's mother about the need to contact the CDJFS. The MCP must include a warning that the baby has not been added or authorized by the caseworker and that the MCP's obligation to cover the newborn is scheduled to end on the last day of the month in which the newborn reaches ninety days of age. The MCP must include in the warning the actual date that the MCP is scheduled to end the newborn's coverage.

The MCP must report to ODJFS each week, information on each newborn that has been identified since the last report. The MCP must report to ODJFS by the fifth of each month, information on each newborn that has reached 90 days of age and has not been added or authorized to the mother's case. Report(s) must be in the format(s) specified by ODJFS.

g. Eligible Individuals - If an eligible individual contacts the MCP, the MCP must provide any MCP-specific managed care program information requested. The MCP must not attempt to assess the eligible individual's health care needs. However, if the eligible individual inquires about continuing/transitioning health care services, MCPs shall

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

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

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

i. Transition of Fee-For-Service (FFS) Members - Providing care coordination for prescheduled health services, access to preventive and specialized care, care management, member services, and education with minimal disruption to members' established relationships with providers and existing care treatment plans, is critical for members transitioning from FFS to managed care. MCPs are not required to allow the continuation of services identified in C.29.i.b and C.29.i.c for a member who resides in a service area in which enrollment in an MCP is not required and the member voluntarily chooses to enroll in the MCP.

a. ABD Member Transition Plan - For FFS members who are transitioning to managed care as an ABD member, MCPs must develop and implement a transition plan that outlines how the MCP will effectively address the unique care coordination issues of members in their first three months of MCP membership and how the various MCP departments will coordinate and share information regarding these new members. The transition plan must include at a minimum:

i. An effective outreach process to identify each new member's existing and/or potential health care needs that results in a new member profile that includes, but is not limited to identification of:

a. Health care needs, including those services received through state sub-recipient agencies [e.g., the Ohio Department of Mental Health (ODMH), the Ohio Department of Developmental Disabilities (DODD) effective October 5, 2009), the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) and the Ohio Department of Aging (ODA)];

b. Existing sources of care (i.e., primary physicians, specialists, case manager(s), ancillary and other care givers); and

c. Current care therapies for all aspects of health care services, including scheduled health care appointments, planned and/or approved surgeries (inpatient or outpatient), ancillary or medical therapies, prescribed drugs, home health care services, private duty nursing (PDN), scheduled lab/radiology tests, necessary durable medical equipment, supplies and needed/approved transportation arrangements.

ii. Strategies for how each new member will obtain care therapies from appropriate sources of care as an MCP member. The MCP's strategies must include at a minimum activities specified in Appendix C.29.i.b, as applicable.

b. ABD and CFC Member Continuation of Services from Out-of-Panel Providers - Allowing their new members that are transitioning from FFS to an MCP as an ABD or CFC member, to receive services from out-of-panel providers if the member or provider contacts the MCP to discuss the scheduled health services in advance of the service date and one of the following applies:

i. The CFC member has appointments within the initial month of MCP membership with specialty physicians that were scheduled prior to the effective date; or, the ABD member has appointments within the initial three months of MCP membership with a primary care provider or specialty physician that was scheduled prior to the effective date of membership;

ii. The CFC or ABD member is in her third trimester of pregnancy and has an established relationship with an obstetrician and/or delivery hospital;

iii. The CFC or ABD member has been scheduled for an inpatient or outpatient surgery and has been prior-approved and/or pre-certified pursuant to OAC rule 5101:3-2-40 (surgical procedures would also include follow-up care as appropriate);

iv. The CFC or ABD member is receiving ongoing chemotherapy or radiation treatment; or

v. The ABD member has been released from the hospital within thirty (30) days prior to MCP enrollment and is following a treatment plan.

If contacted by the member, the MCP must contact the provider's office as expeditiously as the situation warrants to confirm that the service(s) meets the above criteria.

c. ABD and CFC Member Continuation of Homecare Services -Allowing their new members that are transitioning from FFS to continue receiving home care services (i.e., nursing, aide, and skilled therapy services) and private duty nursing (PDN) services if the member or provider contacts the MCP to discuss the health services in advance of the service date. These services must be covered from the date of the member or provider contact at the current service level, and with the current provider, whether a panel or out-of-panel provider, until the MCP conducts a medical necessity review and renders an authorization decision pursuant to OAC rule 5101:3-26-03.1. As soon as the MCP becomes aware of the member's current home care services, the MCP must initiate contact with the current provider and member as applicable to ensure continuity of care and coordinate a transfer of services to a panel provider, if appropriate.

d. ABD and CFC Member FFS Authorizations - Honoring any current FFS prior authorization to allow their new members that are transitioning from FFS to receive services from the authorized provider, whether a panel or out-of-panel provider, for the following approved services:

i. An organ, bone marrow, or hematapoietic stem cell transplant pursuant to OAC rule 5101:3-2-07.1 and 2.b.v of Appendix G;

ii. Dental services that have not yet been received;

iii. Vision services that have not yet been received;

iv. Durable medical equipment (DME) that has not yet been received. Ongoing DME services and supplies are to be covered by the MCP as previously-authorized until the MCP conducts a medical necessity review and renders an authorization decision pursuant to OAC rule 5101:3-26-03.1.

v. Private Duty Nursing (PDN) services. PDN services must be covered at the previously-authorized service level until the MCP conducts a medical necessity review and renders an authorization decision pursuant to OAC rule 5101:3-26-03.1.

As soon as the MCP becomes aware of the member's current FFS authorization approval, the MCP must initiate contact with the authorized provider and member as applicable to ensure continuity of care. The MCP must implement a plan to meet the member's immediate and ongoing medical needs and coordinate the transfer of services to a panel provider,

if appropriate. For organ, bone marrow or hematapoietic stem cell transplants, MCPs must receive prior approval from ODJFS to transfer services to a panel provider.

When an MCP medical necessity review results in a decision to reduce, suspend, or terminate services previously authorized by FFS Medicaid, the MCP must notify the member of their state hearing rights no less than 15 calendar days prior to the effective date of the MCP's proposed action, per OAC rule 5101:3-26-08.4.

e. Out-of-Panel Provider Reimbursement - Reimbursing out-of-panel providers that agree to provide the transition services at 100% of the current Medicaid FFS provider rate for the service(s) identified in Section 29.i. (b, c, and d) of this appendix.

f. Documentation of services - Documenting the provision of transition of services identified in Section 29.i. (b, c, and d) of this appendix as follows:

i. For non-panel providers, notification to the provider confirming the provider's agreement/disagreement to provide the service and accept 100% of the current Medicaid FFS rate as payment. If the provider agrees, the distribution of the MCP's materials as outlined in Appendix G.3.iv.d.

ii. Notification to the member of the non-panel provider's agreement /disagreement to provide the service. If the provider disagrees, notification to the member of the MCP's availability to assist with locating a provider as expeditiously as the member's health condition warrants.

iii. For panel providers, notification to the provider and member confirming the MCP's responsibility to cover the service.

MCPs must use the ODJFS-specified model language for the provider and member notices and maintain documentation of all member and/or provider contacts relating to such services.

g. ABD Drug Transition of Care - Implementing a drug transition of care process that prevents drug access problems for ABD new members that are transitioning from Medicaid FFS. Such a process would involve the MCP covering at least one prescription fill or refill without prior authorization (PA) of any covered prescription drug not requiring PA by FFS. For new members that are transitioning from FFS who utilize ongoing medications for chronic conditions the MCP must educate the member about how to continue to access drugs for their chronic condition before the MCP may implement PA requirements for that

member's specific ongoing medication. The MCP's process for covering the prescription fill or refill without PA must be based on one of the following approaches:

i. The MCP covers without PA all prescriptions written within the two months prior to the effective date of MCP enrollment that do not require PA by Medicaid FFS; or

ii. The MCP covers without PA for at least the initial thirty (30) days of the member's MCP membership all prescriptions that do not require PA by Medicaid FFS.

For any new member transitioning from FFS who utilizes ongoing medications for chronic conditions the MCP may require subsequent PA for those drugs once the MCP has educated the member about the importance of working with their physician to discuss initiating a PA request to continue the current medication and the option of using alternative medications that may be available without PA. Written member notices must use ODJFS-specified model language and be ODJFS-approved. Verbal member education may be done in place of written education but must contain the same information as a written notice and must follow a call script that contains ODJFS-specified model language and be ODJFS-approved.

For those new members who are not utilizing ongoing medications for chronic conditions, no additional drug PA education is required beyond the MCP's general new member education that includes what drugs require MCP PA.

MCPs must receive ODJFS approval prior to implementing their transition of care drug PA process. An MCP's proposal must document how the MCP will:

a. Implement one of the above options to ensure that members transitioning from FFS receive at least one prescription fill or refill without PA of any covered prescription drug not requiring PA by FFS; and

b. Identify new members that are transitioning from FFS who utilize ongoing medications for chronic conditions and provide timely education to the member about how to continue to access drugs for their chronic condition before the MCP will implement PA requirements for that member's specific ongoing medication.

h. <u>ABD Antipsychotic Medications</u> - Covering antipsychotic medications for ABD new members as well as current members as stipulated in Appendix G.3.iv.a.i.

30. Health Information System Requirements - The ability to develop and maintain information management systems capacity is crucial to successful plan performance. ODJFS therefore requires MCPs to demonstrate their ongoing capacity in this area by meeting several related specifications.

a. Health Information System

i. As required by 42 CFR 438.242(a), each MCP 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 MCP membership terminations for other than loss of Medicaid eligibility.

ii. As required by 42 CFR 438.242(b)(1), each MCP must collect data on member and provider characteristics and on services furnished to its members.

iii. As required by 42 CFR 438.242(b)(2), each MCP must ensure that data received from providers is accurate and complete by verifying the accuracy and timeliness of reported data; screening the data for completeness, logic, and consistency; and collecting service information in standardized formats to the extent feasible and appropriate.

iv. As required by 42 CFR 438.242(b)(3), each MCP must make all collected data available upon request by ODJFS or CMS.

v. Acceptance testing of any data that is electronically submitted to ODJFS is required:

a. Before an MCP may submit production files;
b. Whenever an MCP changes the method or preparer of the electronic media; and/or
c. When the ODJFS determines an MCP's data submissions have an unacceptably high error rate.

MCPs that change or modify information systems that are involved in producing any type of electronically submitted files, either internally or by changing vendors, are required to submit to ODJFS for review and approval a transition plan including the submission of test files in the ODJFS-specified formats. Once an acceptable test file is submitted to ODJFS, as determined solely by ODJFS, the MCP can return to submitting production files. ODJFS will inform MCPs in writing when a test file is acceptable. Once an MCP's new or modified information system is operational, that MCP will have up to ninety (90) days to submit

an acceptable test file and an acceptable production file.

Submission of test files can start before the new or modified information system is in production. ODJFS reserves the right to verify any MCP's capability to report elements in the minimum data set prior to executing the provider agreement for the next contract period. Penalties for noncompliance with this requirement are specified in Appendix N of the Agreement, *Compliance Assessment System*.

b. Electronic Data Interchange and Claims Adjudication Requirements

Claims Adjudication

The MCP must have the capacity to electronically accept and adjudicate all claims to final status (payment or denial). Information on claims submission procedures must be provided to non-contracting providers within thirty (30) days of a request. MCPs must inform providers of its ability to electronically process and adjudicate claims and the process for submission. Such information must be initiated by the MCP and not only in response to provider requests.

The MCP must notify providers who have submitted claims of claims status [paid, denied, pended (suspended)] within one month of receipt. Such notification may be in the form of a claim payment/remittance advice produced on a routine monthly, or more frequent, basis.

Electronic Data Interchange
The MCP shall comply with all applicable provisions of HIPAA including electronic data interchange (EDI) standards for code sets and the following electronic transactions:
Health care claims;
Health care claim status request and response;
Health care payment and remittance status;
Standard code sets; and
National Provider Identifier (NPI).

Each EDI transaction processed by the MCP shall be implemented in conformance with the appropriate version of the transaction implementation
guide, as specified by applicable federal rule or regulation.

The MCP must have the capacity to accept the following transactions from the ODJFS consistent with EDI processing specifications in the transaction implementation guides and in conformance with the 820 and 834 Transaction Companion Guides issued by ODJFS:

ASC X12 820 - Payroll Deducted and Other Group Premium Payment for Insurance Products; and

ASC X12 834 - Benefit Enrollment and Maintenance.

The MCP shall comply with the HIPAA mandated EDI transaction standards and code sets no later than the required compliance dates as set forth in the federal regulations.

Documentation of Compliance with Mandated EDI Standards
The capacity of the MCP and/or applicable trading partners and business associates to electronically conduct claims processing and related transactions in compliance with standards and effective dates mandated by HIPAA must be demonstrated, to the satisfaction of ODJFS, as outlined below.

Verification of Compliance with HIPAA (Health Insurance Portability and Accountability Act of 1996)
MCPs shall comply with the transaction standards and code sets for sending and receiving applicable transactions as specified in 45 CFR Part 162 – Health Insurance Reform: Standards for Electronic Transactions (HIPAA regulations). In addition the MCP must enter into the appropriate trading partner agreement and implemented standard code sets. If the MCP has obtained third-party certification of HIPAA compliance for any of the items listed below, that certification may be submitted in lieu of the MCP's written verification for the applicable item(s).

i. Trading Partner Agreements
ii. Code Sets
iii. Transactions

a. Health Care Claims or Equivalent Encounter Information (ASC X12N 837 & NCPDP 5.1)
b. Eligibility for a Health Plan (ASC X12N 270/271)
c. Referral Certification and Authorization (ASC X12N 278)
d. Health Care Claim Status (ASC X12N 276/277)
e. Enrollment and Disenrollment in a Health Plan (ASC X12N 834)
f. Health Care Payment and Remittance Advice (ASC X12N 835)
g. Health Plan Premium Payments (ASC X12N 820)
h. Coordination of Benefits

Trading Partner Agreement with ODJFS
MCPs must complete and submit an EDI trading partner agreement in a format specified by the ODJFS. Submission of the copy of the trading partner agreement prior to entering into this Agreement may be waived at the discretion of ODJFS; if submission prior to entering into this Agreement is waived, the trading partner agreement must be submitted at a subsequent date determined by ODJFS.

Noncompliance with the EDI and claims adjudication requirements will result in the imposition of penalties, as outlined in Appendix N of the Agreement, *Compliance Assessment System*.

c. Encounter Data Submission Requirements

General Requirements

Each MCP must collect data on services furnished to members through an encounter data system and must report encounter data to the ODJFS. MCPs are required to submit this data electronically to ODJFS on a monthly basis in the following standard formats:

- Institutional Claims - UB92 flat file
- Noninstitutional Claims - National standard format
- Prescription Drug Claims - NCPDP

ODJFS relies heavily on encounter data for monitoring MCP performance. The ODJFS uses encounter data to measure clinical performance, conduct access and utilization reviews, reimburse MCPs for newborn deliveries and aid in setting MCP capitation rates. For these reasons, it is important that encounter data is timely, accurate, and complete. Data quality, performance measures, and standards are described in the Agreement.

An encounter represents all of the services, including medical supplies and medications, provided to a member of the MCP by a particular provider, regardless of the payment arrangement between the MCP and the provider. For example, if a member had an emergency department visit and was examined by a physician, this would constitute two encounters, one related to the hospital provider and one related to the physician provider. However, for the purposes of calculating a utilization measure, this would be counted as a single emergency department visit. If a member visits their PCP and the PCP examines the member and has laboratory procedures done within the office, then this is one encounter between the member and their PCP.

If the PCP sends the member to a lab to have procedures performed, then this is two encounters; one with the PCP and another with the lab. For pharmacy encounters, each prescription filled is a separate encounter.

Encounters include services paid for retrospectively, through FFS payment arrangements, and prospectively, through capitated arrangements. Only encounters with services (line items) that are paid by the MCP, fully or in part, and for which no further payment is anticipated, are acceptable encounter data submissions. Immunization services submitted to the MCP must be submitted to ODJFS if these services were paid for by another entity (e.g., free vaccine programs).

All other services that are unpaid or paid in part and for which the MCP anticipates further payment (e.g., unpaid services rendered during a delivery of a newborn) may not

be submitted to ODJFS until they are paid. Penalties for noncompliance with this requirement are specified in Appendix N of the Agreement, *Compliance Assessment System*.

Acceptance Testing
The MCP must have the capability to report all elements in the Minimum Data Set as set forth in the ODJFS Encounter Data Specifications and must submit a test file in the ODJFS-specified medium in the required formats prior to contracting or prior to an information systems replacement or update.

Acceptance testing of encounter data is required as specified in Section 30.a.v. of this Appendix.

Encounter Data File Submission Procedures
A certification letter must accompany the submission of an encounter data file in the ODJFS-specified medium. The certification letter must be signed by the MCP's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for, and who reports directly to, the MCP's CEO or CFO.

Timing of Encounter Data Submissions
ODJFS recommends that MCPs submit encounters no more than thirty-five (35) days after the end of the month in which they were paid (e.g., claims paid in January are due March 5). ODJFS recommends that MCPs submit files in the ODJFS-specified medium by the 5th of each month. This will help to ensure that the encounters are included in the ODJFS master file in the same month in which they were submitted.

d. Information Systems Review
ODJFS or its designee may review the information system capabilities of each MCP, before ODJFS enters into a provider agreement with a new MCP, when a participating MCP undergoes a major information system upgrade or change, when there is identification of significant information system problems, or at ODJFS' discretion. Each MCP must participate in the review. The review will assess the extent to which MCPs are capable of maintaining a health information system including producing valid encounter data, performance measures, and other data necessary to support quality assessment and improvement, as well as managing the care delivered to its members.

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

i. Review the Information Systems Capabilities Assessment (ISCA) forms, as developed by CMS; which the MCP will be required to complete.

ii. Review the completed ISCA and accompanying documents;

iii. Conduct interviews with MCP staff responsible for completing the ISCA, as well as staff responsible for aspects of the MCP's information systems function;

iv. Analyze the information obtained through the ISCA, conduct follow-up interviews with MCP staff, and write a statement of findings about the MCP's information system.

v. Assess the ability of the MCP to link data from multiple sources;

vi. Examine MCP processes for data transfers;

vii. If an MCP has a data warehouse, evaluate its structure and reporting capabilities;

viii. Review MCP processes, documentation, and data files to ensure that they comply with state specifications for encounter data submissions; and

ix. Assess the claims adjudication process and capabilities of the MCP.

31. Delivery Payments – CFC Members Only

MCPs will be reimbursed for paid CFC member deliveries that are identified in the submitted encounters using the methodology outlined in the *ODJFS Delivery Payment and Reporting Procedures document*. The delivery payment represents the facility and professional service costs associated with the delivery event and postpartum care that is rendered in the hospital immediately following the delivery event; no prenatal or neonatal experience is included in the delivery payment.

If a delivery occurred, but the MCP did not reimburse providers for any costs associated with the delivery, then the MCP shall not submit the delivery encounter to ODJFS and is not entitled to receive payment for the delivery. Delivery encounters submitted by MCPs must be received by ODJFS no later than four hundred sixty (460) days after the last date of service (pending ODJFS IT capacity). Delivery encounters which are received by ODJFS after this time will be denied payment. Prior to the implementation of the four hundred sixty (460) day criteria, delivery encounters which are submitted later than three hundred sixty-five (365) days after the last date of service will be denied payment. MCPs will receive notice of the payment denial on the remittance advice.

To capture deliveries outside of institutions (e.g., hospitals) and deliveries in hospitals without an accompanying physician encounter, both the institutional encounters (UB-92) and the non-institutional encounters (NSF) are searched for deliveries.

If a physician and a hospital encounter is found for the same delivery, only one payment will be made. The same is true for multiple births; if multiple delivery encounters are

submitted, only one payment will be made. The method for reimbursing for deliveries includes the delivery of stillborns where the MCP incurred costs related to the delivery.

Rejections

If a delivery encounter is not submitted according to ODJFS specifications, it will be rejected and MCPs will receive this information on the exception report (or error report) that accompanies every file in the ODJFS-specified format. Tracking, correcting and resubmitting all rejected encounters is the responsibility of the MCP and is required by ODJFS.

Timing of Delivery Payments

MCPs will be paid monthly for deliveries. For example, payment for a delivery encounter submitted with the required encounter data submission in March, will be reimbursed in March.

This payment will be a part of the weekly update (adjustment payment) that is in place currently. The third weekly update of the month will include the delivery payment. The remittance advice is in the same format as the capitation remittance advice which is sent once each month.

Updating and Deleting Delivery Encounters

The process for updating and deleting delivery encounters is handled differently from all other encounters. See the *ODJFS Encounter Data File Submission and Specifications* for detailed instructions on updating and deleting delivery encounters.

The process for deleting delivery encounters can be found on page 35 of the UB-92 technical specifications (record/field 20-7) and page III-47 of the NSF technical specifications (record/field CA0-31.0a).

Auditing of Delivery Payments

A delivery payment audit will be conducted periodically. If medical records do not substantiate that a delivery occurred related to the payment that was made, then ODJFS will recoup the delivery payment from the MCP. Also, if it is determined that the encounter which triggered the delivery payment was not a paid encounter, then ODJFS will recoup the delivery payment.

32. If the MCP will be using the Internet functions that will allow approved users to access member information (e.g., eligibility verification), the MCP must ensure that the proper safeguards, firewalls, etc., are in place to protect member data.

33. MCPs must receive prior written approval from ODJFS before adding any information to their website that would require ODJFS prior approval in hard copy form (e.g., provider listings, member handbook information).

34. Pursuant to 42 CFR 438.106(b), the MCP acknowledges that it is prohibited from holding a member liable for services provided to the member in the event that the ODJFS fails to make payment to the MCP.

35. In the event of an insolvency of an MCP, the MCP, as directed by ODJFS, must cover the continued provision of services to members until the end of the month in which insolvency has occurred, as well as the continued provision of inpatient services until the date of discharge for a member who is institutionalized when insolvency occurs.

36. Information Required for MCP Websites

a. On-line Provider Directory – MCPs must have an internet-based provider directory available in the same format as their ODJFS-approved provider directory, that allows members to electronically search for the MCP panel providers based on name, provider type, geographic proximity, and population (as specified in Appendix H). MCP provider directories must include all MCP-contracted providers (except as specified by ODJFS) as well as certain ODJFS non-contracted providers.

b. On-line Member Website - MCPs must have a secure internet-based website which provides members the ability to submit questions, comments, grievances, and appeals, and receive a response (members must be given the option of a return e-mail or phone call). MCP responses to questions or comments must be made within one working day of receipt. MCP responses to grievances and appeals must adhere to the timeframes specified in OAC rule 5101:3-26-08.4. The member website must be regularly updated to include the most current ODJFS-approved materials, although this website must not be the only means for notifying members of new and/or revised MCP information (e.g., change in holiday closures, changes in additional benefits, and revisions to approved member materials).

The MCP member website must also include, at a minimum, the following information which must be accessible to members and the general public without any log-in restriction: (1) MCP contact information, including the MCP's toll-free member services phone number, service hours, and closure dates; (2) a list of counties covered in the MCP's service area; (3) the ODJFS-approved MCP member handbook, recent newsletters and announcements; (4) the MCP's on-line provider directory as referenced in section 37(a) of this appendix; (5) the MCP's current preferred drug list (PDL), including an explanation of the list, which drugs require PA, and how to initiate a PA; and (6) the MCP's current list of drugs covered only with PA, how to initiate a PA, and the MCP's policy for covering name brand drugs. MCPs must ensure that all website member information and materials are clearly labeled for CFC members and/or ABD members, as applicable. ODJFS may require MCPs to include additional information on the member website as needed.

c. On-line Provider Website – MCPs must have a secure internet-based website for contracting providers through which providers can confirm a consumer's enrollment and through which providers can submit and receive responses to prior authorization requests (an e-mail process is an acceptable substitute if the website includes the MCP's e-mail address for such submissions).

The MCP provider website must also include, at a minimum, the following information which must be accessible to providers and the general public without any log-in restrictions: (1) MCP contact information, including the MCP's designated contact for provider issues; (2) a list of counties covered in the MCP's service area; (3) the MCP's provider manual including the MCP's claims submission process, as well as a list of services requiring PA, recent newsletters and announcements; (4) the MCP's on-line provider directory as referenced in section 37(a) of this appendix; (5) the MCP's current PDL, including an explanation of the list, which drugs require PA, and how to initiate a PA; and (6) the MCP's current list of drugs covered only with PA, how to initiate a PA, and the MCP's policy for covering name brand drugs. MCPs must ensure that all website information and materials are clearly labeled for CFC members and/or ABD members, as applicable. ODJFS may require MCPs to include additional information on the provider website as needed.

37. MCPs must provide members with a printed version of their PDL and PA lists, upon request.

38. MCPs must not use, or propose to use, any offshore programming or call center services in fulfilling the program requirements.

39. PCP Feedback – The MCP must have the administrative capacity to offer feedback to individual providers on their: 1) adherence to evidence-based practice guidelines; and 2) positive and negative care variances from standard clinical pathways that may impact outcomes or costs. In addition, the feedback information may be used by the MCP for activities such as provider performance improvement projects that include incentive programs or the development of quality improvement programs.

40. Coordination of Benefits - When a claim is denied due to third party liability, the MCP must timely share appropriate and available information regarding the third party to the provider for the purposes of coordination of benefits, including, but not limited to third party liability information received from the ODJFS.

41. MCP submissions with due dates that fall on a weekend or holiday are due the next business day.

42. Trial Member Level Incentive Programs - The MCP must submit a description of a proposed trial member-level incentive program to ODJFS for review and approval prior to implementation. A trial member level incentive program is defined as a time limited monetary or non-monetary reward offered to a member who complies with the intended

goals of the program as outlined by the MCP (e.g., recommended health screenings) in the submission. The incentive must not be considered a medically-necessary Medicaid-covered service or an additional benefit as offered in the MCP's Member Handbook. The MCP should refer to the Guidance Document for Managed Care Plan Submission for Trial Member Level Incentive Programs for additional clarification.

43. MCPs must subscribe to the ODJFS distribution lists for notification of all 1) OAC rule clearances, and 2) final rules published with medical assistance letters (MALs), Medicaid handbook transmittal letters (MHTLs), and other transmittal letters affecting managed care program requirements. Rule clearances and MALs/MHTLs are managed by separate ODJFS entities. MCPs are solely responsible for submitting their names and email addresses to the appropriate ODJFS distribution lists and are also responsible for ensuring the validity of any e-mail addresses maintained on those distribution lists.

44. In addition to the grievance system requirements specified in OAC rule 5101:3-26-08.4, the MCP must:

a. Notify ODJFS within one working day of any appeals that meet the criteria for expedited resolution.

b. Include the following information in notices of action and appeal decisions not wholly resolved in the member's favor:

i. oral interpretation is available for any language;

ii. written translation is available in prevalent languages as applicable;

iii. written alternative formats may be available as needed; and

iv. how to access the MCP's interpretation and translation services as well as alternative formats that can be provided by the MCP.

45. Pursuant to OAC rule 5101:3-26-08.4(C)(3), MCPs must provide written acknowledgment of an appeal initially filed in writing within three working days of the appeal. Initial filings include any appeals the MCP receives in writing. Therefore, if a member files a verbal appeal and follows the verbal filing with a written appeal, the MCP must acknowledge the written appeal in writing.

46. By no later than February 1, 2010, notify members of the standard and expedited state hearing resolution time frames as outlined in 42 CFR 431.244(f).

47. Transfer of Protected Health Information to ODJFS Fee-For-Service Pharmacy Benefit Manager

Effective February 1, 2010, ODJFS is carving out Pharmacy Benefits from the benefits provided by MCPs to MCP members, and ODJFS has contracted with ACS to serve as the pharmacy benefits manager for ODJFS with respect to the management, provision and payment of Pharmacy Benefits ("the PBM Agreement").

In order to coordinate care for MCP members, ODJFS and its contractor, ACS, requires that certain historic encounter data ("MCP Data") related to Pharmacy Benefits be provided prior to when the carved out Pharmacy Benefits are provided to MCP members. In addition, in order to compile, analyze, prepare and file HEDIS reports, MCP requires certain ongoing data related to the carved out Pharmacy Benefits provided under the PBM Agreement on and after February 1, 2010 to MCP members.

ODJFS and the MCP are covered entities under the Health Insurance Portability and Accountability Act of 1996, and ODJFS asserts that both ACS and MCP are Business Associates of ODJFS, as defined in the Privacy Regulations, and each of ACS and MCP has executed a Business Associate Agreement directly with ODJFS in accordance with the Health Insurance Portability and Accountability Act of 1996 and the Privacy Regulations.

MCP agrees to provide the data required for the management of the carved out Pharmacy Benefits to ODJFS, and ODJFS instructs MCP to transfer such data to ACS as ODJFS's contractor. ODJFS has instructed ACS to provide the data required to compile, analyze, prepare and file HEDIS reports to MCP. The data to be transferred includes Protected Health Information (PHI) as defined in 45 C.F.R. Parts 160 and 164 ("Privacy Regulations").

ODJFS by this Provider Agreement requests that MCP provide to ODJFS the MCP Data, as part of MCP's reporting obligations under the Provider Agreement. ODJFS further authorizes and instructs MCP (i) to transfer the MCP Data directly to ACS, which is receiving such MCP Data as the Business Associate of ODJFS; and (ii) in the unlikely event that ACS has questions regarding the transferred MCP Data, to engage in discussions with ACS regarding the MCP Data as necessary to respond to reasonable questions regarding the MCP Data. Data shall be transferred in electronic format and is limited to the data fields set forth in the data transfer document that has been jointly developed by ODJFS, ACS, and the MCPs. MCP shall transfer such information for a period not to exceed March 31, 2010 unless an extension is jointly agreed upon, in writing, by ODJFS and MCP. ODJFS represent and warrants that separate from this Provider Agreement, a Business Associate agreement that complies fully with the Health Insurance Portability and Accountability Act of 1996 and the HITECH provisions of the American Recovery and Reinvestment Act of 2009 (collectively "HIPAA") and with 45 C.F.R. Parts 160 and 164 (the "Privacy Regulations") has been executed by ACS and is currently effective, and will remain in effect for the Term of this Agreement.

APPENDIX D

ODJFS RESPONSIBILITIES

The following are ODJFS responsibilities or clarifications that are not otherwise specifically stated in OAC Chapter 5101:3-26 or elsewhere in the ODJFS-MCP provider agreement.

General Provisions

1. ODJFS will provide MCPs with an opportunity to review and comment on the rate-setting time line and proposed rates, and proposed changes to the OAC program rules or the provider agreement.

2. ODJFS will notify MCPs of managed care program policy and procedural changes and, whenever possible, offer sufficient time for comment and implementation.

3. ODJFS will provide regular opportunities for MCPs to receive program updates and discuss program issues with ODJFS staff.

4. ODJFS will provide technical assistance sessions where MCP attendance and participation is required. ODJFS will also provide optional technical assistance sessions to MCPs, individually or as a group.

5. ODJFS will provide MCPs with an annual MCP Calendar of Submissions outlining major submissions and due dates.

6. ODJFS will identify contact staff, including the Contract Administrator, selected for each MCP.

7. ODJFS will recalculate the minimum provider panel specifications if ODJFS determines that significant changes have occurred in the availability of specific provider types and the number and composition of the eligible population.

8. ODJFS will recalculate the geographic accessibility standards, using the geographic information systems (GIS) software, if ODJFS determines that significant changes have occurred in the availability of specific provider types and the number and composition of the eligible population and/or the ODJFS provider panel specifications.

9. On a monthly basis, ODJFS will provide MCPs with an electronic file containing their MCP's provider panel as reflected in the ODJFS Managed Care Provider Network (MCPN) database, or other designated system.

10. On a monthly basis, ODJFS will provide MCPs with an electronic Provider Master File containing all the Ohio Medicaid FFS providers, which includes their Medicaid Provider

Number, as well as all providers who have been assigned a provider reporting number for current encounter data purposes. This file also includes NPI information when available.

11. ODJFS utilizes electronic commerce known as Transport Layer Security (TLS) for many processes and procedures that were previously limited by HIPAA privacy concerns to FAX, telephone, or hard copy. The use of TLS means that private health information (PHI) and the identification of consumers as Medicaid recipients can be shared between ODJFS and the contracting MCPs via e-mail such as reports, copies of letters, forms, hospital claims, discharge records, general discussions of member-specific information, etc.

12. ODJFS will immediately report to CMS any breach in privacy or security that compromises PHI, when reported by the MCP or ODJFS staff.

13. Service Area Designation

Membership in a service area is mandatory unless ODJFS approves membership in the service area for consumer initiated selections only. It is ODJFS' current intention to implement a mandatory managed care program in service areas wherever choice and capacity allow and the criteria in 42 CFR 438.50(a) are met.

14. Consumer Information

a. ODJFS, or its delegated entity, will provide membership notices, informational materials, and instructional materials relating to members and eligible individuals in a manner and format that may be easily understood. At least annually, ODJFS or designee will provide current MCP members with an open enrollment notice which describes the managed care program and includes information on the MCP options in the service area and other information regarding the managed care program as specified in 42 CFR 438.10.

b. ODJFS will notify members or ask MCPs to notify members about significant changes affecting contractual requirements, member services or access to providers.

c. If an MCP elects not to provide, reimburse, or cover a counseling service or referral service due to an objection to the service on moral or religious grounds, ODJFS will provide coverage and reimbursement for these services for the MCP's members.

As applicable, ODJFS will provide information to MCP members on what services the MCP will not cover and how and where the MCP's members may obtain these services.

15. Membership Selection and Premium Payment

a. The Managed Care Enrollment Center (MCEC) - The ODJFS-contracted MCEC will provide unbiased education, selection services, and community outreach for the Medicaid

managed care program. The MCEC shall operate a statewide toll-free telephone center to assist eligible individuals in selecting an MCP or choosing a health care delivery option.

The MCEC shall distribute the most current generic consumer guide that provides basic information about the managed care program, as well as ODJFS prior-approved MCP materials, such as solicitation brochures and provider directories, to consumers who request additional materials.

b. Auto-Assignment and New MCPs – When an MCP first enters a region or begins serving a new population within a region, ODJFS for a one year period, has the sole discretion to assign consumers by whatever method and standards it chooses for the region and population, irrespective of the methods and limitations outlined in this Appendix.

c. Auto-Assignment Limitations – In order to ensure market and program stability, ODJFS may limit an MCP's auto-assignments for a population (e.g., ABD or CFC) if they meet any of the following enrollment thresholds:

- 55% of the statewide ABD or CFC eligible population; and/or
- 70% of the ABD or CFC eligibles in any region with two MCPs; and/or
- 55% of the ABD or CFC eligibles in any region with three MCPs

Once an MCP meets one of these enrollment thresholds, the MCP will only be permitted to receive the additional new membership (in the region or statewide, as applicable) through: (1) consumer-initiated enrollment; and (2) auto-assignments which are based on previous enrollment in that MCP or based on an historical provider relationship with a provider who is not on the panel of any other MCP in that region. In the event that an MCP in a region meets one or more of these enrollment thresholds, ODJFS, in their sole discretion, may not impose the auto-assignment limitation and auto-assign members to the MCPs in that region as ODJFS deems appropriate.

d. Performance Based Auto-Assignments – Consumers who do not voluntarily select an MCP or are not auto-assigned to an MCP based on previous enrollment in that MCP or an historical provider relationship with a provider who is not on the panel of another MCP in that region, will be auto-assigned based on the MCP performance using the following performance rating system:

MCPs will be scored based on the following ten measures:

i. MCP Consumer Call Center (see Appendix C)
   - Average speed of answer
   - Abandonment rate
   - Blockage rate

ii. MCP Provider Call Center (measurement and standards will match those set for the MCP Consumer Call Center outlined in Appendix C).
   - Average speed of answer

- Abandonment rate
- Blockage rate

iii. MCP Prior Authorization (see OAC 5101:3-26-03.1)
- Average time to process non-pharmacy requests
- Average time to process pharmacy requests

iv. Prompt Payment of Claims (see Appendix J)
- Percentage of claims paid within 30days
- Percentage of claims paid within 90 days

Each MCP will receive a point for meeting the established standard. If an MCP meets the established standard for each measure, they will receive ten points. Because these are performance based calculations, point calculations will be based solely on information reported by the MCP and will not be impacted by MCP requests for reconsideration under the Compliance Assessment System. For each region, the MCP with the highest score will receive the performance-based auto-assignments for the region. If there is a tie for the highest score, then each tying MCP will be considered equal in the auto-assignment process. Scoring will take place quarterly and will be based on the data that is available at the time the calculations are done. Scoring results will be applied to the auto-assignment process once the results are finalized.

On a regional basis, MCPs that have auto-assignment limitations in accordance with 15.b. do not qualify for performance-based auto-assignments unless (1) there are two MCPs in the region, (2) the auto-assignment limited MCP received 10 points and (3) the other MCP in the regional failed to receive 10 points. In this case, the MCP with the auto-assignment limitation shall receive auto-assignments in the amount of 10% of the performance based auto-assignments for every point the other MCP is below 10 points (i.e. if the other MCP has 7 points then the MCP would receive 30% [3 points * 10%]).

If ODJFS implements a new enrollment freeze on an MCP as outlined in Appendix N, the MCP will not receive any auto-assignments. Should ODJFS remove the new enrollment freeze, the MCP will not be entitled to receive performance based auto-assignments until the next quarterly review is performed and implemented as outlined in this section.

e. Consumer Contact Record (CCR): ODJFS or their designated entity shall forward CCRs to MCPs on no less than a weekly basis. The CCRs are a record of each consumer initiated MCP enrollment, change, or termination, and each MCEC initiated MCP assignment processed through the MCEC. The CCR contains information that is not included on the monthly member roster.

f. Member Roster (MR) - ODJFS verifies MCP enrollment via a membership roster. ODJFS or its designated entity provides a full member roster (F) and a change roster (C) via HIPAA 834 compliant transactions.

g. Monthly Premiums - ODJFS will remit payment to the MCPs via an electronic funds transfer (EFT), or at the discretion of ODJFS, by paper warrant.

h. Remittance Advice RA - ODJFS will confirm all premium payments paid to the MCP during the month via a monthly RA, which is usually sent to the MCP the week following state cut-off. ODJFS or its designated entity provides a record of each payment via HIPAA 820 compliant transactions.

i. MCP Membership/Payment Reconciliation - ODJFS will work with an MCP designated contact(s) in Appendix C to resolve the MCP's member and newborn eligibility inquiries, and premium and delivery inquiries/discrepancies and to review/approve hospital deferment requests.

16. ODJFS will make available a website which includes current program information.

17. ODJFS, or its contracted entity, will regularly provide information to MCPs regarding different aspects of MCP performance including, but not limited to, information on MCP-specific and statewide external quality review organization surveys, focused clinical quality of care studies, consumer satisfaction surveys and provider profiles.

18. ODJFS will periodically review a random sample of online and printed directories to assess whether MCP information is both accessible and updated.

19. Communications

a. ODJFS/BMC: The Bureau of Managed Care (BMC) is responsible for the oversight of the MCPs' provider agreements with ODJFS. Within the BMC, a specific Contract Administrator (CA) has been assigned to each MCP. Unless expressly directed otherwise, MCPs shall first contact their designated CA for questions/assistance related to Medicaid and/or the MCP's program requirements /responsibilities. If their CA is not available and the MCP needs immediate assistance, MCP staff should request to speak to a supervisor within the Contract Administration Section. MCPs should take all necessary and appropriate steps to ensure all MCP staff are aware of, and follow, this communication process.

b. ODJFS Contracting Entities: ODJFS-contracting entities should never be contacted by the MCPs unless the MCPs have been specifically instructed by ODJFS to contact the ODJFS contracting entity directly.

c. MCP Delegated Entities: In that MCPs are ultimately responsible for meeting program requirements, the BMC will not discuss MCP issues with the MCPs' delegated entities unless the applicable MCP is also participating in the discussion. MCP delegated entities, with the applicable MCP participating, should only communicate with the specific CA assigned to that MCP.

APPENDIX E

RATE METHODOLOGY
ABD ELIGIBLE POPULATION

Milliman

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FINAL and CONFIDENTIAL

December 9, 2009

Mr. Jon Barley, Ph.D., Bureau Chief
Bureau of Managed Care
Ohio Department of Job and Family Services
Lazarus Building
50 West Town St., Suite 400
Columbus, OH 43215

RE: CAPITATION RATE CERTIFICATION – AGED, BLIND, OR DISABLED (ABD) – JANUARY 2010 PHARMACY

Dear Jon:

Milliman, Inc. (Milliman) was retained by the State of Ohio, Department of Job and Family Services (ODJFS) to develop the calendar year (CY) 2010 actuarially sound capitation rates for the Aged, Blind, or Disabled (ABD) Risk Based Managed Care (RBMC) program. This letter provides the pharmacy capitation rates to be effective for January 2010 and the corresponding actuarial certification.

LIMITATIONS

The information contained in this letter, including the enclosures, has been prepared for the State of Ohio, Department of Job and Family Services and their consultants and advisors. It is our understanding that the information contained in this letter may be utilized in a public document. To the extent that the information contained in this letter is provided to third parties, the letter should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for ODJFS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this letter must rely upon their own experts in drawing conclusions about the capitation rates, assumptions, and trends.

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Offices in Principal Cities Worldwide

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The information contained in this letter was prepared as documentation of the actuarially sound capitation rates for Medicaid managed care organization health plans in the State of Ohio. The information may not be appropriate for any other purpose.

EXECUTIVE SUMMARY

Beginning February 1, 2010, ODJFS is removing pharmacy services from the Aged, Blind, or Disabled (ABD) Risk-Based Managed Care (RBMC) program. The CY 2010 capitation rates were developed excluding pharmacy and, as such, will require a separate pharmacy only component for the month of January 2010. This letter corresponds to the pharmacy component of the January 2010 capitation rates. Table 1 illustrates the January 2010 projected enrollment, PMPM capitation amount, and the corresponding expenditures for each region as well as the statewide composite amounts.

Table 1

OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
AGED, BLIND, OR DISABLED (ABD)
Pharmacy Capitation Rate – January 2010

Region	Projected Enrollment	PMPM Capitation	Expenditures ($ Millions)
Central	23,506	$ 390.54	$ 9.2
East Central	12,259	398.37	4.9
Northeast	23,179	340.03	7.9
Northeast Central	7,218	393.05	2.8
Northwest	11,306	352.67	4.0
Southeast	12,983	411.44	5.3
Southwest	14,518	367.11	5.3
West Central	10,565	403.16	4.3
Statewide Composite	115,534	$ 378.25	$ 43.7
Federal Only Component			$ 32.1

1. *Federal expenditures based on ARRA enhanced FMAP percentage of 73.47%.*

The values above reflect the projected January 2010 experience using historical fee for service (FFS), managed care encounter, and health plan financial cost report information adjusted for the expected cost in the managed care program.

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The current pharmacy capitation rates and expenditures were integrated with other medical services and included in the capitation rates certified by Milliman and approved by CMS for the period of January 1, 2009 to December 31, 2009. The pharmacy and medical components were separated beginning January 2010. The proposed pharmacy capitation rates are included in this document and the medical component is provided in the CY 2010 Data Book. For purposes of estimating the change in capitation rates and expenditures, the total amount from this document should be combined with the capitation rates and expenditures from the CY 2010 Data Book.

Enclosure 1 contains the actuarial certification regarding the actuarial soundness of the January pharmacy capitation rates.

Enclosure 2 contains the January 2010 pharmacy capitation rates by region on a per member per month (PMPM) basis, including the segmentation of the guaranteed and at-risk components.

Enclosure 3 contains the calendar year (CY) 2008 adjusted base experience and the projected January 2010 pharmacy capitation rates for each region.

Enclosure 4 contains the combined medical and pharmacy capitation rates for January 2010. This exhibit is intended to provide an illustration of the total capitation payment for January. The specific documentation of the medical capitation remains in the CY 2010 Data Book.

DETAILS OF CAPITATION RATE DEVELOPMENT

Milliman developed the January 2010 pharmacy capitation rates using historical FFS, managed care encounter, and health plan financial cost report information adjusted for the expected cost in the managed care program. The following sections summarize the development of the capitation rates.

In general, the methodology is similar to that of the medical component of the capitation rates documented in the CY 2010 Data Book.

Development of CY 2008 Adjusted FFS Data

Milliman summarized historical managed care eligible FFS experience with service incurred dates in calendar years 2007 and 2008 and paid claims run-out through March 31, 2009. The pharmacy data was provided by ODJFS from the data warehouse and identified using ODJFS Category of Service code equal to "30". Pharmacy experience was stratified into geographic region based on the member's county of residence.

The base pharmacy FFS data was adjusted for incomplete data, program and policy changes, payments / refunds occurring outside of normal claim adjudication, managed care penetration, changes expected in the managed care program, and inflation.

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for ODJFS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this letter must rely upon their own experts in drawing conclusions about the capitation rates, assumptions, and trends.

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Table 2 illustrates the summary adjustments to the base FFS pharmacy experience. In certain instances, the values shown are the composite average statewide values. The application of the adjustment factors is consistent with that of the CY 2010 Data Book.

Table 2

STATE OF OHIO
DEPARTMENT OF JOB AND FAMILY SERVICES
AGED, BLIND, OR DISABLED
FFS Base Data Adjustments (NE/NEC/NW Regions Only)

Adjustment Factor Description	CY 2007 Adjustment Factor	CY 2008 Adjustment Factor	Additional Comments
Completion Factors	99.91%	98.74%	• Applied as divisors
Third Party Liability Recoveries	(0.63%)	(1.92%)	• Source: Data Book
Fraud and Abuse Recoveries	(0.17%)	(0.20%)	• Source: Data Book
Gross Invoice Adjustments	(0.01%)	0.00%	• Source: Data Book
Historical Selection Adjustments	(2.19%)	(6.35%)	• Composite value – varies by region • Source: Data Book
Annual Inflation to CY 2008	7.63%	7.63%	• Utilization-2.5%; Unit cost-5.0% • Months of Inflation from Data Book
Base Year Blending Percentages	30.00%	70.00%	• NE, NEC, and NW regions only • Source: Data Book
Managed Care Adjustments	(11.62%)		• Composite value – varies by region • Includes utilization and unit cost

Development of CY 2008 Adjusted Encounter Data

Milliman summarized historical managed care encounter experience with service incurred dates in calendar years 2007 and 2008 and paid claims and submissions run-out through June 30, 2009. The pharmacy data was provided by ODJFS from the data warehouse and identified using ODJFS Category of Service code equal to "30". Pharmacy experience was stratified into geographic region based on the member's county of residence.

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The base pharmacy encounter data was adjusted for incomplete data, program and policy changes, payments/refunds occurring outside of normal claim adjudication, managed care penetration, changes expected in the managed care program, and inflation. The adjustments are summarized in Table 3 and were applied consistent with the methodology used for the CY 2010 Data Book.

Table 3 illustrates the summary adjustments to the base encounter pharmacy experience. In certain instances, the values shown are the composite average statewide values. The application of the adjustment factors is consistent with that of the CY 2010 Data Book.

Table 3

STATE OF OHIO
DEPARTMENT OF JOB AND FAMILY SERVICES
AGED, BLIND, OR DISABLED
Encounter Base Data Adjustments

Adjustment Factor Description	CY 2007 Adjustment Factor	CY 2008 Adjustment Factor	Additional Comments
Completion Factors	99.96%	99.72%	• Applied as divisors
TPL and Fraud/Abuse Recoveries	(0.15%)	(0.12%)	• Source: Data Book
Non State Plan Service Adjustments	(0.02%)	(0.03%)	• Composite value – varies by region
Co-pay Adjustments	(0.73%)	(0.73%)	• Composite value
Historical Selection Adjustments	2.35%	2.36%	• Composite value – varies by region • Source: Data Book
Annual Inflation to CY 2008	7.63%	7.63%	• Utilization-2.5%; Unit cost-5.0% • Months of inflation from Data Book
Base Year Blending Percentages	30.00%	70.00%	• Exception: NEC - 100% CY 2008
Managed Care Adjustments	(15.59%)		• Composite value – varies by region • Includes utilization and unit cost

Development of CY 2008 Adjusted Cost Report Data

Milliman developed adjusted cost report experience based on financial data reported by the managed care plans. The cost report information included incurred service dates in CY 2007 and 2008 with health plan estimated completion amounts. The cost report experience is used in aggregate for each region, with allocations by service category developed from the adjusted encounter data.

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The base cost report data was adjusted for incomplete data, program and policy changes, payments/refunds occurring outside of normal claim adjudication, managed care penetration, changes expected in the managed care program, and inflation. The adjustments are documented in the CY 2010 Data Book.

Development of CY 2010 Capitation Rates

The adjusted CY 2008 utilization and cost per service pharmacy rates were trended forward to January 2010 and adjusted for prospective program and policy changes. The resulting PMPM established the regional adjusted claim cost for pharmacy in January 2010. The non-claim items (administrative cost allowance, sales and use taxes, and the HIC tax) were applied to the adjusted claim cost to develop the January 2010 pharmacy capitation rates. The adjustments are summarized in Table 4.

Table 4

STATE OF OHIO
DEPARTMENT OF JOB AND FAMILY SERVICES
AGED, BLIND, OR DISABLED
CY 2008 to CY 2010 Adjustments

Adjustment Factor Description	Adjustment Factor	Additional Comments
Annual Inflation to CY 2010	7.63%	• Utilization-2.5%; Unit cost-5.0%
OTC Coverage Reductions	(0.30%)	• Composite value
Prospective Selection Adjustments	(1.55%)	• Composite value – varies by region
Clinical Measures Adjustments	0.18%	• Composite value
Rx Carve-out Adjustments	(1.04%)	• Composite value • Revised definition of Carve-out
Data Source Blending Percentages	See Enclosure 3	• Varies by region
Administrative Cost Allowance	3.75%	• Reallocated pharmacy administrative cost.
Sales and Use Tax	6.89%	• Composite value – varies by region
Health Insuring Corporation (HIC) Tax	1.00%	

CDPS+RX Risk Adjustment

The methodology described in this letter and the CY 2010 Data Book was used to develop the base capitation rates for January 2010 for each region. Milliman will then apply the Chronic Illness and Disability Payment System (CDPS) to adjust the actuarially sound base capitation rates for the ABD population on a regional basis for each MCP. Milliman will use the CDPS+Rx 5.1 version of the grouper.

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DATA RELIANCE

In developing the pharmacy capitation rates contained in this letter and the enclosures, Milliman relied upon certain data and information from ODJFS. While limited review was performed for reasonableness, the data and information was accepted without audit. To the extent that the data and information was not accurate or complete, the values shown in this letter and the enclosures will need to be revised to meet any revised data.

◆ ◆ ◆ ◆

If you have any questions regarding the enclosed information, please do not hesitate to contact me at (317) 524-3512.

Sincerely,

Robert M. Damler

Robert M. Damler, FSA, MAAA
Principal and Consulting Actuary

RMD/lrb
Enclosures

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for ODJFS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this letter must rely upon their own experts in drawing conclusions about the capitation rates, assumptions, and trends.

ENCLOSURE 1

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for ODJFS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this letter must rely upon their own experts in drawing conclusions about the capitation rates, assumptions, and trends.

Milliman

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STATE OF OHIO
DEPARTMENT OF JOB AND FAMILY SERVICES
Aged, Blind, or Disabled
Pharmacy Capitation Rates January 1, 2010 to January 31, 2010

Actuarial Certification

I, Robert M. Damler, am a Principal and Consulting Actuary with the firm of Milliman, Inc. I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. I was retained by the State of Ohio, Department of Job and Family Services to perform an actuarial review and certification regarding the development of the pharmacy capitation rates to be effective from January 1, 2010 to January 31, 2010. The capitation rates were developed for the Aged, Blind, or Disabled managed care eligible populations. I have experience in the examination of financial calculations for Medicaid programs and meet the qualification standards for rendering this opinion.

I reviewed the historical claims experience for reasonableness and consistency. I have developed certain actuarial assumptions and actuarial methodologies regarding the projection of healthcare expenditures into future periods. I have complied with the elements of the rate setting checklist CMS developed for its Regional Offices regarding 42 CFR 438.6(c) for capitated Medicaid managed care plans.

The pharmacy capitation rates provided with this certification are effective for a one month rating period beginning January 1, 2010 through January 31, 2010. The capitation rates associated with this certification were previously integrated with other medical services and included in the capitation rates certified by Milliman and approved by CMS for the period of January 1, 2009 through December 31, 2009. This certification reflects the development of a stand-alone capitation rate for pharmacy services. At the end of the one month period, it is anticipated that the pharmacy component will not be part of the risk based managed care program.

The capitation rates provided with this certification are considered actuarially sound, defined as:

- the capitation rates have been developed in accordance with generally accepted actuarial principles and practices;
- the capitation rates are appropriate for the populations to be covered, and the services to be furnished under the contract; and,
- the capitation rates meet the requirements of 42 CFR 438.6(c).

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for ODJFS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this letter must rely upon their own experts in drawing conclusions about the capitation rates, assumptions, and trends.

This actuarial certification has been based on the actuarial methods, considerations, and analyses promulgated from time to time through the Actuarial Standards of Practice by the Actuarial Standards Board.

Robert M. Damler

Robert M. Damler, FSA
Member, American Academy of Actuaries

December 9, 2009
Date

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for ODJFS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this letter must rely upon their own experts in drawing conclusions about the capitation rates, assumptions, and trends.

ENCLOSURE 2

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State of Ohio
Department of Job and Family Services
ABD Pharmacy Capitation Rate Summary (January 2010)

	Projected Jan 2010 Member Months	Jan 2010 Guaranteed Rate	Jan 2010 At Risk Rate	Jan 2010 Rate
Central	23,506	$ 386.94	$ 3.60	$ 390.54
East Central	12,259	394.69	3.68	398.37
Northeast	23,179	336.92	3.11	340.03
Northeast Central	7,218	389.42	3.63	393.05
Northwest	11,306	349.42	3.25	352.67
Southeast	12,983	407.65	3.79	411.44
Southwest	14,518	363.72	3.39	367.11
West Central	10,565	399.45	3.71	403.16
Statewide	115,534	$ 374.76	$ 3.48	$ 378.25

ENCLOSURE 3

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State of Ohio
Department of Job and Family Services
ABD Pharmacy Capitation Rate Development (January 2010)

	Projected Jan 2010	FFS (Adjusted 2008)				Encounter (Adjusted 2008)				Cost Report (Adj. 2008)		Projected Jan 2010	Admin Cost Allowance	Sales and Use Tax	HIC Tax	Total Capitation Rate
	Member Months	Util/1,000	CPS	PMPM	Blend %	Util/1,000	CPS	PMPM	Blend %	PMPM	Blend %	PMPM	PMPM	PMPM	PMPM	PMPM
Central	23,506				0.0%	66,482.0	$ 57.82	$ 320.33	60.0%	$ 310.47	40.0%	$ 346.58	$ 13.50	$ 26.56	$ 3.91	$ 390.54
East Central	12,259				0.0%	60,029.1	64.33	321.81	60.0%	323.09	40.0%	354.56	13.81	26.01	3.98	398.37
Northeast	23,179	49,318.7	62.89	258.47	14.4%	54,361.4	61.10	276.79	51.4%	274.05	34.2%	299.70	11.67	25.26	3.40	340.03
Northeast Central	7,218	57,172.8	67.42	321.22	55.6%	60,431.6	63.19	318.22	44.4%	277.25	0.0%	349.11	13.60	26.41	3.93	393.05
Northwest	11,306	54,669.3	62.29	283.78	20.0%	57,212.3	60.41	288.02	48.0%	282.91	32.0%	313.14	12.20	23.81	3.53	352.67
Southeast	12,983				0.0%	65,134.7	60.21	326.81	60.0%	336.91	40.0%	364.61	14.20	28.51	4.11	411.44
Southwest	14,518				0.0%	59,515.3	59.27	293.96	60.0%	301.68	40.0%	326.74	12.73	23.97	3.67	367.11
West Central	10,565				0.0%	63,297.6	60.33	318.23	60.0%	334.37	40.0%	357.20	13.91	28.02	4.03	403.16

ENCLOSURE 4

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for ODJFS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this letter must rely upon their own experts in drawing conclusions about the capitation rates, assumptions, and trends.

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State of Ohio
Department of Job and Family Services
ABD Capitation Rate Summary - Combined Medical and Pharmacy (January 2010)

Region	Projected Jan 2010 Member Months	Jan 2010 Medical Capitation	Jan 2010 Pharmacy Capitation	Jan 2010 Total Capitation
Central	23,506	$ 976.37	$ 390.54	$ 1,366.91
East Central	12,259	$ 894.39	$ 398.37	$ 1,292.76
Northeast	23,179	$ 1,041.52	$ 340.03	$ 1,381.55
Northeast Central	7,218	$ 933.55	$ 393.05	$ 1,326.60
Northwest	11,306	$ 1,032.09	$ 352.67	$ 1,384.76
Southeast	12,983	$ 761.63	$ 411.44	$ 1,173.07
Southwest	14,518	$ 969.08	$ 367.11	$ 1,336.19
West Central	10,565	$ 963.35	$ 403.16	$ 1,366.51
Statewide	115,534	$ 957.28	$ 378.25	$ 1,335.53

APPENDIX E

RATE METHODOLOGY
CFC ELIGIBLE POPULATION

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FINAL and CONFIDENTIAL

December 9, 2009

Mr. Jon Barley, Ph.D., Bureau Chief
Bureau of Managed Care
Ohio Department of Job and Family Services
Lazarus Building
50 West Town St., Suite 400
Columbus, OH 43215

RE: CAPITATION RATE CERTIFICATION – COVERED FAMILIES AND CHILDREN (CFC) – JANUARY 2010 PHARMACY

Dear Jon:

Milliman, Inc. (Milliman) was retained by the State of Ohio, Department of Job and Family Services (ODJFS) to develop the calendar year (CY) 2010 actuarially sound capitation rates for the Covered Families and Children (CFC) Risk Based Managed Care (RBMC) program. This letter provides the pharmacy capitation rates to be effective for January 2010 and the corresponding actuarial certification.

LIMITATIONS

The information contained in this letter, including the enclosures, has been prepared for the State of Ohio, Department of Job and Family Services and their consultants and advisors. It is our understanding that the information contained in this letter may be utilized in a public document. To the extent that the information contained in this letter is provided to third parties, the letter should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for ODJFS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this letter must rely upon their own experts in drawing conclusions about the capitation rates, assumptions, and trends.

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Offices in Principal Cities Worldwide

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The information contained in this letter was prepared as documentation of the actuarially sound capitation rates for Medicaid managed care organization health plans in the State of Ohio. The information may not be appropriate for any other purpose.

EXECUTIVE SUMMARY

Beginning February 1, 2010, ODJFS is removing pharmacy services from the Covered Families and Children (CFC) Risk Based Managed Care (RBMC) program. The CY 2010 capitation rates were developed excluding pharmacy and, as such, will require a separate pharmacy only component for the month of January 2010. This letter corresponds to the pharmacy component of the January 2010 capitation rates. Table 1 illustrates the January 2010 projected enrollment, PMPM capitation amount, and the corresponding expenditures for each region as well as the statewide composite amounts.

Table 1

OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
COVERED FAMILIES AND CHILDREN (CFC)
Pharmacy Capitation Rate – January 2010

Region	Projected Enrollment	PMPM Capitation	Expenditures ($ Millions)
Central	267,426	$ 41.55	$ 11.1
East Central	148,672	38.65	5.7
Northeast	253,112	37.12	9.4
Northeast Central	69,801	40.32	2.8
Northwest	139,212	38.66	5.4
Southeast	89,533	49.47	4.4
Southwest	165,362	37.63	6.2
West Central	118,955	42.31	5.0
Statewide Composite	1,252,073	$ 40.04	$ 50.1
Federal Only Component			$ 36.8

1. *Federal expenditures based on ARRA enhanced FMAP percentage of 73.47%.*

The values above reflect the projected January 2010 experience using historical managed care encounter and health plan financial cost report information adjusted for the expected cost in a managed care program.

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The current pharmacy capitation rates and expenditures were integrated with other medical services and included in the capitation rates certified by Milliman and approved by CMS for the period of January 1, 2009 to December 31, 2009. The pharmacy and medical components were separated beginning January 2010. The proposed pharmacy capitation rates are included in this document and the medical component is provided in the CY 2010 Data Book. For purposes of estimating the change in capitation rates and expenditures, the total amount from this document should be combined with the capitation rates and expenditures from the CY 2010 Data Book.

Enclosure 1 contains the actuarial certification regarding the actuarial soundness of the January pharmacy capitation rates.

Enclosure 2 contains the January 2010 pharmacy capitation rates by region and rate group on a per member per month (PMPM) basis, including the segmentation of the guaranteed and at-risk components.

Enclosure 3 contains the calendar year (CY) 2008 adjusted base experience and the projected January 2010 pharmacy capitation rates for each region and rate group.

Enclosure 4 contains the combined medical and pharmacy capitation rates for January 2010. This exhibit is intended to provide an illustration of the total capitation payment for January. The specific documentation of the medical capitation remains in the CY 2010 Data Book.

DETAILS OF CAPITATION RATE DEVELOPMENT

Milliman developed the January 2010 pharmacy capitation rates using historical FFS, managed care encounter, and health plan financial cost report information adjusted for the expected cost in the managed care program. The following sections summarize the development of the capitation rates.

In general, the methodology is similar to that of the medical component of the capitation rates documented in the CY 2010 Data Book.

Development of CY 2008 Adjusted Encounter Data

Milliman summarized historical managed care encounter experience with service incurred dates in calendar years 2007 and 2008 and paid claims and submissions run-out through June 30, 2009. The pharmacy data was provided by ODJFS from the data warehouse and identified using ODJFS Category of Service code equal to "30". Pharmacy experience was stratified into geographic region based on the member's county of residence.

The base pharmacy encounter data was adjusted for incomplete data, program and policy changes, payments/refunds occurring outside of normal claim adjudication, managed care penetration, changes expected in the managed care program, and inflation. The adjustments are summarized in Table 3 and were applied consistent with the methodology used for the CY 2010 Data Book.

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Table 2 illustrates the summary adjustments to the base encounter pharmacy experience. In certain instances, the values shown are the composite average statewide values. The application of the adjustment factors is consistent with that of the CY 2010 Data Book.

Table 2

STATE OF OHIO
DEPARTMENT OF JOB AND FAMILY SERVICES
COVERED FAMILIES AND CHILDREN
Encounter Base Data Adjustments

Adjustment Factor Description	CY 2007 Adjustment Factor	CY 2008 Adjustment Factor	Additional Comments
Completion Factors	99.92%	99.66%	• Applied as divisors
TPL and Fraud/Abuse Recoveries	(0.40%)	(0.22%)	• Source: Data Book
Non State Plan Service Adjustments	(0.03%)	(0.07%)	• Composite value – varies by region
Co-pay Adjustments	(0.41%)	(0.41%)	• Composite value
Historical Selection Adjustments	1.18%	1.01%	• Composite value – varies by region • Source: Data Book
Annual Inflation to CY 2008	7.63%	7.63%	• Utilization-2.5%; Unit cost-5.0% • Months of inflation from Data Book
Base Year Blending Percentages	30.00%	70.00%	• Exception: NEC - 100% CY 2008
Managed Care Adjustments	(12.98%)		• Composite value – varies by region • Includes utilization and unit cost

Development of CY 2008 Adjusted Cost Report Data

Milliman developed adjusted cost report experience based on financial data reported by the managed care plans. The cost report information included incurred service dates in CY 2007 and 2008 with health plan estimated completion amounts. The cost report experience is used in aggregate for each region and rate group, with allocations by service category and rate group developed from the adjusted encounter data.

The base cost report data was adjusted for incomplete data, program and policy changes, payments/refunds occurring outside of normal claim adjudication, managed care penetration, changes expected in the managed care program, and inflation. The adjustments are documented in the CY 2010 Data Book.

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Development of CY 2010 Capitation Rates

The adjusted CY 2008 utilization and cost per service pharmacy rates were trended forward to January 2010 and were adjusted for prospective program and policy changes and inflation. The resulting PMPM established the regional and rate group adjusted claim cost for pharmacy in January 2010. The non-claim items (administrative cost allowance, sales and use taxes, and the HIC tax) were applied to the adjusted claim cost to develop the January 2010 pharmacy capitation rates. The adjustments are summarized in Table 3.

Table 3

STATE OF OHIO
DEPARTMENT OF JOB AND FAMILY SERVICES
COVERED FAMILIES AND CHILDREN
CY 2008 to CY 2010 Adjustments

Adjustment Factor Description	Adjustment Factor	Additional Comments
Annual Inflation to CY 2010	7.63%	• Utilization-2.5%; Unit cost-5.0%
OTC Coverage Reductions	(0.25%)	• Composite value
Prospective Selection Adjustments	(0.94%)	• Composite value – varies by region
Clinical Measures Adjustments	0.05%	• Composite value
Rx Carve-out Adjustments	(1.13%)	• Composite value • Revised definition of Carve-out
Data Source Blending Percentages	60% MC, 40% CR	
Administrative Cost Allowance	4.17%	• Reallocated pharmacy administrative cost.
State and Local Tax	6.84%	• Composite value – varies by region
Health Insuring Corporation (HIC) Tax	1.00%	

DATA RELIANCE

In developing the values contained in this letter and the enclosures, we have relied upon certain data and information from ODJFS. While limited review was performed for reasonableness, the data and information was accepted without audit. To the extent that the data and information was not accurate or complete, the values shown in this letter and the enclosures will need to be revised to meet any revised data.

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If you have any questions regarding the enclosed information, please do not hesitate to contact me at (317) 524-3512.

Sincerely,

Robert M. Damler

Robert M. Damler, FSA, MAAA
Principal and Consulting Actuary

RMD/lrb
Enclosures

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for ODJFS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this letter must rely upon their own experts in drawing conclusions about the capitation rates, assumptions, and trends.

ENCLOSURE 1

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STATE OF OHIO
DEPARTMENT OF JOB AND FAMILY SERVICES
COVERED FAMILIES AND CHILDREN
Pharmacy Capitation Rates January 1, 2010 to January 31, 2010

Actuarial Certification

I, Robert M. Damler, am a Principal and Consulting Actuary with the firm of Milliman, Inc. I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. I was retained by the State of Ohio, Department of Job and Family Services to perform an actuarial review and certification regarding the development of the pharmacy capitation rates to be effective from January 1, 2010 to January 31, 2010. The capitation rates were developed for the Covered Families and Children managed care eligible populations. I have experience in the examination of financial calculations for Medicaid programs and meet the qualification standards for rendering this opinion.

I reviewed the historical claims experience for reasonableness and consistency. I have developed certain actuarial assumptions and actuarial methodologies regarding the projection of healthcare expenditures into future periods. I have complied with the elements of the rate setting checklist CMS developed for its Regional Offices regarding 42 CFR 438.6(c) for capitated Medicaid managed care plans.

The pharmacy capitation rates provided with this certification are effective for a one month rating period beginning January 1, 2010 through January 31, 2010. The capitation rates associated with this certification were previously integrated with other medical services and included in the capitation rates certified by Milliman and approved by CMS for the period of January 1, 2009 through December 31, 2009. This certification reflects the development of a stand-alone capitation rate for pharmacy services. At the end of the one month period, it is anticipated that the pharmacy component will not be part of the risk based managed care program.

The capitation rates provided with this certification are considered actuarially sound, defined as:

- the capitation rates have been developed in accordance with generally accepted actuarial principles and practices;
- the capitation rates are appropriate for the populations to be covered, and the services to be furnished under the contract; and,
- the capitation rates meet the requirements of 42 CFR 438.6(c).

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This actuarial certification has been based on the actuarial methods, considerations, and analyses promulgated from time to time through the Actuarial Standards of Practice by the Actuarial Standards Board.

Robert M. Damler

Robert M. Damler, FSA
Member, American Academy of Actuaries

December 9, 2009
Date

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State of Ohio
Department of Job and Family Services
CFC Pharmacy Capitation Rate Summary (January 2010)

	Projected Jan 2010 Member Months	Jan 2010 Guaranteed Rate	Jan 2010 At Risk Rate	Jan 2010 Rate
Central				
HF/HST <1 M+F	15,258	$ 15.74	$ 0.15	$ 15.89
HF/HST 1 M+F	14,122	17.01	0.16	17.17
HF/HST 2-13 M+F	127,077	25.13	0.23	25.36
HF/HST 14-18 M	18,047	37.70	0.35	38.05
HF/HST 14-18 F	18,911	36.94	0.34	37.28
HF 19-44 M	15,553	62.83	0.58	63.41
HF 19-44 F	49,430	80.14	0.75	80.89
HF 45+ M+F	5,642	158.00	1.47	159.47
HST 19-64 F	3,386	37.27	0.35	37.62
Composite	267,426	$ 41.17	$ 0.38	$ 41.55
East Central				
HF/HST <1 M+F	8,379	$ 19.66	$ 0.18	$ 19.84
HF/HST 1 M+F	7,201	17.74	0.17	17.91
HF/HST 2-13 M+F	68,741	27.38	0.26	27.64
HF/HST 14-18 M	10,509	40.65	0.38	41.03
HF/HST 14-18 F	11,256	32.99	0.31	33.30
HF 19-44 M	8,550	44.10	0.41	44.51
HF 19-44 F	28,629	63.36	0.59	63.95
HF 45+ M+F	3,495	132.74	1.24	133.98
HST 19-64 F	1,912	33.50	0.31	33.81
Composite	148,672	$ 38.29	$ 0.36	$ 38.65
Northeast				
HF/HST <1 M+F	13,308	$ 17.78	$ 0.16	$ 17.94
HF/HST 1 M+F	11,941	17.10	0.16	17.26
HF/HST 2-13 M+F	117,799	25.06	0.23	25.29
HF/HST 14-18 M	19,459	29.50	0.27	29.77
HF/HST 14-18 F	20,702	29.33	0.27	29.60
HF 19-44 M	11,430	47.33	0.44	47.77
HF 19-44 F	48,809	65.15	0.60	65.75
HF 45+ M+F	6,753	137.07	1.27	138.34
HST 19-64 F	2,911	30.50	0.28	30.78
Composite	253,112	$ 36.78	$ 0.34	$ 37.12
Northeast Central				
HF/HST <1 M+F	3,523	$ 22.18	$ 0.21	$ 22.39
HF/HST 1 M+F	3,202	17.02	0.16	17.18
HF/HST 2-13 M+F	31,871	26.96	0.25	27.21
HF/HST 14-18 M	5,480	36.02	0.34	36.36
HF/HST 14-18 F	5,730	34.90	0.33	35.23
HF 19-44 M	3,898	54.57	0.51	55.08
HF 19-44 F	13,410	68.83	0.64	69.47
HF 45+ M+F	1,772	128.34	1.20	129.54
HST 19-64 F	915	39.50	0.37	39.87
Composite	69,801	$ 39.95	$ 0.37	$ 40.32
Northwest				
HF/HST <1 M+F	8,683	$ 24.38	$ 0.23	$ 24.61
HF/HST 1 M+F	7,206	20.97	0.20	21.17
HF/HST 2-13 M+F	64,525	26.13	0.24	26.37
HF/HST 14-18 M	9,350	36.44	0.34	36.78
HF/HST 14-18 F	9,867	33.49	0.31	33.80
HF 19-44 M	8,281	45.01	0.42	45.43
HF 19-44 F	26,534	67.27	0.63	67.90
HF 45+ M+F	2,835	137.17	1.28	138.45
HST 19-64 F	1,931	34.30	0.32	34.62
Composite	139,212	$ 38.31	$ 0.36	$ 38.66
Southeast				

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State of Ohio
Department of Job and Family Services
CFC Pharmacy Capitation Rate Summary (January 2010)

	Projected Jan 2010 Member Months	Jan 2010 Guaranteed Rate	Jan 2010 At Risk Rate	Jan 2010 Rate
HF/HST <1 M+F	4,702	$ 25.02	$ 0.23	$ 25.25
HF/HST 1 M+F	3,909	21.30	0.20	21.50
HF/HST 2-13 M+F	39,886	31.92	0.30	32.22
HF/HST 14-18 M	6,852	44.17	0.41	44.58
HF/HST 14-18 F	6,998	42.14	0.39	42.53
HF 19-44 M	7,233	56.97	0.53	57.50
HF 19-44 F	16,790	88.67	0.82	89.49
HF 45+ M+F	2,182	172.97	1.61	174.58
HST 19-64 F	981	39.31	0.37	39.68
Composite	89,533	$ 49.01	$ 0.46	$ 49.47
Southwest				
HF/HST <1 M+F	10,737	$ 10.09	$ 0.09	$ 10.18
HF/HST 1 M+F	9,125	14.74	0.14	14.88
HF/HST 2-13 M+F	80,231	26.09	0.24	26.33
HF/HST 14-18 M	10,819	39.30	0.37	39.67
HF/HST 14-18 F	11,943	35.84	0.33	36.17
HF 19-44 M	7,453	56.21	0.52	56.73
HF 19-44 F	29,686	67.03	0.63	67.66
HF 45+ M+F	3,175	154.70	1.44	156.14
HST 19-64 F	2,193	34.31	0.32	34.63
Composite	165,362	$ 37.28	$ 0.35	$ 37.63
West Central				
HF/HST <1 M+F	7,280	$ 15.49	$ 0.14	$ 15.63
HF/HST 1 M+F	6,209	17.33	0.16	17.49
HF/HST 2-13 M+F	56,030	27.64	0.26	27.90
HF/HST 14-18 M	7,956	45.97	0.43	46.40
HF/HST 14-18 F	8,687	39.56	0.37	39.93
HF 19-44 M	6,319	58.06	0.54	58.60
HF 19-44 F	22,440	75.48	0.70	76.18
HF 45+ M+F	2,512	158.18	1.47	159.65
HST 19-64 F	1,522	32.97	0.31	33.28
Composite	118,955	$ 41.92	$ 0.39	$ 42.31
Statewide				
HF/HST <1 M+F	71,870	$ 17.68	$ 0.16	$ 17.84
HF/HST 1 M+F	62,915	17.53	0.17	17.70
HF/HST 2-13 M+F	586,160	26.43	0.24	26.67
HF/HST 14-18 M	88,472	37.45	0.35	37.80
HF/HST 14-18 F	94,094	34.80	0.32	35.12
HF 19-44 M	68,717	53.53	0.50	54.03
HF 19-44 F	235,728	71.42	0.66	72.08
HF 45+ M+F	28,366	146.76	1.37	148.13
HST 19-64 F	15,751	34.63	0.32	34.95
Composite	1,252,073	$ 39.67	$ 0.37	$ 40.04

ENCLOSURE 3

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State of Ohio
Department of Job and Family Services
CFC Pharmacy Capitation Rate Development (January 2010)

	Projected Jan 2010	Encounter (Adjusted 2008)			Cost Report (Adj. 2008)	Projected Jan 2010	Admin Cost Allowance	Sales and Use Tax	HIC Tax	Total Capitation Rate
	Member Months	Util/1,000	CPS	PMPM	PMPM	PMPM	PMPM	PMPM	PMPM	PMPM
Central										
HF/HST <1 M+F	15,258	4,598.5	$ 31.51	$ 12.07	$ 13.76	$ 14.05	$ 0.60	$ 1.08	$ 0.16	$ 15.89
HF/HST 1 M+F	14,122	5,295.7	29.33	12.94	14.75	15.13	0.70	1.16	0.17	17.17
HF/HST 2-13 M+F	127,077	4,730.4	48.69	19.19	21.87	22.39	1.00	1.72	0.25	25.36
HF/HST 14-18 M	18,047	5,090.5	68.06	28.87	32.89	33.59	1.50	2.58	0.38	38.05
HF/HST 14-18 F	18,911	7,968.5	42.70	28.35	32.31	32.98	1.40	2.53	0.37	37.28
HF 19-44 M	15,553	12,187.4	47.73	48.48	55.22	56.08	2.40	4.30	0.63	63.41
HF 19-44 F	49,430	18,520.8	40.02	61.77	70.36	71.50	3.10	5.48	0.81	80.89
HF 45+ M+F	5,642	32,191.6	45.43	121.87	138.73	140.96	6.10	10.81	1.59	159.47
HST 19-64 F	3,386	11,883.1	29.12	28.84	32.86	33.29	1.40	2.55	0.38	37.62
Composite	267,426	8,658.6	$ 45.60	$ 31.62	$ 36.02	$ 36.71	$ 1.61	$ 2.82	$ 0.41	$ 41.55
East Central										
HF/HST <1 M+F	8,379	4,878.2	$ 39.07	$ 15.88	$ 15.95	$ 17.54	$ 0.80	$ 1.30	$ 0.20	$ 19.84
HF/HST 1 M+F	7,201	5,835.4	29.41	14.30	14.36	15.86	0.70	1.17	0.18	17.91
HF/HST 2-13 M+F	68,741	5,015.9	52.89	22.11	22.19	24.46	1.10	1.81	0.28	27.64
HF/HST 14-18 M	10,509	5,453.1	72.50	32.95	33.07	36.34	1.60	2.68	0.41	41.03
HF/HST 14-18 F	11,256	7,793.2	41.20	26.76	26.86	29.49	1.30	2.18	0.33	33.30
HF 19-44 M	8,550	10,280.0	42.03	36.01	36.14	39.45	1.70	2.91	0.45	44.51
HF 19-44 F	28,629	16,659.5	37.22	51.67	51.86	56.63	2.50	4.18	0.64	63.95
HF 45+ M+F	3,495	29,969.8	43.35	108.27	108.48	118.68	5.20	8.76	1.34	133.98
HST 19-64 F	1,912	12,216.0	26.91	27.39	27.51	29.96	1.30	2.21	0.34	33.81
Composite	148,672	8,513.1	$ 47.27	$ 31.08	$ 31.20	$ 34.22	$ 1.52	$ 2.53	$ 0.39	$ 38.65
Northeast										
HF/HST <1 M+F	13,308	4,575.4	$ 37.10	$ 14.15	$ 14.36	$ 15.74	$ 0.70	$ 1.32	$ 0.18	$ 17.94
HF/HST 1 M+F	11,941	5,457.8	29.83	13.57	13.78	15.12	0.70	1.27	0.17	17.26
HF/HST 2-13 M+F	117,799	4,206.8	56.82	19.92	20.23	22.18	1.00	1.86	0.25	25.29
HF/HST 14-18 M	19,459	4,219.2	66.97	23.55	23.90	26.18	1.10	2.19	0.30	29.77
HF/HST 14-18 F	20,702	6,630.5	42.41	23.43	23.79	26.03	1.10	2.18	0.30	29.60
HF 19-44 M	11,430	9,595.0	47.58	38.04	38.54	41.98	1.80	3.51	0.48	47.77
HF 19-44 F	48,809	15,312.1	40.96	52.27	53.04	57.76	2.50	4.83	0.66	65.75
HF 45+ M+F	6,753	27,974.0	47.18	109.98	111.52	121.49	5.30	10.17	1.38	138.34
HST 19-64 F	2,911	10,400.5	28.27	24.50	24.88	27.01	1.20	2.26	0.31	30.78
Composite	253,112	7,574.5	$ 50.05	$ 29.40	$ 29.83	$ 32.59	$ 1.43	$ 2.73	$ 0.37	$ 37.12
Northeast Central										
HF/HST <1 M+F	3,523	6,249.5	$ 35.40	$ 18.44	$ 17.07	$ 19.76	$ 0.90	$ 1.50	$ 0.22	$ 22.39
HF/HST 1 M+F	3,202	6,601.7	25.69	14.13	13.09	15.16	0.70	1.15	0.17	17.18
HF/HST 2-13 M+F	31,871	5,277.2	51.04	22.45	20.79	24.11	1.00	1.83	0.27	27.21
HF/HST 14-18 M	5,480	5,692.0	63.32	30.03	27.81	32.16	1.40	2.44	0.36	36.36
HF/HST 14-18 F	5,730	8,404.2	41.56	29.11	26.96	31.11	1.40	2.36	0.35	35.23
HF 19-44 M	3,898	11,545.6	47.57	45.77	42.39	48.73	2.10	3.70	0.55	55.08
HF 19-44 F	13,410	17,270.4	40.10	57.71	53.45	61.41	2.70	4.66	0.69	69.47
HF 45+ M+F	1,772	30,781.0	42.00	107.73	99.44	114.55	5.00	8.69	1.30	129.54
HST 19-64 F	915	11,938.4	33.47	33.30	30.83	35.30	1.50	2.68	0.40	39.87
Composite	69,801	9,065.2	$ 46.52	$ 33.39	$ 30.91	$ 35.67	$ 1.54	$ 2.71	$ 0.40	$ 40.32

FINAL AND CONFIDENTIAL

State of Ohio
Department of Job and Family Services
CFC Pharmacy Capitation Rate Development (January 2010)

	Projected Jan 2010	Encounter (Adjusted 2008)			Cost Report (Adj. 2008)	Projected Jan 2010	Admin Cost Allowance	Sales and Use Tax	HIC Tax	Total Capitation Rate
	Member Months	Util/1,000	CPS	PMPM	PMPM	PMPM	PMPM	PMPM	PMPM	PMPM
Northwest										
HF/HST <1 M+F	8,683	5,028.4	$ 47.23	$ 19.79	$ 19.71	$ 21.80	$ 0.90	$ 1.66	$ 0.25	$ 24.61
HF/HST 1 M+F	7,206	5,769.4	35.25	16.95	16.88	18.73	0.80	1.43	0.21	21.17
HF/HST 2-13 M+F	64,525	4,605.2	54.99	21.10	21.02	23.33	1.00	1.78	0.26	26.37
HF/HST 14-18 M	9,350	4,982.1	71.06	29.50	29.38	32.53	1.40	2.48	0.37	36.78
HF/HST 14-18 F	9,867	7,611.7	42.78	27.14	27.03	29.88	1.30	2.28	0.34	33.80
HF 19-44 M	8,281	10,319.6	42.73	36.75	36.57	40.21	1.70	3.07	0.45	45.43
HF 19-44 F	26,534	16,436.3	40.04	54.84	54.61	60.04	2.60	4.58	0.68	67.90
HF 45+ M+F	2,835	30,229.0	44.37	111.77	111.18	122.42	5.30	9.35	1.38	138.45
HST 19-64 F	1,931	11,964.8	28.18	28.10	27.98	30.64	1.30	2.34	0.35	34.62
Composite	139,212	8,149.1	$ 49.53	$ 31.10	$ 30.97	$ 34.20	$ 1.47	$ 2.61	$ 0.39	$ 38.66
Southeast										
HF/HST <1 M+F	4,702	6,467.5	$ 36.78	$ 19.82	$ 20.71	$ 22.24	$ 1.00	$ 1.75	$ 0.25	$ 25.25
HF/HST 1 M+F	3,909	7,527.7	26.91	16.88	17.64	18.99	0.80	1.49	0.22	21.50
HF/HST 2-13 M+F	39,886	6,692.1	45.30	25.26	26.40	28.46	1.20	2.24	0.32	32.22
HF/HST 14-18 M	6,852	6,712.6	62.66	35.05	36.63	39.34	1.70	3.10	0.45	44.58
HF/HST 14-18 F	6,998	10,287.7	39.08	33.50	35.01	37.55	1.60	2.96	0.43	42.53
HF 19-44 M	7,233	14,078.7	38.80	45.52	47.52	50.73	2.20	4.00	0.58	57.50
HF 19-44 F	16,790	22,433.0	37.89	70.83	74.03	78.98	3.40	6.22	0.89	89.49
HF 45+ M+F	2,182	35,820.5	46.25	138.06	144.08	154.00	6.70	12.13	1.75	174.58
HST 19-64 F	981	15,565.5	24.29	31.51	32.92	35.03	1.50	2.76	0.40	39.68
Composite	89,533	11,355.1	$ 42.77	$ 39.00	$ 40.75	$ 43.67	$ 1.87	$ 3.44	$ 0.49	$ 49.47
Southwest										
HF/HST <1 M+F	10,737	4,521.9	$ 21.65	$ 8.16	$ 8.19	$ 9.01	$ 0.40	$ 0.66	$ 0.10	$ 10.18
HF/HST 1 M+F	9,125	5,354.8	26.65	11.89	11.94	13.16	0.60	0.97	0.15	14.88
HF/HST 2-13 M+F	80,231	4,630.4	54.74	21.12	21.21	23.35	1.00	1.72	0.26	26.33
HF/HST 14-18 M	10,819	5,178.7	73.91	31.90	32.00	35.19	1.50	2.59	0.40	39.67
HF/HST 14-18 F	11,943	7,705.0	45.26	29.06	29.18	32.05	1.40	2.36	0.36	36.17
HF 19-44 M	7,453	12,332.0	44.61	45.84	46.03	50.26	2.20	3.70	0.57	56.73
HF 19-44 F	29,686	16,653.2	39.40	54.68	54.87	59.97	2.60	4.41	0.68	67.66
HF 45+ M+F	3,175	31,481.6	48.11	126.21	126.55	138.40	6.00	10.18	1.56	156.14
HST 19-64 F	2,193	12,470.3	27.02	28.08	28.19	30.73	1.30	2.26	0.35	34.63
Composite	165,362	8,046.2	$ 47.91	$ 30.30	$ 30.41	$ 33.35	$ 1.44	$ 2.45	$ 0.38	$ 37.63
West Central										
HF/HST <1 M+F	7,280	5,327.4	$ 28.06	$ 12.46	$ 12.58	$ 13.79	$ 0.60	$ 1.09	$ 0.16	$ 15.63
HF/HST 1 M+F	6,209	5,913.9	28.16	13.88	14.02	15.40	0.70	1.22	0.17	17.49
HF/HST 2-13 M+F	56,030	5,144.8	51.75	22.19	22.41	24.58	1.10	1.94	0.28	27.90
HF/HST 14-18 M	7,956	5,714.3	77.73	37.01	37.39	40.91	1.80	3.22	0.46	46.40
HF/HST 14-18 F	8,687	8,496.3	45.09	31.92	32.24	35.26	1.50	2.78	0.40	39.93
HF 19-44 M	6,319	12,184.0	46.47	47.18	47.61	51.74	2.20	4.07	0.59	58.60
HF 19-44 F	22,440	18,178.1	40.40	61.20	61.79	67.22	2.90	5.29	0.76	76.18
HF 45+ M+F	2,512	32,775.5	46.93	128.18	129.37	140.86	6.10	11.10	1.60	159.65
HST 19-64 F	1,522	13,111.0	24.48	26.75	26.99	29.33	1.30	2.31	0.33	33.28
Composite	118,955	8,996.9	$ 47.45	$ 33.85	$ 34.17	$ 37.32	$ 1.63	$ 2.94	$ 0.42	$ 42.31

ENCLOSURE 4

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for ODJFS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this letter must rely upon their own experts in drawing conclusions about the capitation rates, assumptions, and trends.

FINAL AND CONFIDENTIAL

State of Ohio
Department of Job and Family Services
CFC Capitation Rate Summary - Combined Medical and Pharmacy (January 2010)

Region	Rate Group	Projected Jan 2010 MMs/Deliveries	Jan 2010 Medical Capitation	Jan 2010 Pharmacy Capitation	Jan 2010 Total Capitation
Central	HF/HST <1 M+F	15,258	$ 602.30	$ 15.89	$ 618.19
Central	HF/HST 1 M+F	14,122	142.05	17.17	159.22
Central	HF/HST 2-13 M+F	127,077	87.78	25.36	113.14
Central	HF/HST 14-18 M	18,047	107.02	38.05	145.07
Central	HF/HST 14-18 F	18,911	160.58	37.28	197.86
Central	HF 19-44 M	15,553	224.28	63.41	287.69
Central	HF 19-44 F	49,430	320.91	80.89	401.80
Central	HF 45+ M+F	5,642	473.10	159.47	632.57
Central	HST 19-64 F	3,386	451.07	37.62	488.69
Central	Composite Non-Delivery	267,426	190.21	41.55	231.76
Central	Delivery CFC	962	4,232.27	-	4,232.27
Central	Composite with Delivery	267,426	$ 205.44	$ 41.55	$ 246.99
East Central	HF/HST <1 M+F	8,379	$ 573.65	$ 19.84	$ 593.49
East Central	HF/HST 1 M+F	7,201	135.30	17.91	153.21
East Central	HF/HST 2-13 M+F	68,741	83.61	27.64	111.25
East Central	HF/HST 14-18 M	10,509	101.94	41.03	142.97
East Central	HF/HST 14-18 F	11,256	152.95	33.30	186.25
East Central	HF 19-44 M	8,550	213.63	44.51	258.14
East Central	HF 19-44 F	28,629	305.66	63.95	369.61
East Central	HF 45+ M+F	3,495	450.64	133.98	584.62
East Central	HST 19-64 F	1,912	429.67	33.81	463.48
East Central	Composite Non-Delivery	148,672	183.59	38.65	222.24
East Central	Delivery CFC	575	4,768.34	-	4,768.34
East Central	Composite with Delivery	148,672	$ 202.05	$ 38.65	$ 240.70
Northeast	HF/HST <1 M+F	13,308	$ 565.76	$ 17.94	$ 583.70
Northeast	HF/HST 1 M+F	11,941	133.42	17.26	150.68
Northeast	HF/HST 2-13 M+F	117,799	82.45	25.29	107.74
Northeast	HF/HST 14-18 M	19,459	100.53	29.77	130.30
Northeast	HF/HST 14-18 F	20,702	150.83	29.60	180.43
Northeast	HF 19-44 M	11,430	210.68	47.77	258.45
Northeast	HF 19-44 F	48,809	301.42	65.75	367.17
Northeast	HF 45+ M+F	6,753	444.41	138.34	582.75
Northeast	HST 19-64 F	2,911	423.70	30.78	454.48
Northeast	Composite Non-Delivery	253,112	178.85	37.12	215.97
Northeast	Delivery CFC	861	4,753.44	-	4,753.44
Northeast	Composite with Delivery	253,112	$ 195.03	$ 37.12	$ 232.15
Northeast Central	HF/HST <1 M+F	3,523	$ 608.83	$ 22.39	$ 631.22
Northeast Central	HF/HST 1 M+F	3,202	143.60	17.18	160.78
Northeast Central	HF/HST 2-13 M+F	31,871	88.73	27.21	115.94
Northeast Central	HF/HST 14-18 M	5,480	108.19	36.36	144.55
Northeast Central	HF/HST 14-18 F	5,730	162.34	35.23	197.57
Northeast Central	HF 19-44 M	3,898	226.72	55.08	281.80
Northeast Central	HF 19-44 F	13,410	324.37	69.47	393.84
Northeast Central	HF 45+ M+F	1,772	478.28	129.54	607.82
Northeast Central	HST 19-64 F	915	456.00	39.87	495.87
Northeast Central	Composite Non-Delivery	69,801	192.75	40.32	233.07
Northeast Central	Delivery CFC	225	4,510.62	-	4,510.62
Northeast Central	Composite with Delivery	69,801	$ 207.26	$ 40.32	$ 247.58
Northwest	HF/HST <1 M+F	8,683	$ 583.07	$ 24.61	$ 607.68
Northwest	HF/HST 1 M+F	7,206	137.50	21.17	158.67
Northwest	HF/HST 2-13 M+F	64,525	84.98	26.37	111.35
Northwest	HF/HST 14-18 M	9,350	103.60	36.78	140.38
Northwest	HF/HST 14-18 F	9,867	155.46	33.80	189.26
Northwest	HF 19-44 M	8,281	217.12	45.43	262.55
Northwest	HF 19-44 F	26,534	310.63	67.90	378.53
Northwest	HF 45+ M+F	2,835	457.96	138.45	596.41
Northwest	HST 19-64 F	1,931	436.66	34.62	471.28
Northwest	Composite Non-Delivery	139,212	188.35	38.66	227.01
Northwest	Delivery CFC	568	4,405.28	-	4,405.28
Northwest	Composite with Delivery	139,212	$ 206.32	$ 38.66	$ 244.98

FINAL AND CONFIDENTIAL

State of Ohio
Department of Job and Family Services
CFC Capitation Rate Summary - Combined Medical and Pharmacy (January 2010)

Region	Rate Group	Projected Jan 2010 MMs/Deliveries	Jan 2010 Medical Capitation	Jan 2010 Pharmacy Capitation	Jan 2010 Total Capitation
Southeast	HF/HST <1 M+F	4,702	$ 560.73	$ 25.25	$ 585.98
Southeast	HF/HST 1 M+F	3,909	132.23	21.50	153.73
Southeast	HF/HST 2-13 M+F	39,886	81.72	32.22	113.94
Southeast	HF/HST 14-18 M	6,852	99.64	44.58	144.22
Southeast	HF/HST 14-18 F	6,998	149.51	42.53	192.04
Southeast	HF 19-44 M	7,233	208.82	57.50	266.32
Southeast	HF 19-44 F	16,790	298.73	89.49	388.22
Southeast	HF 45+ M+F	2,182	440.45	174.58	615.03
Southeast	HST 19-64 F	981	419.98	39.68	459.66
Southeast	Composite Non-Delivery	89,533	179.16	49.47	228.63
Southeast	Delivery CFC	302	3,972.00	-	3,972.00
Southeast	Composite with Delivery	89,533	$ 192.58	$ 49.47	$ 242.05
Southwest	HF/HST <1 M+F	10,737	$ 649.98	$ 10.18	$ 660.16
Southwest	HF/HST 1 M+F	9,125	153.29	14.88	168.17
Southwest	HF/HST 2-13 M+F	80,231	94.73	26.33	121.06
Southwest	HF/HST 14-18 M	10,819	115.50	39.67	155.17
Southwest	HF/HST 14-18 F	11,943	173.31	36.17	209.48
Southwest	HF 19-44 M	7,453	242.05	56.73	298.78
Southwest	HF 19-44 F	29,686	346.28	67.66	413.94
Southwest	HF 45+ M+F	3,175	510.55	156.14	666.69
Southwest	HST 19-64 F	2,193	486.81	34.63	521.44
Southwest	Composite Non-Delivery	165,362	206.03	37.63	243.66
Southwest	Delivery CFC	682	4,823.78	-	4,823.78
Southwest	Composite with Delivery	165,362	$ 225.91	$ 37.63	$ 263.54
West Central	HF/HST <1 M+F	7,280	$ 591.91	$ 15.63	$ 607.54
West Central	HF/HST 1 M+F	6,209	139.58	17.49	157.07
West Central	HF/HST 2-13 M+F	56,030	86.26	27.90	114.16
West Central	HF/HST 14-18 M	7,956	105.18	46.40	151.58
West Central	HF/HST 14-18 F	8,687	157.82	39.93	197.75
West Central	HF 19-44 M	6,319	220.41	58.60	279.01
West Central	HF 19-44 F	22,440	315.35	76.18	391.53
West Central	HF 45+ M+F	2,512	464.92	159.65	624.57
West Central	HST 19-64 F	1,522	443.28	33.28	476.56
West Central	Composite Non-Delivery	118,955	189.38	42.31	231.69
West Central	Delivery CFC	473	5,057.19	-	5,057.19
West Central	Composite with Delivery	118,955	$ 209.47	$ 42.31	$ 251.78
Statewide	HF/HST <1 M+F	71,870	$ 593.54	$ 17.84	$ 611.38
Statewide	HF/HST 1 M+F	62,915	139.97	17.70	157.67
Statewide	HF/HST 2-13 M+F	586,160	86.36	26.67	113.03
Statewide	HF/HST 14-18 M	88,472	105.00	37.80	142.80
Statewide	HF/HST 14-18 F	94,094	157.63	35.12	192.75
Statewide	HF 19-44 M	68,717	219.91	54.03	273.94
Statewide	HF 19-44 F	235,728	315.15	72.08	387.23
Statewide	HF 45+ M+F	28,366	463.27	148.13	611.40
Statewide	HST 19-64 F	15,751	444.22	34.95	479.17
Statewide	Composite Non-Delivery	1,252,073	188.28	40.04	228.32
Statewide	Delivery CFC	4,648	4,583.44	-	4,583.44
Statewide	Composite with Delivery	1,252,073	$ 205.30	$ 40.04	$ 245.34

MCP:

APPENDIX F

ABD REGIONAL RATES

PREMIUM RATES WITH AT-RISK AMOUNTS

An MCP will be put at-risk for a portion (1%) of the premiums received for members beginning with the MCP's twenty-fifth month of membership in each region. The at-risk amount will be determined separately for each region that an MCP serves and will be shared with individual plans through the plan specific ABD rate letters prepared by the ODJFS actuary. The status of an MCP's at-risk amount is determined in accordance with Appendix O of this provider agreement.

Should the amount of the premium at-risk change due to plan specific risk adjusted rates, ODJFS will notify the MCP through the risk adjusted plan specific letters prepared by the state's actuary and the new at-risk amount shall be incorporated into this provider agreement without further process or execution.

MCP:

APPENDIX F

CFC REGIONAL RATES

Please refer to Appendix E of the Provider Agreement to review the specific rates for this time period.

An at-risk amount of 1% is applied to the MCP rates. The status of the at-risk amount is determined in accordance with Appendix O, *Pay-for-Performance (P4P).*

MCPs will be put at-risk for a portion of the premiums received for members in regions they serve beginning with the MCP's twenty-fifth month of membership in each region. The at-risk amount will be determined separately for each region an MCP serves.

MCP regions at-risk:

APPENDIX G

COVERAGE AND SERVICES

1. Basic Benefit Package

Pursuant to OAC rule 5101:3-26-03(A), with limited exclusions (see section G.2 of this appendix), MCPs must ensure that members have access to medically-necessary services covered by the Ohio Medicaid fee-for-service (FFS) program, and any additional services as specified in OAC rule 5101:3-26-03. For information on Medicaid-covered services, MCPs must refer to the ODJFS website. The following is a general list of the benefits covered by the FFS program:

- Inpatient hospital services
- Outpatient hospital services
- Rural health clinics (RHCs) and federally qualified health centers (FQHCs)
- Physician services whether furnished in the physician's office, the covered person's home, a hospital, or elsewhere
- Laboratory and x-ray services
- Screening, diagnosis, and treatment services to children under the age of twenty-one (21) under the HealthChek, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program
- Family planning services and supplies
- Home health and private duty nursing services
- Podiatry
- Chiropractic services
- Physical therapy, occupational therapy, developmental therapy, and speech therapy
- Nurse-midwife, certified family nurse practitioner, and certified pediatric nurse practitioner services
- Prescription drugs
- Ambulance and ambulette services

- Dental services
- Durable medical equipment and medical supplies
- Vision care services, including eyeglasses
- Nursing facility stays as specified in OAC rule 5101:3-26-03
- Hospice care
- Behavioral health services (see section G.2.b.iii of this appendix)
- Immunizations

2. Exclusions, Limitations and Clarifications

a. Exclusions

MCPs are not required to pay for FFS program non-covered services, except as specified in OAC rule 5101:3-26-03. For information regarding Medicaid noncovered services, MCPs must refer to the ODJFS website. The following is a general list of the services not covered by the FFS program:

- Services or supplies that are not medically necessary
- Experimental services and procedures, including drugs and equipment, not covered by Medicaid, and not in accordance with customary standards of practice.
- Abortions, except in the case of a reported rape, incest, or when medically necessary to save the life of the mother
- Infertility services for males or females
- Voluntary sterilization if under 21 years of age or legally incapable of consenting to the procedure
- Reversal of voluntary sterilization procedures
- Plastic or cosmetic surgery that is not medically necessary*
- Treatment of obesity unless medically necessary*
- Custodial or supportive care not covered by Medicaid

- Sexual or marriage counseling
- Acupuncture and biofeedback services
- Services to find cause of death (autopsy) or services related to forensic studies.
- Comfort items in the hospital (e.g., TV or phone)
- Paternity testing
- Services determined by another third-party payor as not medically necessary.
- Assisted suicide which are services for the purpose of causing, or assisting to cause, the death of an individual. This does not pertain to withholding or withdrawing of medical treatment of care, nutrition or hydration or to the provision of a service for the purpose of alleviating pain or discomfort, even if the use may increase the risk of death, so long as the service is not furnished for the specific purpose of causing death.
- Patient convenience items, including television services.

MCPs are also not required to pay for non-emergency services or supplies received without members following the directions in their MCP member handbook, unless otherwise directed by ODJFS.

*****These services could be deemed medically necessary if medical complications/conditions in addition to the obesity or physical imperfection are present.

b. Limitations & Clarifications

i. Member Cost-Sharing

As specified in OAC rules 5101:3-26-05(D) and 5101:3-26-12, MCPs are permitted to impose the applicable member co-payment amount(s) for dental services, vision services, non-emergency emergency department services, or prescription drugs, other than generic drugs. MCPs must notify ODJFS if they intend to impose a co-payment. ODJFS must approve the notice to be sent to the MCP's members and the timing of when the co-payments will begin to be imposed. If ODJFS determines that an MCP's decision to impose a particular co-payment on their members would constitute a significant change for those members, ODJFS may require the effective date of the co-payment to coincide with the "Open Enrollment" month.

Notwithstanding the preceding paragraph, MCPs must provide an ODJFS-approved notice to all their members 90 days in advance of the date that the MCP will impose the co-payment. With the exception of member co-payments the

MCP has elected to implement in accordance with OAC rules 5101:3-26-05(D) and 5101:3-26-12, the MCP's payment constitutes payment in full for any covered services and their subcontractors must not charge members or ODJFS any additional co-payment, cost sharing, down-payment, or similar charge, refundable or otherwise.

ii. Abortion and Sterilization

The use of federal funds to pay for abortion and sterilization services is prohibited unless the specific criteria found in 42 CFR 441 and OAC rules 5101:3-17-01 and 5101:3-21-01 are met. MCPs must verify that all of the information on the required forms (JFS 03197, 03198, and 03199) is provided and that the service meets the required criteria before any such claim is paid.

Additionally, payment must not be made for associated services such as anesthesia, laboratory tests, or hospital services if the abortion or sterilization itself does not qualify for payment. MCPs are responsible for educating their providers on the requirements; implementing internal procedures including systems edits to ensure that claims are only paid once the MCP has determined if the applicable forms are completed and the required criteria are met, as confirmed by the appropriate certification/consent forms; and for maintaining documentation to justify any such claim payments.

iii. Behavioral Health Services

Coordination of Services: MCPs must have a process to coordinate benefits of and referrals to the publicly funded community behavioral health system. MCPs must ensure that members have access to all medically-necessary behavioral health services covered by the FFS program and are responsible for coordinating those services with other medical and support services. MCPs must notify members via the member handbook and provider directory of where and how to access behavioral health services, including the ability to self-refer to mental health services offered through ODMH community mental health centers (CMHCs) as well as substance abuse services offered through Ohio Department of Alcohol and Drug Addiction Services (ODADAS)-certified Medicaid providers. Pursuant to ORC Section 5111.16, alcohol, drug addiction and mental health services covered by Medicaid are not to be paid by the managed care program when the non-federal share of the cost of those services is provided by a board of alcohol, drug addiction, and mental health services or a state agency other than ODJFS. MCPs are also not responsible for providing mental health services to persons between 22 and 64 years of age while residing in an institution for mental disease (IMD) as defined in Section 1905(i) of the Social Security Act.

MCPs must provide Medicaid-covered behavioral health services for members who are unable to timely access services or are unwilling to access services through community providers.

Mental Health Services: There are a number of Medicaid-covered mental health (MH) services available through ODMH CMHCs.

Where an MCP is responsible for providing MH services for their members, the MCP is responsible for ensuring access to counseling and psychotherapy, physician/psychologist/psychiatrist services, outpatient clinic services, general hospital outpatient psychiatric services, pre-hospitalization screening, diagnostic assessment (clinical evaluation), crisis intervention, psychiatric hospitalization in general hospitals (for all ages), and Medicaid-covered prescription drugs and laboratory services. MCPs are not required to cover partial hospitalization, or inpatient psychiatric care in a private or public free-standing psychiatric hospital. However, MCPs are required to cover the payment of physician services in a private or public free-standing psychiatric hospital when such services are billed independent of the hospital. The payment of physician services in an IMD is also covered by the MCPs, as long as the member is 21 years of age and under or 65 years of age and older.

Substance Abuse Services: There are a number of Medicaid-covered substance abuse services available through ODADAS-certified Medicaid providers.

Where an MCP is responsible for providing substance abuse services for their members, the MCP is responsible for ensuring access to alcohol and other drug (AOD) urinalysis screening, assessment, counseling, physician/psychologist/psychiatrist AOD treatment services, outpatient clinic AOD treatment services, general hospital outpatient AOD treatment services, crisis intervention, inpatient detoxification services in a general hospital, and Medicaid-covered prescription drugs and laboratory services. MCPs are not required to cover outpatient detoxification, intensive outpatient programs (IOP) or methadone maintenance.

Financial Responsibility for Behavioral Health Services: MCPs are responsible for the following:

- Payment of Medicaid-covered prescription drugs prescribed by an ODMH CMHC or ODADAS-certified provider when obtained through an MCP's panel pharmacy;

- Payment of Medicaid-covered services provided by an MCP's panel laboratory when referred by an ODMH CMHC or ODADAS-certified provider;

- Payment of all other Medicaid-covered behavioral health services obtained through providers other than those who are ODMH CMHCs or ODADAS-certified providers when arranged/authorized by the MCP.

Limitations:

- Pursuant to ORC Section 5111.16, alcohol, drug addiction and mental health services covered by Medicaid are not to be paid by the managed care program when the non-federal share of the cost of those services is provided by a board of alcohol, drug addiction, and mental health services or a state agency other than ODJFS. As part of this limitation:

- MCPs are not responsible for paying for behavioral health services provided through ODMH CMHCs and ODADAS-certified Medicaid providers;

- MCPs are not responsible for payment of partial hospitalization (mental health), inpatient psychiatric care in a private or public free-standing inpatient psychiatric hospital, outpatient detoxification, intensive outpatient programs (IOP) (substance abuse) or methadone maintenance.

- MCPs are required to cover the payment of physician services in a private or public free-standing psychiatric hospital when such services are billed independent of the hospital.

iv. Pharmacy Benefit: In providing the Medicaid pharmacy benefit to their members, MCPs must cover the same drugs covered by the FFS program, in accordance with OAC rule 5101:3-26-03(A) and (B).

Pursuant to ORC Section 5111.172, MCPs may, subject to ODJFS approval, implement strategies for the management of drug utilization. (See appendix G.3.iv.a).

v. Organ Transplants: MCPs must ensure coverage for organ transplants and related services in accordance with OAC 5101-3-2- 07.1 (B)(4)&(5). Coverage for all organ transplant services, except kidney transplants, is contingent upon review and recommendation by the "Ohio Solid Organ Transplant Consortium" based on criteria established by Ohio organ transplant surgeons and authorization from the ODJFS prior authorization unit. Reimbursement for bone marrow transplant and hematapoietic stem cell transplant services, as defined in OAC 3701:84-01, is contingent upon review and recommendation by the "Ohio Hematapoietic Stem Cell Transplant Consortium" again based on criteria established by Ohio experts in the field of bone marrow transplant. While MCPs may require prior authorization for these transplant services, the approval criteria would be limited to confirming the consumer is being considered and/or has been recommended for a transplant by either consortium and authorized by ODJFS. Additionally, in

accordance with OAC 5101:3-2-03 (A)(4) all services related to organ donations are covered for the donor recipient when the consumer is Medicaid eligible.

3. Health Management Programs

In an effort to improve access, quality, and continuity of care for MCP members, each MCP must:

i. Establish a primary care provider (PCP) for each member and encourage the member to have an ongoing relationship with the PCP. For this requirement, a PCP as defined in OAC 5101:3-26-01, serves as the ongoing source of primary and preventive care; assists with coordination of care as appropriate for the member's health care needs; recommends referrals to specialists for the member; triages the member appropriately; notifies the MCP of a member who may benefit from care management services; and participates in development of the Care Management care treatment plan. The MCP must ensure the PCP agrees to perform the care coordination responsibilities as outlined in OAC 5101: 3-26-03.1.

ii. Provide education and outreach to each member to emphasize the importance of disease prevention and health/wellness promotion. The MCP must encourage and enable the member to make informed decisions about accessing and utilizing health care services appropriately.

iii. Direct and monitor coordination of care efforts for each member for medical services delivered across the continuum of care. The MCP should incorporate the requirements in Sections 3 c, d, and e in its overall strategy for care coordination.

iv. Develop and implement a strategy to identify members who display risk factors for developing a disease and/or who over-/under-utilize health care services, and would benefit from targeted outreach or education. For this requirement, the MCP must implement mechanisms to identify such members and should include the following information sources: administrative data review (e.g., pharmacy claims, emergency department claims, or inpatient hospital admissions), provider/self referrals, telephone interviews, home visits, referrals resulting from internal MCP operations, and data as reported by the MCEC during membership selection. Should the MCP identify members characterized as having an increased risk for developing a disease or who inappropriately utilize health care services, the MCP must offer education and outreach initiatives (e.g., educational mailing) designed to mitigate the risk factors, and prevent the member from requiring more progressive interventions, such as care management services.

v. Implement Utilization Management Programs as outlined in Section 3.a. to maximize effectiveness of care provided to members.

vi. Each MCP must implement a Care Management Program as outlined in Section 3.b. which coordinates and monitors the care for members with special health care needs. The Care Management Program must be designed to ensure the intensity of interventions provided by the MCP corresponds to the member's level of need.

a. Utilization Management Programs

General Provisions - Pursuant to OAC rule 5101:3-26-03.1(A)(7), MCPs must implement a utilization management (UM) program to maximize the effectiveness of the care provided to members and may develop other UM programs, subject to prior approval by ODJFS. For the purposes of this requirement, the specific UM programs which require ODJFS prior-approval are an MCP's general pharmacy program, a controlled substances and member management program, and any other program designed by the MCP with the purpose of redirecting or restricting access to a particular service or service location.

i. Pharmacy Programs - Pursuant to ORC Sec. 5111.172, MCPs may, subject to ODJFS prior-approval, implement strategies for the management of drug utilization. Pharmacy utilization management strategies may include developing preferred drug lists, requiring PA of certain drugs, placing limitations on the type of provider and locations where certain medications may be administered, and developing and implementing a specialized pharmacy program to address the utilization of controlled substances, as defined in section 3719.01 of the ORC. MCPs may also implement a retrospective drug utilization review program designed to promote the appropriate clinical prescribing of covered drugs.

Drug Prior Authorizations - MCPs must receive prior approval from ODJFS for the medications that they wish to cover through PA. MCPs must establish their PA system so that it does not unnecessarily impede member access to medically-necessary Medicaid-covered services. As outlined in paragraph 29.i.g. of Appendix C, MCPs must adhere to specific PA limitations to assist with the transition of new ABD members from FFS Medicaid. MCPs must make their approved list of drugs covered only with PA available to members and providers, as outlined in paragraphs 37(b) and (c) of Appendix C.

While MCPs may, with ODJFS approval, require PA for the coverage of 2nd generation antipsychotic drugs, MCPs must allow any member to continue receiving a specific 2nd generation antipsychotic drug if the member is stabilized on that particular medication. The MCP must continue to cover that specific antipsychotic for the stabilized member

for as long as that medication continues to be effective for the member. MCPs must exempt from PA those 2nd generation antipsychotics without an available generic or bio-equivalent when prescribed for ABD members by contracting psychiatrists and ODMH-identified CMHC psychiatrists. MCPs must also collaborate with ODJFS in the retrospective review of 2nd generation antipsychotic utilization.

MCPs must comply with the provisions of 1927(d)(5) of the Social Security Act, 42 USC 1396r-8(k)(3), and OAC rule 5101:3-26-03.1 regarding the timeframes for prior authorization of covered outpatient drugs.

Controlled Substances and Member Management Programs: MCPs may also, with ODJFS prior approval, develop and implement Controlled Substances and Member Management (CSMM) programs designed to address use of controlled substances. Utilization management strategies may include PA as a condition of obtaining a controlled substance, as defined in section 3719.01 of the ORC. CSMM strategies may also include processes for requiring MCP members at high risk for fraud or abuse involving controlled substances to have their controlled substances prescribed by designated provider/providers and filled by a pharmacy, medical provider, or health care facility designated by the program.

ii. Emergency Department Diversion (EDD) – MCPs must provide access to services in a way that assures access to primary, specialist and urgent care in the most appropriate settings and that minimizes frequent, preventable utilization of emergency department (ED) services. OAC rule 5101:3-26-03.1(A)(7)(d) requires MCPs to implement the ODJFS-required EDD program for frequent utilizers.

Each MCP must establish an ED diversion (EDD) program with the goal of minimizing frequent ED utilization. The MCP's EDD program must include the monitoring of ED utilization, identification of frequent ED utilizers, and targeted approaches designed to reduce avoidable ED utilization. MCP EDD programs must, at a minimum, address those ED visits which could have been prevented through improved education, access, quality, or care management approaches.

Although there is often an assumption that frequent ED visits are solely the result of a preference on the part of the member and education is therefore the standard remedy, it is also important to

ensure that a member's frequent ED utilization is not due to problems such as their PCP's lack of accessibility or failure to make appropriate specialist referrals. The MCP's EDD program must therefore also include the identification of providers who serve as PCPs for a substantial number of frequent ED utilizers and the implementation of corrective action with these providers as so indicated.

This requirement does not replace the MCP's responsibility to inform and educate all members regarding the appropriate use of the ED.

MCPs must also implement the ODJFS-required EDD program for frequent users. In that ODJFS has developed the parameters for an MCP's EDD program, it therefore does not require ODJFS prior approval.

b. Care Management Programs

In accordance with 5101:3-26-03.1(A)(8), MCPs must offer and provide care management services which coordinate and monitor the care of members with special health care needs.

i. Each MCP must inform all members and contracting providers of the MCP's care management services.

ii. The MCP's care management program must include, at a minimum, the following components:

a. <u>Identification Strategies</u>
The MCP must implement mechanisms to identify members potentially eligible for care management services. These mechanisms must include an administrative data review of pharmacy claims, emergency department visits, and inpatient hospital admissions (e.g. diagnosis, cost threshold, and/or service utilization) and may also include telephone interviews; provider/self-referrals; information as reported by the MCEC during membership selection, home visits, or referrals resulting from internal MCP operations (e.g., utilization management, 24/7 nurse advice line, members services, etc.).

Each MCP must incorporate identification strategies (i.e., mechanisms and criteria) as specified in *ODJFS Care Management Program Requirements.*

b. Risk Stratification Levels

The MCP must develop a strategy to assign members to low, medium, or high-risk stratification levels based on the results of the identification and/or assessment processes. This will be a continual process and the risk levels should be adjusted by the MCP based on the completion of the health assessment and the member's demonstrated progress in meeting the goals of the care treatment plan. Each MCP must incorporate risk stratification levels as specified in *ODJFS Care Management Program Requirements.*

c. Health Assessment

Once a member has been identified by the MCP as being potentially eligible for care management, the MCP must arrange for, or conduct, a health assessment to determine the member's need for care management services. The health assessment completed by the MCP will depend on the member's initial assignment to a low-, medium-, or high-risk stratification level. ODJFS recognizes that the completion of an assessment may result in the assignment of the member to a different risk stratification level (i.e., than the level originally assigned) or that the member may not demonstrate a need for care management services.

For members assigned to the low- or medium-risk stratification levels, the MCP must, at a minimum, complete a health assessment based on a review of administrative claims data. The health assessment must be able to identify the severity of the member's condition/ disease state and must be reviewed by a qualified health professional appropriate for the member's health condition. If an MCP opts to use a disease management methodology/algorithm to assign members to a risk stratification level as part of the assessment, there must be clinical input to the development of the algorithm.

For members assigned to a high risk stratification level, the MCP must complete a health assessment that is comprehensive and evaluates the member's medical condition(s), including physical, behavioral, social, and psychological needs. The health assessment must also evaluate if the member has co-morbidities, or multiple complex health care conditions. The goals of the assessment are to identify the member's existing and/or potential health care needs and assess the member's need for care management services.

The MCP must ensure that the health assessment is completed, or contributed to, by a health care professional(s) who is appropriately qualified for the member's health care condition, follows the state's licensure/credentialing requirements, and operates within the scope of practice as allowed by the state. This applies to the initial and ongoing health assessment performed by MCP staff and for each care management risk stratification level.

The MCP must address the health assessment components as specified in *ODJFS Care Management Program Requirements.*

d. Care Treatment Plan-
The care treatment plan is defined by ODJFS as the one developed by the MCP for the member. The development of the care treatment plan must be based on the health assessment, and reflect the member's health care needs. The care treatment plan must also include specific provisions for periodic reviews of the member's health care needs. Periodic reviews may include administrative data reviews or screening questions to alert the appropriately qualified MCP staff to update the health assessment and the care treatment plan. The frequency of contact with the member must correspond to the member's risk stratification level and must include a provision for two-way communication or feedback between the member and the MCP.

The member and the member's PCP must be actively involved in the development, of and revisions~~,~~ to, the care treatment plan. The designated PCP is the provider, or specialist, who will manage and coordinate the overall care for the member. Ongoing communication regarding the status of the care treatment plan may be accomplished between the MCP and the PCP's designee (i.e., qualified health professional). Revisions to the clinical portion of the care treatment plan should be completed in consultation with the PCP.

The elements of a care treatment plan include:

(a) Goals and actions that address health care conditions identified in the health assessment;

(b) Member level interventions, (i.e., referrals and making appointments) that assist members in obtaining services, providers

and programs related to the health care conditions identified in the health assessment; and

(c) Continuous review, revision and contact follow-up, as needed, with members to ensure the care treatment plan is adequately monitored including the following:

- Identification of gaps between recommended care and actual care provided; and
- Re-evaluation of a member's risk stratification level with adjustment to the level of care management services provided.

The MCP must address care treatment plan components as specified in *ODJFS Care Management Program Requirements.*

e. Coordination of Care and Communication

The MCP must assign an accountable point of contact (i.e., care manager) who can help obtain medically necessary care, assist with health-related services and coordinate care needs. The MCP must arrange or provide for professional care management services that are performed collaboratively by a team of professionals appropriate for the member's condition and health care needs. The MCP's care manager must attempt to coordinate with the member's care manager from other health systems. The MCP must have a process to facilitate, maintain, and coordinate both care and communication with the member, PCP, and other service providers and care managers. The MCP must also have a process to coordinate care for a member that is receiving services from state sub-recipient agencies as appropriate [e.g., the Ohio Department of Mental Health (ODMH); the Ohio Department of Developmental Disabilities (DODD) effective October 5, 2009), and Ohio Department of Alcohol and Drug Addiction Services (ODADAS)]. The MCP must have a provision to disseminate information to the member/caregiver concerning the health condition, types of services that may be available, and how to access services.

f. Member Enrollment in the Care Management Program

The MCP must assure and coordinate the placement of the member into the Care Management Program –including the identification of the member's need for care management services, completion of the health assessment, and timely development of the care

treatment plan. This process must occur within the following timeframes for:

a) Newly enrolled members: 90 days from the effective date of enrollment for those members who are identified as meeting the criteria for care management; and
b) Existing members: 90 days from identifying their need for care management.

For members assigned to the low or medium risk stratification levels, the MCP may choose to implement an "opt out" process for members. MCPs that implement an opt out process must provide care management services to the member until the member declines the offer to participate in the program. The opt out process must be clearly defined in all member materials, and the MCP must have a documented process for honoring any opt out requests. For members assigned to a low- or medium-risk level, the MCP may obtain verbal or written confirmation of the member's care management status in the care management records. For members assigned to the high-risk stratification level, the MCP must obtain written or verbal confirmation of the member's care management status in the care management record.

g. Provider and Member Notifications

The MCP must have a process to inform members and their PCPs that they have been identified as meeting the criteria for care management, including their enrollment into the care management program. The MCP must create the following notifications for members enrolled in the care management program:

1. Member Enrollment in the Care Management Program: This must include a description of the opt out process (if an MCP implements) for members in the low- and medium-risk stratification levels; contact information for the member's care manager; and the care management services available to the member.

2. Member Disenrollment from the Care Management Program: This notice must include the rationale for disenrolling the member from the care management program (e.g., declines participation in the program, meets goals in care treatment plan, etc.), and information for the member to contact the MCP if future assistance is needed.

h. Access to Specialists

The MCP must implement mechanisms to notify all Members with Special Health Care Needs of their right to directly access a specialist. Such access may be assured through, for example, a standing referral or an approved number of visits, and documented in the care treatment plan.

i. Care Management Strategies

The MCP must follow best-practice and/or evidence based clinical guidelines when developing interventions for the risk stratification levels, the care treatment plan and coordinating the care management needs. The MCP must develop and implement mechanisms to educate and equip providers and care managers with evidence-based clinical guidelines or best practice approaches to assist in providing a high level of quality of care to members.

j. Care Management Program Staffing

The MCP must identify the staff that will be involved in the operations of the care management program, including but not limited to: care manager supervisors, care managers, and administrative support staff. The MCP must identify the role and functions of each care management staff member as well as the educational requirements, clinical licensure standards, certification and relevant experience with care management standards and/or activities. The MCP must provide care manager staff/member ratios based on the member risk stratification and different levels of care being provided to members.

k. Information Technology System for Care Management Program

The MCP's information technology system for its care management program must maximize the opportunity for communication between the plan, the PCP, the member, and other service providers and care managers. The MCP must have an integrated database that allows MCP staff that may be contacted by a member in care management to have immediate access to, and review of, the most recent information with the MCP's information systems relevant to the case. The integrated database may include the following: administrative data, call center communications, service authorizations, care treatment plans, patient assessments, care management notes, and PCP notes. The information technology system must also have the capability to share relevant information with the member, the PCP, and other service providers

and care managers. The goal is to integrate member information from a variety of sources in an effort to facilitate care management needs.

l. Care Management Data Submission

The MCP must submit a monthly electronic report to the Care Management System (CAMS) for all members who are provided care management services by the MCP as outlined in the *ODJFS Care Management File and Submission Specifications*. In order for a member to be submitted as care managed in CAMS, the MCP must complete the steps as outlined in Section ii.f: Enrollment in the Care Management Program. ODJFS, or its designated entity, the external quality review vendor, will validate on an annual basis the accuracy of the information contained in CAMS with the member's care management record.

The CAMS files are due the 15th calendar day of each month.

The MCP must also have an ODJFS-approved care management program which includes the items in this section. Each MCP must implement an evaluation process to review, revise and/or update the care management program on an annual basis. If the evaluation process results in a revision to identification strategies, health assessment(s), risk stratification strategies, then the MCP must notify ODJFS of the change in writing, which may be subject to review and approval by ODJFS.

c. Care Coordination with ODJFS-Designated Providers

Per OAC rule 5101:3-26-03.1(A)(4), MCPs are required to share specific information with certain ODJFS-designated non-contracting providers in order to ensure that these providers have been supplied with specific information needed to coordinate care for the MCP's members. Once an MCP has obtained a provider agreement, but within the first month of operation, the MCP must provide to the ODJFS-designated providers (i.e., ODMH CMHCs, ODADAS-certified Medicaid providers, FQHCs/RHCs, qualified family planning providers [QFPPs], certified nurse midwives [CNMs], certified nurse practitioners [CNPs] [if applicable], and hospitals) a quick reference information packet which includes the following:

i. A brief cover letter explaining the purpose of the mailing; and

ii. A brief summary document that includes the following information:

- Claims submission information including the MCP's Medicaid provider number for each region;
- The MCP's prior authorization and referral procedures or the MCP's website which includes this information;
- A picture of the MCP's member ID card (front and back);
- Contact numbers and/or website location for obtaining information for eligibility verification, claims processing, referrals/prior authorization, post-stabilization care services and information regarding the MCP's behavioral health administrator;
- A listing of the MCP's major pharmacy chains and the contact number for the MCP's PBM;
- A listing of the MCP's laboratories and radiology providers; and
- A listing of the MCP's contracting behavioral health providers and how to access services through them (this information is only to be provided to non-contracting community mental health and substance abuse providers).

d. Care coordination with Non-Contracting Providers

Per OAC rule 5101:3-26-05(A)(9), MCPs authorizing the delivery of services from a provider who does not have an executed subcontract must ensure that they have a mutually agreed upon compensation amount for the authorized service and notify the provider of the applicable provisions of paragraph D of OAC rule 5101:3-26-05. This notice is provided when an MCP authorizes a non-contracting provider to furnish services on a one-time or infrequent basis to an MCP member and must include required ODJFS-model language and information. This notice must also be included with the transition of services form sent to providers as outlined in paragraph 29.h. of Appendix C.

e. Integration of Member Care

The MCP must ensure that a discharge plan is in place to meet a member's health care needs following discharge from a nursing facility, and integrated into the member's continuum of care. The discharge plan must address the services to be provided for the member and must be developed prior to the date of discharge from the nursing facility. The MCP must ensure follow-up contact occurs with the member, or authorized representative, within thirty (30) days of the member's discharge from the nursing facility to ensure that the member's health care needs are being met.

APPENDIX H

PROVIDER PANEL SPECIFICATIONS

1. GENERAL PROVISIONS

MCPs must provide or arrange for the delivery of all medically necessary, Medicaid-covered health services, as well as assure that they meet all applicable provider panel requirements for their entire designated service area. The ODJFS provider panel requirements are specified in the charts included with this appendix and must be met prior to the MCP receiving a provider agreement with ODJFS. The MCP must remain in compliance with these requirements for the duration of the provider agreement.

If an MCP is unable to provide the medically necessary, Medicaid-covered services through their contracted provider panel, the MCP must ensure access to these services on an as needed basis. For example, if an MCP meets the orthopedist requirement but a member is unable to obtain a timely appointment from an orthopedist on the MCP's provider panel, the MCP will be required to secure an appointment from a panel orthopedist or arrange for an out-of-panel referral to an orthopedist.

MCPs are **required** to make transportation available to any member requesting transportation when they **must** travel 30 miles or more from their home to receive a medically-necessary Medicaid-covered service. If the MCP offers transportation to their members as an additional benefit and this transportation benefit only covers a limited number of trips, the required transportation listed above may **not** be counted toward this trip limit (as specified in Appendix C).

In developing the provider panel requirements, ODJFS considered, on a county-by-county basis, the population size and utilization patterns of the Ohio Medicaid ABD and CFC consumers, as well as the potential availability of the designated provider types. ODJFS has integrated existing utilization patterns into the provider network requirements to avoid disruption of care. Most provider panel requirements are county-specific but in certain circumstances, ODJFS requires providers to be located anywhere in the region. Although all provider types listed in this appendix are required provider types, only those listed on the attached charts must be submitted to the Managed Care Provider Network (MCPN).

2. PROVIDER SUBCONTRACTING

Unless otherwise specified in this appendix or OAC rule 5101:3-26-05, all MCPs are required to enter into fully-executed subcontracts with their providers. These subcontracts must include a baseline contractual agreement, as well as the appropriate ODJFS-approved Model Medicaid Addendum. The Model Medicaid Addendum incorporates all applicable OAC rule requirements specific to provider subcontracting and therefore cannot be modified except to add personalizing information such as the MCP's name.

MCPs must submit for ODJFS review a copy of the complete subcontract, including the Medicaid addendum for all new, subcontracting hospitals, Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs) before they can be listed in the MCPN or the MCP online provider directory. MCPs may not employ or contract with providers excluded from participation in federal health care programs under either section 1128 or section 1128A of the Social Security Act. MCPs must submit documentation verifying that all necessary contract documents have been appropriately completed. ODJFS will verify the submission and process this information using the ODJFS MCPN, maintained by the MCEC, or other designated process. The MCPN is a centralized database system that maintains information on the status of all MCP-submitted providers.

Only those providers who meet the applicable criteria specified in this document, and as determined by ODJFS, will be counted toward meeting minimum panel requirements. MCPs must credential/recredential providers in accordance with OAC rule 5101:3-26-05. The MCP must ensure that the provider has met all applicable credentialing criteria before the provider can render services to the MCP's members.

MCPs must notify ODJFS of the addition and deletion of their contracting providers as specified in OAC rule 5101:3-26-05, and must notify ODJFS within one working day in instances where the MCP has identified that they are not in compliance with the provider panel requirements specified in this appendix.

3. PROVIDER PANEL REQUIREMENTS

The provider network criteria that must be met by each MCP are as follows:

a. Primary Care Providers (PCPs)

PCP means an individual physician (M.D. or D.O.), certain physician group practice/clinic (Primary Care Clinics [PCCs]), or an advanced practice nurse (APN) as defined in ORC 4723.43 or advanced practice nurse group practice within an acceptable specialty, contracting with an MCP to provide services as specified in paragraph (B) of OAC rule 5101: 3-26-03.1. The APN capacity can count up to 10% of the total requirement for the county. Acceptable specialty types for PCPs include family/general practice, internal medicine, pediatrics, and obstetrics/ gynecology (OB/GYN). Acceptable PCCs include FQHCs, RHCs and the acceptable group practices/clinics specified by ODJFS. As part of their subcontract with an MCP, PCPs must stipulate the total Medicaid member capacity that they can ensure for that individual MCP.

Each PCP must have the capacity and agree to serve at least 50 Medicaid MCP members at each practice site in order for the PCP to count toward minimum provider panel requirements.

ODJFS reviews the capacity totals for each PCP to determine if they appear excessive.
ODJFS reserves the right to request clarification from an MCP for any PCP whose total stated capacity for all MCP networks added together exceeds 2000 Medicaid members.
Where indicated, ODJFS may set a cap on the maximum amount of capacity that we will recognize for a specific PCP. ODJFS may allow up to an additional 750 member capacity for each nurse practitioner or physician's assistant that is used to provide clinical support for a PCP.

For PCPs contracting with more than one MCP, the MCP must ensure that the capacity figure stated by the PCP in their subcontract reflects only the capacity the PCP intends to provide for that one MCP. ODJFS utilizes each approved PCP's capacity figure to determine if an MCP meets the provider panel requirements and this stated capacity figure does not prohibit a PCP from actually having a caseload that exceeds the capacity figure indicated in their subcontract.

ODJFS recognizes that MCPs will need to utilize specialty providers to serve as PCPs for some special needs members. In these situations the MCP would submit these specialists to the MCPN database, or other system as PCPs, however they will not count toward minimum provider panel PCP requirements they must be submitted to MCPN, or other system, as the appropriate required provider type and coded as a PCP. Also, in some situations (e.g., continuity of care) a PCP may only want to serve a very small number of members for an MCP. These PCPs will, however, need to execute a subcontract with the MCP which includes the appropriate Model Medicaid Addendum.

The PCP requirement is based on an MCP having sufficient PCP capacity to serve 40% of the eligibles in the region if three MCPs are serving the region and 55% of the eligibles in the region if two MCPs are serving the region. At a minimum, each MCP serving CFC members must meet the PCP capacity requirement for that region, each MCP serving ABD members must meet the PCP capacity requirements and the minimum number of PCP requirements for that region. MCPs must also satisfy a PCP geographic accessibility standard. ODJFS will match the PCP practice sites and the stated PCP capacity with the geographic location of the eligible population in that region (on a county-specific basis) and perform analysis using GIS software. The analysis will be used to determine if at least 40% of the eligible population is located within 10 miles of a PCP with available capacity in urban counties and 40% of the eligible population within 30 miles of a PCP with available capacity in rural counties. Rural areas are defined pursuant to 42 CFR 412.62(f)(1)(iii).

In addition to the PCP capacity requirement, MCPs serving CFC members must also contract with the specified number of pediatric PCPs for each region. These pediatric PCPs will have their stated capacity counted toward the PCP capacity requirement.

A pediatric PCP must maintain a general pediatric practice (e.g., a pediatric neurologist would not meet this definition unless this physician also operated a practice as a general pediatrician) at a site(s) located within the county/region and be listed as a pediatrician with the Ohio State Medical Board. In addition, half of the required number of pediatric PCPs must also be certified by the American Board of Pediatrics. The provider panel requirements for pediatricians are included in the practitioner charts in this appendix.

b. Non-PCP Provider Network

In addition to the PCP capacity requirements, each MCP is also required to maintain adequate capacity in the remainder of its provider network within the following categories: hospitals, dentists, vision care providers, OB/GYNs, allergists, general surgeons, otolaryngologists, orthopedists, FQHCs/RHCs and QFPPs. CNMs, CNPs, FQHCs/RHCs and QFPPs are federally-required provider types.

Each MCP serving ABD members is required to maintain adequate capacity in addition to the remainder of its provider network within the following categories: cardiovascular, gastroenterology, nephrology, neurology, oncology, physical medicine, podiatry, psychiatry, and urology.

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

Although there are currently no capacity requirements of the non-PCP required provider types, MCPs are required to ensure that adequate access is available to members for all required provider types. Additionally, for certain non-PCP required provider types, MCPs must ensure that these providers maintain a full-time practice at a site(s) located in the specified county/region (i.e., the ODJFS-specified county within the region or anywhere within the region if no particular county is specified). A full-time practice is defined as one where the provider is available to patients at their practice site(s) in the specified county/region for at least 25 hours a week. ODJFS will monitor access to services through a variety of data sources, including: consumer satisfaction surveys; member appeals/grievances/complaints and state hearing notifications/requests; clinical quality studies; encounter data volume; provider complaints, and clinical performance measures.

Hospitals - MCPs must contract with the number and type of hospitals specified by ODJFS for each county/region. In developing these hospital requirements, ODJFS considered, on a county-by-county basis, the population size and utilization patterns of the Ohio Medicaid ABD and CFC consumers and integrated the existing utilization patterns into the hospital network requirements to avoid disruption of care. For this reason, ODJFS may require that MCPs contract with out-of-state hospitals (i.e. Kentucky, West Virginia, etc.).

For each Ohio hospital, ODJFS utilizes the hospital's most current Annual Hospital Registration and Planning Report, as filed with the Ohio Department of Health (ODH), in verifying types of services that hospital provides. Although ODJFS has the authority, under certain situations, to obligate a non-contracting hospital to provide non-emergency hospital services to an MCP's members, MCPs must still contract with the specified number and type of hospitals unless

ODJFS approves a provider panel exception (see Section 4 of this appendix, *Provider Panel Exceptions*).

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

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

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

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

Vision Care Providers - MCPs must contract with the specified number of ophthalmologists/ optometrists for each specified county/region, all of whom must maintain a full-time practice at a site(s) located in the specified county/region to count toward minimum panel requirements. All ODJFS-approved vision providers must regularly perform routine eye exams. MCPs will be expected to contract with an adequate number of ophthalmologists as part of their overall provider panel, but only ophthalmologists who regularly perform routine eye exams can be used to meet the vision care provider panel requirement. If optical dispensing is not sufficiently available in a region through the MCP's contracting ophthalmologists/optometrists, the MCP must separately contract with an adequate number of optical dispensers located in the region.

Dental Care Providers - MCPs must contract with the specified number of dentists. In order to assure sufficient access to adult CFC MCP members, no more than two-thirds of the dentists used to meet the CFC provider panel requirement may be pediatric dentists.

FQHCs/RHCs - MCPs are required to ensure member access to any FQHCs/RHCs, regardless of contracting status. Contracting FQHC/RHC providers must be submitted for ODJFS review via the MCPN process, or other designated process. Even if no FQHC/RHC is available within the

region, MCPs must have mechanisms in place to ensure coverage for FQHC/RHC services in the event that a member accesses these services outside of the region.

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

- MCPs must provide expedited reimbursement on a service-specific basis in an amount no less than the payment made to other providers for the same or similar service.

- If the MCP has no comparable service-specific rate structure, the MCP must use the regular Medicaid FFS payment schedule for non-FQHC/RHC providers.

- MCPs must make all efforts to pay FQHCs/RHCs as quickly as possible and not just attempt to pay these claims within the prompt pay time frames.

MCPs are required to educate their staff and providers on the need to assure member access to FQHC/RHC services.

Qualified Family Planning Providers (QFPPs) - All MCP members must be permitted to self-refer for services and supplies allowed under Title X of the Public Health Services Act (Title X services) provided by a QFPP. A QFPP is defined as any public or not-for-profit health care provider that complies with Title X guidelines/standards, and receives either Title X funding or family planning funding from the ODH.. MCPs must reimburse all medically-necessary Medicaid-covered Title X services provided to eligible members by a QFPP provider (including on-site pharmacy and diagnostic services) on a patient self-referral basis, regardless of the provider's status as a panel or non-panel provider. A description of Title X services can be found on the ODH website.

MCPs will be required to work with QFPPs in the region to develop mutually-agreeable HIPAA compliant policies and procedures to preserve patient/provider confidentiality, and convey pertinent information to the member's PCP and/or MCP.

Behavioral Health Providers – MCPs must assure member access to all Medicaid-covered behavioral health services for members as specified in Appendix G.2. b.iii. herein. Although ODJFS is aware that certain outpatient substance abuse services may only be available through Medicaid providers certified by the ODADAS in some areas, MCPs must maintain an adequate number of contracted mental health providers in the region to assure access for members who are unable to timely access services or unwilling to access services through community mental health centers. MCPs are not to contract with ODMH community mental health centers and /or ODADAS certified alcohol and other drug treatment providers for behavioral health services as the non-federal share of the cost for these services is provided by a board of alcohol, drug addiction and mental health services or a state agency other than ODJFS. MCP members are therefore permitted to self-refer to such providers for carved out services. However, MCPs may contract with medical clinics owned and operated by ODMH community mental health centers

and/or ODADAS alcohol and other drug treatment providers based on MCP business or operational needs (for example, to bolster MCPs provider networks or enhance patient-centered care coordination) for physical health services.

Other Specialty Types (allergists, pediatricians, general surgeons, otolaryngologists, orthopedists for the CFC population and general surgeons, otolaryngologists, orthopedists, cardiologists, gastroenterologists, nephrologists, neurologists, oncologists, podiatrists, physiatrists, psychiatrists, and urologists for the ABD population) - MCPs must contract with the specified number of all other ODJFS designated specialty provider types. In order to be counted toward meeting the provider panel requirements, these specialty providers must maintain a full-time practice at a site(s) located within the specified county/region. Only contracting general surgeons, orthopedists, and otolaryngologists, cardiologists, gastroenterologists, nephrologists, neurologists, oncologists, physiatrists, and urologists with admitting privileges at a hospital under contract with the MCP in the region can be submitted to the MCPN, or other system, count towards MCP minimum panel requirements, and be listed in the MCP's provider directory.

4. PROVIDER PANEL EXCEPTIONS

ODJFS may specify provider panel criteria for a service area that deviates from that specified in this appendix if:

- the MCP presents sufficient documentation to ODJFS to verify that they have been unable to meet or maintain certain provider panel requirements in a particular service area despite all reasonable efforts on their part to secure such a contract(s), and

- if notified by ODJFS, the provider(s) in question fails to provide a reasonable argument why they would not contract with the MCP, and

- the MCP presents sufficient assurances to ODJFS that their members will have adequate access to the services in question.

If an MCP is unable to contract with or maintain a sufficient number of providers to meet the ODJFS-specified provider panel criteria, the MCP may request an exception to these criteria by submitting a provider panel exception request as specified by ODJFS. ODJFS will review the exception request and determine whether the MCP has sufficiently demonstrated that all reasonable efforts were made to obtain contracts with providers of the type in question and that they will be able to provide access to the services in question.

A provider panel exception request (PPE) may be approved for a period of not more than one year. Approvals shall have an effective date of the 1st day of the month in which the PPE is approved by ODJFS. Once the MCP has resolved the deficiency, the PPE is no longer valid. If the MCP becomes deficient in the same area a new PPE request will need to be submitted prior to the next compliance review.

ODJFS will aggressively monitor access to all services related to the approval of a provider panel exception request through a variety of data sources, including: consumer satisfaction surveys; member appeals/grievances/complaints and state hearing notifications/requests; member just-cause for termination requests; clinical quality studies; encounter data volume; provider complaints, and clinical performance measures. ODJFS approval of a PPE request does not exempt the MCP from assuring access to the services in question. If ODJFS determines that an MCP has not provided sufficient access to these services, the MCP may be subject to sanctions.

5. PROVIDER DIRECTORIES

MCP provider directories must include all MCP-contracted providers [except as specified by ODJFS] as well as certain non-contracted providers. At the time of ODJFS' review, the information listed in the MCP's provider directory for all ODJFS-required provider types specified on the attached charts must exactly match the data currently on file in the ODJFS MCPN, or other designated process.

MCP provider directories must utilize a format specified by ODJFS. Directories may be region-specific or include multiple regions, however, the providers within the directory must be divided by region, county, and provider type, in that order.

The directory must also specify:

- provider address(es) and phone number(s);
- an explanation of how to access providers (e.g. referral required vs. self-referral);
- an indication of which providers are available to members on a self-referral basis;
- foreign-language speaking PCPs and specialists and the specific foreign language(s) spoken;
- how members may obtain directory information in alternate formats that takes into consideration the special needs of eligible individuals including but not limited to, visually-limited, LEP, and LRP eligible individuals,
- any PCP or specialist practice limitations; and
- An indication of whether the provider is accepting new members.

Printed Provider Directory

Prior to receiving a provider agreement, all MCPs must develop a printed provider directory that shall be prior-approved by ODJFS for each covered population. For example, an MCP who serves CFC and ABD in the Central Region would have two provider directories, one for CFC and one for ABD. Once approved, this directory may be regularly updated with provider additions or deletions by the MCP without ODJFS prior-approval, however, copies of the revised directory (or inserts) must be submitted to ODJFS prior to distribution to members.

On a quarterly basis, MCPs **must** create an insert to each printed directory that lists those providers **deleted** from the MCP's provider panel during the previous three months. Although this insert does not need to be prior approved by ODJFS, copies of the insert must be submitted to ODJFS two weeks prior to distribution to members.

Internet Provider Directory

MCPs are required to have an internet-based provider directory available in a format prior approved by ODJFS. This internet directory must allow members to electronically search for MCP panel providers based on name, provider type, and geographic proximity. If an MCP has one internet-based directory for multiple populations, each provider must include a description of which population they serve.

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

6. FEDERAL ACCESS STANDARDS

MCPs must demonstrate that they are in compliance with the following federally defined provider panel access standards as required by 42 CFR 438.206:

In establishing and maintaining their provider panel, MCPs must consider the following:

- The anticipated Medicaid membership.
- The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the MCP.
- The number and types (in terms of training, experience, and specialization) of panel providers required to deliver the contracted Medicaid services.
- The geographic location of panel providers and Medicaid members, considering distance, travel time, the means of transportation ordinarily used by Medicaid members, and whether the location provides physical access for Medicaid members with disabilities.
- MCPs must adequately and timely cover services to an out-of-network provider if the MCP's contracted provider panel is unable to provide the services covered under the MCP's provider agreement. The MCP must cover the out-of-network services for as long as the MCP network is unable to provide the services. MCPs must coordinate with the out-of-network provider with respect to payment and ensure that the provider agrees with the applicable requirements.

Contracting providers must offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid FFS, if the provider serves only Medicaid members. MCPs must ensure that services are available 24 hours a day, 7 days a week, when medically necessary. MCPs must establish mechanisms to ensure that panel providers comply with timely access requirements, and must take corrective action if there is failure to comply.

In order to demonstrate adequate provider panel capacity and services, 42 CFR 438.206 and 438.207 stipulates that the MCP must submit documentation to ODJFS, in a format specified by ODJFS, that demonstrates it offers an appropriate range of preventive, primary care and specialty services adequate for the anticipated number of members in the service area, while maintaining a provider panel that is sufficient in number, mix, and geographic distribution to meet the needs of the number of members in the service area.

This documentation of assurance of adequate capacity and services must be submitted to ODJFS no less frequently than at the time the MCP enters into a contract with ODJFS; at any time there is a significant change (as defined by ODJFS) in the MCP's operations that would affect adequate capacity and services (including changes in services, benefits, geographic service or payments); and at any time there is enrollment of a new population in the MCP.

Central Region

	Crawford	Delaware	Fairfield	Fayette	Franklin	Hocking	Knox	Licking	Logan	Madison	Marion	Morrow	Perry	Pickaway	Pike	Ross	Scioto	Union	Additional Required: In-Region	Total Required
PCP Capacity - ABD																				
Capacity	170	174	395	152	4,670	176	211	502	131	104	367	102	243	222	375	543	1,196	74		9,807
PCPs	2	2	3	2	17	2	2	4	2	1	3	1	3	2	3	4	5	1		59
PCP Capacity - CFC																				
Capacity	2,016	2,307	4,698	1,341	55,101	1,672	2,236	5,897	1,656	1,378	3,042	1,492	2,263	2,123	2,116	4,442	5,204	1,269		100,253

*Any additional CFC required capacity must be located within the region.

Hospitals - ABD																				
General Hospital			1	1				1			1			1		1	1		3	10
Hospital System					2															2
Hospitals - CFC																				
General Hospital	1		1	1	1		1	1	1	1	1			1		1	1	1	1	14
Hospital System					2															2

*ABD hospital systems include: physician networks and therefore these physicians could be considered when fulfilling contracts for PCP and non-PCP provider panel requirements.
*CFC general hospitals must provide obstetrical services if such a hospital is available in the county/region.
*CFC Franklin county general hospital must include one hundred fifty (150) pediatric beds and twenty-five (25) pediatric intensive care unit (PICU) beds.
*Genesis Health Care System, Inc. is the additional CFC required general hospital.

Practitioners - ABD

Central Region

	Crawford	Delaware	Fairfield	Fayette	Franklin	Hocking	Knox	Licking	Logan	Madison	Marion	Morrow	Perry	Pickaway	Pike	Ross	Scioto	Union	Additional Required: In-Region	Total Required
Cardiovascular					2														3	5
Dentists		1	1		15		1	1			1					1				21
Gastroenterology					1														2	3
General Surgeons		1	1		5											1	1		1	10
Nephrology					1														1	2
Neurology					1														2	3
OB/GYNs		1	1		6														2	10
Oncology																			1	1
Orthopedists			1		3			1			1					1				7
Otolaryngologist		1			2															3
Physical Med Rehab					1														2	3
Podiatry		1			3														3	7
Psychiatry			1		5														4	10
Urology																			4	4
Vision	1	1	1		5		1	1	1		1					1	1			14

*All required providers and additional required providers must be located within the region.

Practitioners - CFC

Pediatricians		4	3		55		1	2	1	1	2			1		2	2	1	11	86
OB/GYNs		2	2		12		1	1			1					1	1		3	24
Vision	1	2	2		15		1	1	1		1			1		1	1	1	3	31
General Surgeons	1	1	1		10		1	1	1		1					1	1	1	2	22
Otolaryngologist		1			4														1	6
Allergists					2														2	4
Orthopedists			1		7			1			1					1			2	13
Dentists	1	2	3	1	45	1	2	3	1	1	2	1	1	1	1	3	2	1	5	77

*All required providers and additional required providers must be located within the region.
*Half of the pediatricians must be certified by the American Board of Pediatrics. No more than two-thirds of this number can be pediatric dentists.

East Central Region

	Ashland	Carroll	Holmes	Portage	Richland	Stark	Summit	Tuscarawas	Wayne	Additional Required: In-Region	Total Required
PCP Capacity - ABD											
Capacity	106	97	57	327	530	1,332	2,121	327	357		5,254
PCPs	1	1	1	2	3	4	5	2	2		21
PCP Capacity - CFC											
Capacity	1,732	1,226	794	4,329	5,363	14,376	20,279	3,616	3,291		55,006

*Any additional CFC required capacity must be located within the region.

Hospitals - ABD											
General Hospital				1	1	1		1	1	2	7
Hospital System							1				1
Hospitals - CFC											
General Hospital	1		1	1	1	1	1	1	1		8
Hospital System							1				1

*ABD hospital systems include: physician networks and therefore these physicians could be considered when fulfilling contracts for PCP and non-PCP provider panel requirements.

*CFC general hospitals must provide obstetrical services if such a hospital is available in the county/region.

*CFC Summit county general hospital must be a hospital that includes one hundred (100) pediatric beds and five (5) pediatric intensive care unit (PICU) beds.

Practitioners - ABD											
Cardiovascular						1	1			1	3

East Central Region

	Ashland	Carroll	Holmes	Portage	Richland	Stark	Summit	Tuscarawas	Wayne	Additional Required: In-Region	Total Required
Dentists	1				2	4	6	1			14
Gastroenterology										2	2
General Surgeons					1	1	2		1	2	7
Nephrology										1	1
Neurology										2	2
OB/GYNs						2	4				6
Oncology										1	1
Orthopedists						1	1			2	4
Otolaryngologist						1	1				2
Physical Med Rehab										2	2
Podiatry						1	2			1	4
Psychiatry						2	3			1	6
Urology										2	2
Vision					1	2	3			2	8

*All required providers and additional required providers must be located within the region.

Practitioners - CFC

Pediatricians	1			2	3	14	20	2	2	5	49
OB/GYNs					1	5	8		1	2	17
Vision					1	5	8			4	18
General Surgeons				1	2	3	4	1	1	1	13
Otolaryngologist						2	2			3	7
Allergists						1	1			1	3
Orthopedists					1	2	2		1	3	9
Dentists	2			3	5	13	17	3	3	2	48

*All required providers and additional required providers must be located within the region.

*Half of the pediatricians must be certified by the American Board of Pediatrics. No more than two-thirds of this number can be pediatric dentists.

Northeast Region

	Ashtabula	Cuyahoga	Erie	Geauga	Huron	Lake	Lorain	Medina	Additional Required: In-Region	Total
PCP Capacity - ABD										
Capacity	585	7,370	213	85	173	385	990	180		9,981
PCPs	4	16	2	1	1	2	4	1		31
PCP Capacity - CFC										
Capacity	5,256	66,564	2,873	1,111	2,612	5,210	11,431	3,155		98,212
*Any additional required CFC capacity must be located within the region.										
Hospitals - ABD										
General Hospital	1			1	1	1	1	1		6
Hospital System		1							1	2
Hospitals - CFC										
General Hospital	1	1	1	1	1	1	1	1		8
Hospital System		1								1
*ABD hospital systems include: physician networks and therefore these physicians could be considered when fulfilling contracts for PCP and non-PCP provider panel requirements. *CFC general hospitals must provide obstetrical services if such a hospital is available in the county/region. *The Cuyahoga CFC general hospital requirement may be met by either contracting with (1) that includes fifty (50) pediatric beds and five (5) pediatric intensive care unit (PICU) beds OR (2) a single general hospital that includes fifty (50) pediatric beds and five (5) pediatric intensive care unit (PICU) beds and a hospital system.										

Practitioners - ABD										
Cardiovascular		3					1		2	6

Northeast Region

	Ashtabula	Cuyahoga	Erie	Geauga	Huron	Lake	Lorain	Medina	Additional Required: In-Region	Total
Dentists	1	20				2	3	1	1	28
Gastroenterology		2							1	3
General Surgeons		6	1		1	1	1	1		11
Nephrology		1							1	2
Neurology		2							1	3
OB/GYNs		8	1				1		2	12
Oncology									1	1
Orthopedists		4					1		2	7
Otolaryngologist		1					1		1	3
Physical Med Rehab		2							1	3
Podiatry		4					2		2	8
Psychiatry		5					3		3	11
Urology		2							2	4
Vision	1	7	1			1	1		3	14
*All required providers and additional required providers must be located within the region.										
Practitioners - CFC										
Pediatricians	1	66	2			3	8	3	7	90
OB/GYNs	1	16	1		1	1	2	1	2	25
Vision	1	25	1			1	2	1	2	33
General Surgeons		12	1		1	1	2	1	2	20
Otolaryngologist		2					1		3	6
Allergists		2					1		2	5
Orthopedists		8	1			1	2	1	3	16
Dentists	2	65	1	1	1	5	10	3	1	89
*All required providers and additional required providers must be located within the region.										
*Half of the pediatricians must be certified by the American Board of Pediatrics. No more than two-thirds of this number can be pediatric dentists.										

Northeast Central Region

	Columbiana	Mahoning	Trumbull	Additional Required: In-Region	Total
PCP Capacity - ABD					
Capacity	582	1,440	1,007		3,029
PCPs	3	4	4		11
PCP Capacity - CFC					
Capacity	5,281	12,039	9,047	5,000	31,367

*Any additional required CFC capacity must be located within the region.

Hospitals - ABD					
General Hospital	1	1	1		3
Hospital System	0	0	0		0
Hospitals - CFC					
General Hospital	1	1	1		3
Hospital System	0	0	0		0

*CFC general hospitals must provide obstetrical services if such a hospital is available in the county/region.

*Mahoning county CFC general hospital must be a hospital that includes thrity (30) pediatric beds and five (5) pediatric intensive care unit (PICU) beds.

Practitioners - ABD					
Cardiovascular		1		1	2
Dentists	1	3	3		7

Northeast Central Region

	Columbiana	Mahoning	Trumbull	Additional Required: In-Region	Total
Gastroenterology				1	1
General Surgeons	1	1	1		3
Nephrology				1	1
Neurology				1	1
OB/GYNs	1	1	1	1	4
Oncology				1	1
Orthopedists		1		1	2
Otolaryngologist		1			1
Physical Med Rehab				1	1
Podiatry				1	1
Psychiatry		3	2	1	6
Urology				1	1
Vision		2	2	1	5
*All required providers and additional required providers must be located within the region.					
Practitioners - CFC					
Pediatricians	2	10	6	5	23
OB/GYNs	1	3	2	1	7
Vision		3	2	2	7
General Surgeons	1	3	1	1	6
Otolaryngologist		1		1	2
Allergists				1	1
Orthopedists		2	1	1	4
Dentists	2	11	8	2	23
*All required providers and additional required providers must be located within the region. *Half of the pediatricians must be certified by the American Board of Pediatrics. No more than two-thirds of this number can be pediatric dentists.					

Northwest Region

	Allen	Auglaize	Defiance	Fulton	Hancock	Hardin	Henry	Lucas	Mercer	Ottawa	Paulding	Putnam	Sandusky	Seneca	Van Wert	Williams	Wood	Wyandot	Additional Required: In-Region	Total
PCP Capacity - ABD																				
Capacity	400	66	102	71	152	127	40	2,833	65	85	68	44	166	179	70	91	170	40		4,769
PCPs	3	1	1	1	2	2	1	9	1	1	1	1	2	2	1	1	2	1		33
PCP Capacity - CFC																				
Capacity	4,262	1,228	1,555	1,270	2,038	1,096	894	24,752	821	1,271	710	770	2,142	2,128	847	1,478	2,444	634	18,200	68,540

*Any additional required CFC capacity must be located within the region.

Hospitals - ABD																				
General Hospital	1		1		1								1						3	7
Hospital System								1												1
Hospitals - CFC																				
General Hospital	1		1	1	1				1				1		1	1		1	1	10
Hospital System								1												1

*ABD hospital systems include: physician networks and therefore these physicians could be considered when fulfilling contracts for PCP and non-PCP provider panel requirements.
*CFC general hospitals must provide obstetrical services if such a hospital is available in the county/region.
*Lucas county CFC hospital system must be a hospital system that includes forty-five (45) pediatric beds and ten (10) pediatric intensive care unit (PICU) beds.

Practitioners - ABD																				
Cardiovascular								1											2	3

Northwest Region

	Allen	Auglaize	Defiance	Fulton	Hancock	Hardin	Henry	Lucas	Mercer	Ottawa	Paulding	Putnam	Sandusky	Seneca	Van Wert	Williams	Wood	Wyandot	Additional Required: In-Region	Total
Dentists	1			1				6				1	1			1				11
Gastroenterology								1											1	2
General Surgeons	1							2									1		1	5
Nephrology																			1	1
Neurology								1											1	2
OB/GYNs	1							2					1	1			1			6
Oncology																			1	1
Orthopedists	1				1			1									1			4
Otolaryngologist								1											1	2
Physical Med Rehab								1											1	2
Podiatry								2									1		1	4
Psychiatry	1							3											1	5
Urology								1											1	2
Vision	1		1					2	1				1		1					7

*All required providers and additional required providers must be located within the region.

Practitioners - CFC																				
Pediatricians	4				1			23					1			1	2		13	45
OB/GYNs	2				1			5					1	1			1		2	13
Vision	2	1	1		1			7	1				1			1	2		1	18
General Surgeons	2				1			4					1			1	2		2	13
Otolaryngologist	1				1			2											3	7
Allergists	1							1											1	3
Orthopedists	2				1			2					1				1			7
Dentists	4	1	1	1	2	1	1	20	1	1		1	2	2	1	1	2	1	2	45

*All required providers and additional required providers must be located within the region.
*Half of the pediatricians must be certified by the American Board of Pediatrics. No more than two-thirds of this number can be pediatric dentists.

Southwest Region

	Adams	Brown	Butler	Clermont	Clinton	Hamilton	Highland	Warren	Additional Required: In-Region	Total
PCP Capacity - ABD										
Capacity	346	187	1,157	507	146	3,268	241	238		6,090
PCPs	3	1	4	3	1	6	2	2		22
PCP Capacity - CFC										
Capacity	2,063	2,122	12,296	5,787	1,705	29,787	2,240	2,754		58,754

*Any additional required CFC capacity must be located within the region.

Hospitals - ABD										
General Hospital		1	1		1	1	1		1	6
Hospital System						2				2
Hospitals - CFC										
General Hospital		1	1		1	1	1		1	6
Hospital System						2				2

*ABD hospital systems include: physician networks and therefore these physicians could be considered when fulfilling contracts for PCP and non-PCP provider panel requirements.
*CFC general hospitals must provide obstetrical services if such a hospital is available in the county/region.
*Hamilton county CFC general hospital must be a hospital that includes two-hundred (200) pediatric beds and thirty-five (35) pediatric intensive care unit (PICU) beds.
*Grandview OR Miami Valley is the additional required CFC general hospital.

Practitioners - ABD										
Cardiovascular						1		1	2	4

Southwest Region

	Adams	Brown	Butler	Clermont	Clinton	Hamilton	Highland	Warren	Additional Required: In-Region	Total
Dentists			3	1		8	1	1	1	15
Gastroenterology									2	2
General Surgeons			1	1	1	3	2	1		9
Nephrology									1	1
Neurology									2	2
OB/GYNs		1	1			4		1		7
Oncology									1	1
Orthopedists			1			2			2	5
Otolaryngologist						1			1	2
Physical Med Rehab									2	2
Podiatry			1			2			2	5
Psychiatry						3			4	7
Urology									3	3
Vision			1		1	3	1	1	1	8

*All required providers and additional required providers must be located within the region.

Practitioners - CFC										
Pediatricians			7	2	1	39			10	59
OB/GYNs		1	2	1	1	9		1	1	16
Vision			3	1	1	11	1	1	3	21
General Surgeons			2	1	1	7		1	1	13
Otolaryngologist			1			3		1	1	6
Allergists						4			3	7
Orthopedists			2			5			2	9
Dentists	1	1	10	4	1	26	2	2	3	50

*All required providers and additional required providers must be located within the region.

*Half of the pediatricians must be certified by the American Board of Pediatrics. No more than two-thirds of this number can be pediatric dentists.

Southeast Region

	Athens	Belmont	Coshocton	Gallia	Guernsey	Harrison	Jackson	Jefferson	Lawrence	Meigs	Monroe	Morgon	Muskingum	Noble	Vinton	Washington	Additional Required: In-Region	Total
PCP Capacity - ABD																		
Capacity	536	478	178	334	289	127	340	556	802	273	102	116	633	55	139	353		5,311
PCPs	2.00	2.00	1.00	2.00	2.00	1.00	2.00	3.00	4.00	2.00	1.00	1.00	3.00	1.00	1.00	2.00		30.00
PCP Capacity - CFC																		
Capacity	2,664	3,178	1,840	1,918	2,518	810	2,107	3,418	4,021	1,557	750	930	5,304	581	1,061	2,755	7,000	42,412

*Any additional required CFC capacity must be located within the region.

Hospitals - ABD																		
General Hospital	1	1	1	1	1			1					1			1		8
Hospital System																		0
Hospitals - CFC																		
General Hospital	1	1	1	1	1			1					1			1	3	11
Hospital System																		0

*CFC general hospitals must provide obstetrical services if such a hospital is available in the county/region.
*Additional CFC general hospitals must include Cabell AND King's Daughter AND Children's Hospital Columbus.

Practitioners - ABD																		
Cardiovascular				1													1	2

Southeast Region

	Athens	Belmont	Coshocton	Gallia	Guernsey	Harrison	Jackson	Jefferson	Lawrence	Meigs	Monroe	Morgon	Muskingum	Noble	Vinton	Washington	Additional Required: In-Region	Total
Dentists	1	1			1				1				1			1	2	8
Gastroenterology																	2	2
General Surgeons		1		1	1			1					1					5
Nephrology																	1	1
Neurology																	2	2
OB/GYNs	1				1			1					1			1	1	6
Oncology																	1	1
Orthopedists				1													3	4
Otolaryngologist				1									1					2
Physical Med Rehab																	2	2
Podiatry		1											1				2	4
Psychiatry		1											1				2	4
Urology																	2	2
Vision	1	1		1	1		1		1				1			1		8
*All required providers and additional required providers must be located within the region.																		
Practitioners - CFC																		
Pediatricians	1	1		2	1			1					2			1	22	31
OB/GYNs	1				1			1					1			1	4	9
Vision	1	1		1	1		1	1	1				2			1	3	13
General Surgeons		1		1	1			1					1			1	2	8
Otolaryngologist				1									1				1	3
Allergists																	1	1
Orthopedists				1													4	5
Dentists	2	3	1	1	3		1	3	2				3			2	9	30

*All required providers and additional required providers must be located within the region.
*Half of the pediatricians must be certified by the American Board of Pediatrics. No more than two-thirds of this number can be pediatric dentists.

West Central Region

	Champaign	Clark	Darke	Greene	Miami	Montgomery	Preble	Shelby	Additional Required: In-Region	Total
PCP Capacity - ABD										
Capacity	98	690	120	351	215	2,557	110	118		4,259
PCPs	1.00	4.00	1.00	2.00	2.00	6.00	1.00	1.00		18.00
PCP Capacity - CFC										
Capacity	1,472	7,225	1,476	4,347	2,550	22,751	1,541	1,422		42,784

*Any additional CFC required capacity/FTEs must be located within the region.

Hospitals - ABD										
General Hospital		1		1	1				2	5
Hospital System						1				1
Hospitals - CFC										
General Hospital		1	1	1	1	1		1		6
Hospital System						1				1

*ABD hospital systems include: physician networks and therefore these physicians could be considered when fulfilling contracts for PCP and non-PCP provider panel requirements.

*CFC general hospitals must provide obstetrical services if such a hospital is available in the county/region.

*Montgomery county CFC general hospital must be a hospital that includes seventy-five (75) pediatric beds and ten (10) pediatric intensive care unit (PICU) beds.

Practitioners - ABD										

West Central Region

	Champaign	Clark	Darke	Greene	Miami	Montgomery	Preble	Shelby	Additional Required: In-Region	Total
Cardiovascular						1			2	3
Dentists		1				3			1	5
Gastroenterology									1	1
General Surgeons		1		1		1			2	5
Nephrology									1	1
Neurology									2	2
OB/GYNs		1		1		3				5
Oncology									1	1
Orthopedists				1		1			1	3
Otolaryngologist						1			1	2
Physical Med Rehab									2	2
Podiatry						2			2	4
Psychiatry				1		2			2	5
Urology									2	2
Vision		1		1		3			2	7

*All required providers and additional required providers must be located within the region.

Practitioners - CFC										
Pediatricians		2		3	1	22			8	36
OB/GYNs		2		1	1	6		1	1	12
Vision		2	1	2	2	10		1	2	20
General Surgeons		2		2	1	3			2	10
Otolaryngologist		1				3			3	7
Allergists						2			2	4
Orthopedists				1		2			2	5
Dentists	1	5	1	3	3	20		1	4	38

*All required providers and additional required providers must be located within the region.
*Half of the pediatricians must be certified by the American Board of Pediatrics. No more than two-thirds of this number can be pediatric dentists.

APPENDIX I

PROGRAM INTEGRITY

MCPs must comply with all applicable program integrity requirements, including those specified in 42 CFR 455 and 42 CFR 438 Subpart H.

1. Fraud and Abuse Program:
In addition to the specific requirements of OAC rule 5101:3-26-06, MCPs must have a program that includes administrative and management arrangements or procedures, including a mandatory compliance plan to guard against fraud and abuse. The MCP's compliance plan must designate staff responsibility for administering the plan and include clear goals, milestones or objectives, measurements, key dates for achieving identified outcomes, and explain how the MCP will determine the compliance plan's effectiveness.

In addition to the requirements in OAC rule 5101:3-26-06, the MCP's compliance program which safeguards against fraud and abuse must, at a minimum, specifically address the following:

a. Employee education about false claims recovery: In order to comply with Section 6032 of the Deficit Reduction Act of 2005 MCPs must, as a condition of receiving Medicaid payment, do the following:

i. Establish and make readily available to all employees, including the MCP's management, the following written policies regarding false claims recovery:

a. Detailed information about the federal False Claims Act and other state and federal laws related to the prevention and detection of fraud, waste, and abuse, including administrative remedies for false claims and statements as well as civil or criminal penalties;

b. The MCP's policies and procedures for detecting and preventing fraud, waste, and abuse; and

c. The laws governing the rights of employees to be protected as whistleblowers.

ii. Include in any employee handbook the required written policies regarding false claims recovery;

iii. Establish written policies for any MCP contractors and agents that provide detailed information about the federal False Claims Act and other state and federal laws related to the prevention and detection of fraud, waste, and abuse, including administrative remedies for false claims and statements as well as civil

or criminal penalties; the laws governing the rights of employees to be protected as whistleblowers; and the MCP's policies and procedures for detecting and preventing fraud, waste, and abuse. MCPs must make such information readily available to their subcontractors; and

iv. Disseminate the required written policies to all contractors and agents, who must abide by those written policies.

b. Monitoring for fraud and abuse: The MCP's program which safeguards against fraud and abuse must specifically address the MCP's prevention, detection, investigation, and reporting strategies in at least the following areas:

i. Embezzlement and theft – MCPs must monitor activities on an ongoing basis to prevent and detect activities involving embezzlement and theft (e.g., by staff, providers, contractors, etc.) and respond promptly to such violations.

ii. Underutilization of services – MCPs must monitor for the potential underutilization of services by their members in order to assure that all Medicaid-covered services are being provided, as required. If any underutilized services are identified, the MCP must immediately investigate and, if indicated, correct the problem(s) which resulted in such underutilization of services.

The MCP's monitoring efforts must, at a minimum, include the following activities: a) an annual review of their prior authorization procedures to determine that they do not unreasonably limit a member's access to Medicaid-covered services; b) an annual review of the procedures providers are to follow in appealing the MCP's denial of a prior authorization request to determine that the process does not unreasonably limit a member's access to Medicaid-covered services; and c) ongoing monitoring of MCP service denials and utilization in order to identify services which may be underutilized.

iii. Claims submission and billing – On an ongoing basis, MCPs must identify and correct claims submission and billing activities which are potentially fraudulent including, at a minimum, double-billing and improper coding, such as upcoding and bundling, to the satisfaction of ODJFS.

c. Reporting MCP fraud and abuse activities: Pursuant to OAC rule 5101:3-26-06, MCPs are required to submit annually to ODJFS a report which summarizes the MCP's fraud and abuse activities for the previous year in each of the areas specified above. The MCP's report must also identify any proposed changes to the MCP's compliance plan for the coming year.

d. Reporting fraud and abuse: MCPs are required to promptly report all instances of provider fraud and abuse to ODJFS and member fraud to the CDJFS. The MCP,

at a minimum, must report the following information on cases where the MCP's investigation has revealed that an incident of fraud and/or abuse has occurred:

i. Provider's name, NPI number and either their Medicaid provider number or provider reporting number (PRN);

ii. Source of complaint;

iii. Type of provider;

iv. Nature of complaint;

v. Approximate range of dollars involved, if applicable;

vi. Results of MCP's investigation and actions taken;

vii. Name(s) of other agencies/entities (e.g., medical board, law enforcement) notified by MCP; and

viii. Legal and administrative disposition of case, including actions taken by law enforcement officials to whom the case has been referred.

e. Monitoring for prohibited affiliations: The MCP's policies and procedures for ensuring that, pursuant to 42 CFR 438.610, the MCP will not knowingly have a relationship with individuals debarred by Federal Agencies, as specified in Article XII of the Agreement.

2. Data Certification:
Pursuant to 42 CFR 438.604 and 42 CFR 438.606, MCPs are required to provide certification as to the accuracy, completeness, and truthfulness of data and documents submitted to ODJFS which may affect MCP payment.

a. MCP Submissions: MCPs must submit the appropriate ODJFS-developed certification concurrently with the submission of the following data or documents:

i. Encounter Data [as specified in the Data Quality Appendix (Appendix L)]

ii. Prompt Pay Reports [as specified in the Fiscal Performance Appendix (Appendix J)]

iii. Cost Reports [as specified in the Fiscal Performance Appendix (Appendix J)]

iv. Case Management Data [as specified in the Data Quality Appendix (Appendix L)]

b. Source of Certification: The above MCP data submissions must be certified by one of the following:

i. The MCP's Chief Executive Officer;

ii. The MCP's Chief Financial Officer, or

iii. An individual who has delegated authority to sign for, or who reports directly to, the MCP's Chief Executive Officer or Chief Financial Officer.

ODJFS may also require MCPs to certify as to the accuracy, completeness, and truthfulness of additional submissions.

MCP:

APPENDIX J

FINANCIAL PERFORMANCE

1. SUBMISSION OF FINANCIAL STATEMENTS AND REPORTS

MCPs must submit the following financial reports to ODJFS:

a. The National Association of Insurance Commissioners (NAIC) quarterly and annual Health Statements (hereafter referred to as the "Financial Statements"), as outlined in OAC rule 5101:3-26-09(B). The Financial Statements must include all required Health Statement filings, schedules and exhibits as stated in the NAIC Annual Health Statement Instructions including, but not limited to, the following sections: Assets, Liabilities, Capital and Surplus Account, Cash Flow, Analysis of Operations by Lines of Business, Five-Year Historical Data, and the Exhibit of Premiums, Enrollment and Utilization. The Financial Statements must be submitted to the Bureau of Managed Care (BMC) even if the ODI does not require the MCP to submit these statements to ODI. A signed hard copy and an electronic copy of the reports in the NAIC-approved format must both be provided to ODJFS;

b. Hard copies of annual financial statements for those entities who have an ownership interest totaling five percent or more in the MCP or an indirect interest of five percent or more, or a combination of direct and indirect interest equal to five percent or more in the MCP;

c. Annual audited Financial Statements prepared by a licensed independent external auditor as submitted to the ODI, as outlined in OAC rule 5101:3-26-09(B);

d. Medicaid MCP Annual ODJFS Cost Reports for both the ABD and CFC programs and the auditor's certification of the cost report, as outlined in OAC rule 5101:3-26-09(B);

e. Medicaid MCP Annual Restated Cost Report for both the ABD and CFC programs for the prior calendar year. The restated cost report shall be audited upon the BMC's request;

f. Annual physician incentive plan disclosure statements and disclosure of and changes to the MCP's physician incentive plans, as outlined in OAC rule 5101:3-26-09(B);

g. Reinsurance agreements, as outlined in OAC rule 5101:3-26-09(C);

h. Prompt Pay Reports, in accordance with OAC rule 5101:3-26-09(B). A hard copy and an electronic copy of the reports in the ODJFS-specified format must be provided to ODJFS;

i. Notification of requests for information and copies of information released pursuant to a tort action (i.e., third party recovery), as outlined in OAC rule 5101:3-26-09.1;

j. Financial, utilization, and statistical reports, when ODJFS requests such reports, based on a concern regarding the MCP's quality of care, delivery of services, fiscal operations or solvency, in accordance with OAC rule 5101:3-26-06(D);

k. MCPs must submit ODJFS-specified reports for the calculation of items 2b. and 2c. below in hard copy and electronic formats.

Penalty for noncompliance: Noncompliance with submission of the above items will result in penalties, as outlined in Appendix N of the Provider Agreement.

2. FINANCIAL PERFORMANCE MEASURES AND STANDARDS

This Appendix establishes specific expectations concerning the financial performance of MCPs. In the interest of administrative simplicity and non-duplication of areas of the ODI authority, ODJFS' emphasis is on the assurance of access to and quality of care. ODJFS will focus only on a limited number of indicators and related standards to monitor plan performance. The three indicators and standards for this contract period are identified below, along with the calculation methodologies. The source for each indicator will be the NAIC Quarterly and Annual Financial Statements. The report period that will be used to determine compliance will be the annual Financial Statement.

a. **Indicator**: **Net Worth as measured by Net Worth Per Member**

Please refer to the ODJFS Methods for Financial Performance Measures for the definition and calculations for the Net Worth Per Member indicator.

Standard: For the period of July, 2009 through June, 2010, a minimum net worth per member of $_____, was determined from the annual CY 2008 Financial Statement submitted to ODI and the ODJFS.

b. **Indicator:** **Administrative Expense Ratio**

Please refer to the ODJFS Methods for Financial Performance Measures for the definition and calculations for the Administration Expense Ratio indicator.

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

c. **Indicator:** **Overall Expense Ratio**

Please refer to the ODJFS Methods for Financial Performance Measures for the definition and calculations for the Overall Expense Ratio indicator.

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

Penalty for noncompliance: Noncompliance with the above standards will result in penalties, as outlined in Appendix N of the Provider Agreement.

In addition, ODJFS will review two liquidity indicators if a plan demonstrates potential problems in meeting related administrative requirements or the standards listed above. The two standards, 2.d and 2.e, reflect ODJFS' expected level of performance. At this time, ODJFS has not established penalties for noncompliance with these standards; however, ODJFS will consider the MCP's performance regarding the liquidity measures, in addition to indicators 2.a., 2.b., and 2.c., in determining whether to impose a new enrollment freeze, as outlined above, or to not issue or renew a contract with an MCP. The source for each indicator will be the NAIC Quarterly and annual Financial Statements.

Long-term investments that can be liquidated without significant penalty within 24 hours, which a plan would like to include in cash and short-term investments in the next two measurements, must be disclosed in footnotes on the NAIC Reports. Descriptions and amounts should be disclosed. Please note that "significant penalty" for this purpose is any penalty greater than 20%. Also, enter the amortized cost of the investment, the market value of the investment, and the amount of the penalty.

d. **Indicator**: **Days Cash on Hand**

Please refer to the ODJFS Methods for Financial Performance Measures for the definition and calculations for the Days Cash on Hand liquidity measure.

Standard: Greater than 25 days as determined from the annual Financial Statement submitted to ODI and ODJFS.

e. **Indicator**: **Ratio of Cash to Claims Payable**

Please refer to the ODJFS Methods for Financial Performance Measures for the definition and calculations for the Ratio of Cash to Claims Payable

liquidity measure.

Standard: Greater than 0.83 as determined from the annual Financial Statement submitted to ODI and ODJFS.

3. REINSURANCE REQUIREMENTS

Pursuant to the provisions of OAC rule 5101:3-26-09(C), each MCP must carry reinsurance coverage from a licensed commercial carrier to protect against inpatient-related medical expenses incurred by Medicaid members.

The annual deductible or retention amount for such insurance must be specified in the reinsurance agreement and must not exceed $75,000.00, except as provided below. Except for transplant services, and as provided below, this reinsurance must cover, at a minimum, 80% of inpatient costs incurred by one member in one year, in excess of $75,000.00.

For transplant services, the reinsurance must cover, at a minimum, 50% of inpatient transplant related costs incurred by one member in one year, in excess of $75,000.00.

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

a. Whether the MCP has sufficient reserves available to pay unexpected claims;

b. The MCP's history in complying with financial indicators 2.a., 2.b., and 2.c., as specified in this Appendix;

c. The number of members covered by the MCP;

d. How long the MCP has been covering Medicaid or other members on a full risk basis;

e. Risk based capital ratio greater than 2.5 or higher calculated from the last annual ODI financial statement.;

f. Scatter diagram or bar graph from the last calendar year that shows the number of reinsurance claims that exceeded the current reinsurance deductible graph/chart showing

the claims history for reinsurance above the previously approved deductible from the last calendar year.

For the ABD population, the MCP has been approved to have a reinsurance policy with a deductible amount of $_____ that covers 80% of inpatient costs in excess of the deductible amount for non-transplant services.

For the CFC population, the MCP has been approved to have a reinsurance policy with a deductible amount of $_____ that covers 80% of inpatient costs in excess of the deductible amount for non-transplant services.

Penalty for noncompliance: Noncompliance with submission of the above items will result in penalties, as outlined in Appendix N of the Provider Agreement.

4. PROMPT PAY REQUIREMENTS

In accordance with 42 CFR 447.46, MCPs must pay 90% of all submitted clean claims within 30 days of the date of receipt and 99% of such claims within 90 days of the date of receipt, unless the MCP and its contracted provider(s) have established an alternative payment schedule that is mutually agreed upon and described in their contract. The clean pharmacy and non-pharmacy claims will be separately measured against the 30 and 90 day prompt pay standards. The prompt pay requirement applies to the processing of both electronic and paper claims for contracting and non-contracting providers by the MCP and delegated claims processing entities.

The date of receipt is the date the MCP receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or date of electronic payment transmission. A claim means a bill from a provider for health care services that is assigned a unique identifier. A claim does not include an encounter form.

A “claim” can include any of the following: (1) a bill for services; (2) a line item of services; or (3) all services for one recipient within a bill. A “clean claim” is a claim that can be processed without obtaining additional information from the provider of a service or from a third party.

Clean claims do not include payments made to a provider of service or a third party where the timing of the payment is not directly related to submission of a completed claim by the provider of service or third party (e.g., capitation). A clean claim also does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Penalty for noncompliance: Noncompliance with submission of the above items will result in penalties, as outlined in Appendix N of the Provider Agreement.

5. PHYSICIAN INCENTIVE PLAN DISCLOSURE REQUIREMENTS

MCPs must comply with the physician incentive plan requirements stipulated in 42 CFR 438.6(h)**.** If the MCP operates a physician incentive plan, no specific payment can be made directly or indirectly under this physician incentive plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

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

In accordance with 42 CFR 417.479 and 42 CFR 422.210, MCPs must maintain copies of the following required documentation and submit to ODJFS upon request:

a. A description of the types of physician incentive arrangements the MCP has in place which indicates whether they involve a withhold, bonus, capitation, or other arrangement. If a physician incentive arrangement involves a withhold or bonus, the percent of the withhold or bonus must be specified.

b. A description of information/data feedback to a physician/group on their: 1) adherence to evidence-based practice guidelines; and 2) positive and/or negative care variances from standard clinical pathways that may impact outcomes or costs. The feedback information may be used by the MCP for activities such as physician performance improvement projects that include incentive programs or the development of quality improvement initiatives.

c. A description of the panel size for each physician incentive plan. If patients are pooled, then the pooling method used to determine if substantial financial risk exists must also be specified.

d. If more than 25% of the total potential payment of a physician/group is at risk for referral services, the MCP must maintain a copy of the results of the required patient satisfaction survey and documentation verifying that the physician or physician group has adequate stop-loss protection, including the type of coverage (e.g., per member per year, aggregate), the threshold amounts, and any coinsurance required for amounts over the threshold.

Upon request by a member or a potential member and no later than 14 calendar days after the request, the MCP must provide the following information to the member: (1) whether the MCP uses a physician incentive plan that affects the use of referral services; (2) the

type of incentive arrangement; (3) whether stop-loss protection is provided; and (4) a summary of the survey results if the MCP was required to conduct a survey. The information provided by the MCP must adequately address the member's request.

6. NOTIFICATION OF REGULATORY ACTION

Any MCP notified by the ODI of proposed or implemented regulatory action must report such notification and the nature of the action to ODJFS no later than one working day after receipt from ODI. The ODJFS may request, and the MCP must provide, any additional information as necessary to assure continued satisfaction of program requirements. MCPs may request that information related to such actions be considered proprietary in accordance with established ODJFS procedures. Failure to comply with this provision will result in an immediate enrollment freeze.

APPENDIX K

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM AND EXTERNAL QUALITY REVIEW

1. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM

As required by federal regulation, 42 CFR 438.240, each managed care plan (MCP) must have an ongoing Quality Assessment and Performance Improvement Program (QAPI) that is annually prior-approved by the Ohio Department of Job and Family Services (ODJFS). The program must include the following elements:

a. PERFORMANCE IMPROVEMENT PROJECTS

Each MCP must conduct performance improvement projects (PIPs), including those specified by ODJFS. PIPs must achieve, through periodic measurements and intervention, significant and sustained improvement in clinical and non-clinical areas which are expected to have a favorable effect on health outcomes and satisfaction. MCPs must adhere to ODJFS PIP content and format specifications.

All ODJFS-specified PIPs must be prior-approved by ODJFS. In addition, the MCP must annually submit to ODJFS the status and results of each PIP. external quality review organization (EQRO) will assist MCPs with conducting PIPs by providing technical assistance, and will annually validate the PIPs. As a result of the EQRO validation process, the MCP must implement specific actions based on pre-established performance levels as outlined in the *Standards for Performance Improvement Project Accountability*.

The MCPs will be required to participate in a PIP collaborative beginning in SFY 2009, and as specified by ODJFS. A PIP Collaborative is defined as a cooperative quality improvement effort by the MCP, ODJFS, and the EQRO to address a clinical or non-clinical topic area relevant to the Medicaid managed care program, which is designed to identify, develop, and implement standardized measures and statewide interventions to optimize health outcomes for MCP members and improve efficiencies related to health care service delivery.

MCPs serving CFC members must initiate and complete the following PIPs:

i. Non-Clinical Topic: Identifying members with special health care needs.
ii. Clinical Topic: Percentage of members aged 2 to 21 years that access dental services.
iii. PIP Collaborative Clinical Topic: Increasing access to Early Periodic Screening Diagnosis and Treatment (EPSDT) services for members aged 0 to 21 years.

For MCPs serving ABD members, ODJFS will identify the clinical and/or non-clinical study topics by July 2010.

Initiation of the PIPs will begin in the second year of participation in the Medicaid managed care program.

b. HEALTH CARE SERVICE UTILIZATION

Each MCP must have mechanisms in place to detect under- and over-utilization of health care services. The MCP must specify the mechanisms used to monitor utilization in its annual submission of the QAPI program to ODJFS.

It should also be noted that pursuant to the program integrity provisions outlined in Appendix I, MCPs must monitor for the potential under-utilization of services by their members in order to assure that all Medicaid-covered services are being provided, as required. If any under-utilized services are identified, the MCP must immediately investigate and correct the problem(s) which resulted in such under-utilization of services.

In addition the MCP must conduct an ongoing review of service denials and must monitor utilization on an ongoing basis in order to identify services which may be under-utilized.

c. SPECIAL HEALTH CARE NEEDS

Each MCP must have mechanisms in place to assess the quality and appropriateness of care furnished to members with special health care needs. The MCP must specify the mechanisms used in its annual submission of the QAPI program to ODJFS.

d. SUBMISSION OF PERFORMANCE MEASUREMENT DATA

Each MCP must submit clinical performance measurement data as required by ODJFS that enables ODJFS to calculate standard measures. Refer to Appendix M "Performance Evaluation" for a more comprehensive description of the clinical performance measures.

Each MCP must also submit clinical performance measurement data as required by ODJFS that uses standard measures as specified by ODJFS. MCPs serving CFC members are required to submit HEDIS audited data for the following measures:

i. Well Child Visits in the First 15 Months of Life
ii. Child Immunization Status

The measures must have received a "report" designation from the HEDIS certified auditor and must be specific to the Medicaid population. Data must be submitted annually and in an electronic format as specified by ODJFS. Data will be used for MCP

clinical performance monitoring and will be incorporated into comparative reports developed by the EQRO.

MCPs serving ABD members will be required to submit Healthcare Effectiveness Data and Information Set (HEDIS) audited data for measures that will be identified by ODJFS by July 2010.

Initiation of submission of performance data for ABD will begin in the second year of participation in the Medicaid managed care program.

e. QAPI PROGRAM SUBMISSION

Each MCP must implement an evaluation process to review, revise, and/or update the QAPI program. The MCP must annually submit its QAPI program for review and approval by ODJFS.

2. EXTERNAL QUALITY REVIEW

In addition to the following requirements, MCPs must participate in external quality review activities as outlined in OAC 5101:3-26-07.

a. EQRO ADMINISTRATIVE REVIEWS

The EQRO will conduct annual focused administrative compliance assessments for each MCP which will include, but not be limited to, the following domains as specified by ODJFS: member rights and services, QAPI program, care management, provider networks, grievance system, coordination and continuity of care, and utilization management. In addition, the EQRO will complete a comprehensive administrative compliance assessment every three (3) years as required by 42 CFR 438.358 and specified by ODJFS.

In accordance with 42 CFR 438.360 and 438.362, MCPs with accreditation from a national accrediting organization approved by the CMS may request a non-duplication exemption from certain specified components of the administrative review. ODJFS will inform the MCPs when a non-duplication exemption may be requested.

b. EXTERNAL QUALITY REVIEW PERFORMANCE

In accordance with OAC rule 5101:3-26-07, each MCP must participate in an annual external quality review survey. If the EQRO cites a deficiency in performance, the MCP will be required to complete a Corrective Action Plan (CAP) (e.g., ODJFS technical assistance session) or Quality Improvement Directives (QIDs) depending on the severity of the deficiency. An example of a deficiency is if an MCP fails to meet certain clinical or administrative standards as supported by national evidence-based guidelines or best practices. Serious deficiencies may result in immediate termination or non-renewal of

the provider agreement. These quality improvement measures recognize the importance of ongoing MCP performance improvement related to clinical care and service delivery.

APPENDIX L

DATA QUALITY

A high level of performance on the data quality measures established in this appendix is crucial in order for the ODJFS to determine the value of the ABD and CFC Medicaid Managed Health Care programs and to evaluate Medicaid consumers' access to and quality of services. Data collected from MCPs are used in key performance assessments such as the external quality review, clinical performance measures, utilization review, care coordination and care management, and in determining incentives. The data will also be used in conjunction with the cost reports in setting the premium payment rates. Data sets collected from MCPs with data quality standards include: encounter data; care management data; data used in the external quality review; members' PCP data; and appeal and grievance data.

The following measures, as specified in this appendix, will be calculated per MCP and include all Ohio Medicaid members receiving services from the MCP (i.e., ABD and CFC membership, if applicable): Incomplete Outpatient Hospital Data, Rejected Encounters, Acceptance Rate, Encounter Data Accuracy, and Generic Provider Number Usage. All other measures will be calculated separately for each program (i.e., ABD and CFC) an MCP serves, with the exception of the Incomplete Data For Last Menstrual Period measure which will be calculated for the CFC program only.

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

1. ENCOUNTER DATA

For detailed descriptions of the encounter data quality measures below, see *ODJFS Methods for the CFC and ABD Encounter Data Quality Measures*.

1.a. Encounter Data Completeness

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

1.a.i. Encounter Data Volume

This measure is calculated separately for each program (i.e., ABD and CFC) an MCP serves.

Measure: The volume measure for each service category, as listed in the tables below, is the rate of utilization (e.g., discharges, visits) per 1,000 member months (MM). The measure will be calculated per MCP separately for each program (i.e., ABD and CFC).

Report Period: The report periods for the SFY 2010 and SFY 2011 contract periods are listed in Table 1 below.

Table 1. Report Periods for the SFY 2010 and SFY 2011 Contract Periods

CFC Quarterly Report Periods	ABD Quarterly Report Periods	Data Source: Estimated Encounter Data File Update	Quarterly Report Estimated Issue Date	Contract Period
Qtr 2 thru Qtr 4: 2006, Qtr 1 thru Qtr 4: 2007, 2008 Qtr 1 2009	Qtr 1 thru Qtr 4 2007, Qtr 1 thru Qtr 4 2008, Qtr 1 2009	July 2009	August 2009	SFY 2010
Qtr 3, Qtr 4: 2006, Qtr 1 thru Qtr 4: 2007, 2008 Qtr 1, Qtr 2: 2009	Qtr 1 thru Qtr 4 2007, Qtr 1 thru Qtr 4 2008, Qtr 1, Qtr 2 2009	October 2009	November 2009	
Qtr 4: 2006, Qtr 1 thru Qtr 4: 2007, 2008 Qtr 1 thru Qtr 3: 2009	Qtr 1 thru Qtr 4 2007, Qtr 1 thru Qtr 4 2008, Qtr 1 thru Qtr 3 2009	January 2010	February 2010	
Qtr 1 thru Qtr 4: 2007, 2008, 2009	Qtr 1 thru Qtr 4 2007, Qtr 1 thru Qtr 4 2008, Qtr 1 thru Qtr 4 2009	April 2010	May 2010	
Qtr 2 thru Qtr 4: 2007, Qtr 1 thru Qtr 4: 2008, 2009 Qtr 1 2010	Qtr 1 thru Qtr 4 2008, Qtr 1 thru Qtr 4 2009, Qtr 1 2010	July 2010	August 2010	SFY 2011
Qtr 3, Qtr 4: 2007, Qtr 1 thru Qtr 4: 2008, 2009 Qtr 1, Qtr 2: 2010	Qtr 1 thru Qtr 4 2008, Qtr 1 thru Qtr 4 2009, Qtr 1, Qtr 2 2010	October 2010	November 2010	
Qtr 4: 2007, Qtr 1 thru Qtr 4: 2008, 2009 Qtr 1 thru Qtr 3: 2010	Qtr 1 thru Qtr 4 2008, Qtr 1 thru Qtr 4 2009, Qtr 1 thru Qtr 3 2010	January 2011	February 2011	
Qtr 1 thru Qtr 4: 2008, 2009, 2010	Qtr 1 thru Qtr 4 2008, Qtr 1 thru Qtr 4 2009, Qtr 1 thru Qtr 4 2010	April 2011	May 2011	

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

ABD Statewide Interim Approach

ODJFS will evaluate MCP performance using the ABD statewide interim standards for encounter data volume for dates of service through June 30, 2009. The quarterly report issued in November, 2009 for dates of service through June 30, 2009 will be the last evaluation using the ABD statewide interim standards.

Interim Data Quality Standard: The utilization rate for all service categories listed in Table 2 below must be equal to or greater than the interim standards established in Table 2.

Table 2. ABD Statewide Interim Standards – Encounter Data Volume

Category	Measure per 1,000/MM	Standard for Dates of Service from 1/1/2007 Thru 6/30/2009	Description
Inpatient Hospital	Discharges	2.7	General/acute care, excluding newborns and mental health and chemical dependency services
Emergency Department	Visits	25.3	Includes physician and hospital emergency department encounters
Dental		25.5	Non-institutional and hospital dental visits
Vision		5.3	Non-institutional and hospital outpatient optometry and ophthalmology visits
Primary and Specialist Care		116.6	Physician/practitioner and hospital outpatient visits
Ancillary Services		66.8	Ancillary visits
Behavioral Health	Service	5.2	Inpatient and outpatient behavioral encounters
Pharmacy	Prescriptions	246.1	Prescribed drugs

ABD Statewide Approach

Transition to the statewide approach will occur for dates of service beginning July 1, 2009. The first evaluation using the ABD statewide standards will be issued in February, 2010. Encounter data volume will be evaluated by MCP, statewide (i.e., one utilization rate per service category for all regions in the state).

Data Quality Standard: The utilization rate for all service categories listed in Table 3 below must be equal to or greater than the standards established in Table 3.

Table 3. ABD Statewide Standards – Encounter Data Volume

Category	Measure per 1,000/MM	Standard for Dates of Service on or after July 1, 2009	Description
Inpatient Hospital	Discharges	22.0	General/acute care, excluding newborns and mental health and chemical dependency services
Emergency Department	Visits	135.0	Includes physician and hospital emergency department encounters
Dental		28.1	Non-institutional and hospital dental visits
Vision		19.2	Non-institutional and hospital outpatient optometry and ophthalmology visits
Primary and Specialist Care		452.0	Physician/practitioner and hospital outpatient visits
Ancillary Services		589.1	Ancillary visits
Behavioral Health	Service	75.5	Inpatient and outpatient behavioral encounters
Pharmacy	Prescriptions	4260.4	Prescribed drugs

CFC Interim Statewide Approach

Prior to the transition to the statewide approach, encounter data volume will be evaluated by MCP, using a CFC interim statewide approach. All regions with managed care membership will be included in results for an interim statewide encounter data volume measure until statewide evaluation is implemented (see Statewide Approach below). Encounter data volume will be evaluated by MCP. The utilization rate for all service categories listed in Table 5 must be equal to or greater than the standard established in Table 5 below. The standards listed in Table 5 below are based on utilization data for counties with managed care membership as of February 1, 2006, and have been adjusted to accommodate estimated differences in utilization for all counties in a region, including counties that did not have membership as of February 1, 2006.

Prior to implementation of the CFC statewide approach, an MCP's encounter data volume will be evaluated using and the CFC interim statewide approach.

Data Quality Standard, Interim Statewide Approach: The standards in Table 5 below apply to the MCP's CFC interim statewide results. The utilization rate for all service categories listed in Table 5 must be equal to or greater than the standard established in Table 5.

Table 5. CFC Interim Statewide Standards – Encounter Data Volume

Category	Measure per 1,000/MM	Standard for Dates of Service from 7/1/2006 thru 6/30/2009	Description
Inpatient Hospital	Discharges	2.7	General/acute care, excluding newborns and mental health and chemical dependency services
Emergency Department	Visits	25.3	Includes physician and hospital emergency department encounters
Dental		25.5	Non-institutional and hospital dental visits
Vision		5.3	Non-institutional and hospital outpatient optometry and ophthalmology visits
Primary and Specialist Care		116.6	Physician/practitioner and hospital outpatient visits
Ancillary Services		66.8	Ancillary visits
Behavioral Health	Service	5.2	Inpatient and outpatient behavioral encounters
Pharmacy	Prescriptions	246.1	Prescribed drugs

CFC Statewide Approach

Transition to the CFC statewide approach will occur for dates of service beginning July 1, 2009. The first evaluation using the CFC statewide standards will be issued in February, 2010. Encounter data volume will be evaluated by MCP, statewide (i.e., one utilization rate per service category for all regions in the state).

Data Quality Standard, Statewide Approach:
The standards in Table 6 below apply to the MCP's CFC statewide results. The standards listed in Table 6 are based on utilization data for regions and have been adjusted to accommodate estimated differences in utilization for all counties in a region, including counties that did not have membership as of February 1, 2006. The utilization rate for all service categories listed in Table 6 must be equal to or greater than the standard established in Table 6.

Table 6. CFC Statewide Standards for Dates of Service on or after July 1, 2009 – Encounter Data Volume

Category	Measure per 1,000/MM	Standard for Dates of Service on or after July 1, 2009	Description
Inpatient Hospital	Discharges	4.6	General/acute care, excluding newborns and mental health and chemical dependency services
Emergency Department	Visits	61.6	Includes physician and hospital emergency department encounters
Dental		34.0	Non-institutional and hospital dental visits
Vision		11.6	Non-institutional and hospital outpatient optometry and ophthalmology visits
Primary and Specialist Care		267.5	Physician/practitioner and hospital outpatient visits
Ancillary Services		152.5	Ancillary visits
Behavioral Health	Service	16.0	Inpatient and outpatient behavioral encounters
Pharmacy	Prescriptions	579.9	Prescribed drugs

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

1.a.ii. Incomplete Outpatient Hospital Data

This measure is calculated per MCP and includes all Ohio Medicaid members receiving services from the MCP (i.e., ABD and CFC membership, if applicable).

Since July 1, 1997, MCPs have been required to provide both the revenue code and the HCPCS code on applicable outpatient hospital encounters. ODJFS will be monitoring, on a quarterly basis, the percentage of hospital encounters which contain a revenue code and CPT/HCPCS code. A CPT/HCPCS code must accompany certain revenue center codes. These codes are listed in Appendix B of OAC rule 5101:3-2-21 (FFS outpatient hospital policies) and in the methods for calculating the completeness measures.

Measure: The percentage of outpatient hospital line items with certain revenue center codes, as explained above, which had an accompanying valid procedure (CPT/HCPCS) code. The measure will be calculated per MCP for all programs an MCP serves.

Report Period: For the report periods for the SFY 2010 and SFY 2011 contract periods, performance will be evaluated using the report periods are listed in Table 7 below.

Table 7. Report Periods for the SFY 2010 and SFY 2011 Contract Periods

Combined CFC and ABD Quarterly Report Periods	Data Source: Estimated Encounter Data File Update	Quarterly Report Estimated Issue Date	Contract Period
Qtr 2 thru Qtr 4: 2006, Qtr 1 thru Qtr 4: 2007, 2008 Qtr 1 2009	July 2009	August 2009	SFY 2010
Qtr 3, Qtr 4: 2006, Qtr 1 thru Qtr 4: 2007, 2008 Qtr 1, Qtr 2: 2009	October 2009	November 2009	
Qtr 4: 2006, Qtr 1 thru Qtr 4: 2007, 2008 Qtr 1 thru Qtr 3: 2009	January 2010	February 2010	
Qtr 1 thru Qtr 4: 2007, 2008, 2009	April 2010	May 2010	
Qtr 2 thru Qtr 4: 2007, Qtr 1 thru Qtr 4: 2008, 2009 Qtr 1 2010	July 2010	August 2010	SFY 2011
Qtr 3, Qtr 4: 2007, Qtr 1 thru Qtr 4: 2008, 2009 Qtr 1, Qtr 2: 2010	October 2010	November 2010	
Qtr 4: 2007, Qtr 1 thru Qtr 4: 2008, 2009 Qtr 1 thru Qtr 3: 2010	January 2011	February 2011	
Qtr 1 thru Qtr 4: 2008, 2009, 2010	April 2011	May 2011	

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

Data Quality Standard: The data quality standard is a minimum rate of 95%.

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

1.a.iii. CFC - Incomplete Data For Last Menstrual Period

This measure is calculated for the CFC program only.

As outlined in *ODJFS Encounter Data Specifications*, the last menstrual period (LMP) field is a required encounter data field. It is discussed in Item 14 of the "HCFA 1500 Billing

Instructions." The date of the LMP is essential for calculating the clinical performance measures and allows the ODJFS to adjust performance expectations for the length of a pregnancy.

The occurrence code and date fields on the UB-92, which are "optional" fields, can also be used to submit the date of the LMP. These fields are described in Items 32a & b, 33a & b, 34a & b, 35a & b of the "Inpatient Hospital" and "Outpatient Hospital UB-92 Claim Form Instructions."

An occurrence code value of '10' indicates that a LMP date was provided. The actual date of the LMP would be given in the 'Occurrence Date' field.

Measure: The percentage of recipients with a live birth during the report period where a "valid" LMP date was given on one or more of the recipient's perinatal claims. If the LMP date is before the date of birth and there is a difference of between 119 and 315 days between the date the recipient gave birth and the LMP date, then the LMP date will be considered a valid date. The measure will be calculated per MCP (i.e., to include the MCP's service area for the CFC.

Report Period: For the SFY 2010 contract period, performance will be evaluated using the January - December 2009 report period. For the SFY 2011 contract period, performance will be evaluated using the January - December 2010 report period.

Data Quality Standard: The data quality standard is a minimum rate of 80%.

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

1.a.iv. Rejected Encounters

Encounters submitted to ODJFS that are incomplete or inaccurate are rejected and reported back to the MCPs on the Exception Report. If an MCP does not resubmit rejected encounters, ODJFS' encounter data set will be incomplete.

These measures are calculated per MCP and include all Ohio Medicaid members receiving services from the MCP (i.e., ABD and CFC membership, if applicable).

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

Measure 1: The percentage of encounters submitted to ODJFS that are rejected. The measure will be calculated per MCP.

Report Period: For the SFY 2010 contract period, performance will be evaluated using the following report periods: July - September 2009; October - December 2009; January - March 2010; and April – June 2010. For the SFY 2011 contract period, performance will be evaluated using the following report periods: July - September 2010; October - December 2010; January - March 2011; and April – June 2010.

Data Quality Standard for measure 1: The data quality standard for measure 1 is a maximum encounter data rejection rate of 10% for each file type in the ODJFS-specified medium per format. The measure will be calculated per MCP.

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

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

Measure 2: The percentage of encounters submitted to ODJFS that are rejected. The measure will be calculated per MCP.

Report Period: The report period for Measure 2 is monthly. Results are calculated and performance is monitored monthly. The first reporting month begins with the third month of enrollment.

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

Third through sixth month with membership: 50%

Seventh through twelfth month with membership: 25%

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

1.a.v. Acceptance Rate

This measure is calculated per MCP and includes all Ohio Medicaid members receiving services from the MCP (i.e., ABD and CFC membership, if applicable).

This measure only applies to MCPs that have had Medicaid membership for one year or less.

Measure: The rate of encounters that are submitted to ODJFS and accepted (i.e. accepted encounters per 1,000 member months). The measure will be calculated per MCP.

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

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

Third through sixth month with membership:
50 encounters per 1,000 MM for NCPDP
65 encounters per 1,000 MM for NSF
20 encounters per 1,000 MM for UB-92

Seventh through twelfth month of membership:
250 encounters per 1,000 MM for NCPDP
350 encounters per 1,000 MM for NSF
100 encounters per 1,000 MM for UB-92

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

1.b. Encounter Data Accuracy

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

1.b.i. Encounter Data Accuracy Studies

Measure 1 (CFC program only): The focus of this accuracy study will be on delivery encounters. Its primary purpose will be to verify that MCPs submit encounter data accurately and to ensure only one payment is made per delivery. The rate of appropriate payments will be determined by comparing a sample of delivery payments to the medical record. The measure will be calculated per MCP for MCPs serving the CFC program (i.e., to include the MCP's entire service area for the CFC membership).

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

Medical records retrieval from the provider and submittal to ODJFS or its designee is an integral component of the validation process. ODJFS has optimized the sampling to minimize the number of records required. This methodology requires a high record submittal rate. To aid MCPs in achieving a high submittal rate, ODJFS will give at least an 8 week period to retrieve and submit medical records as a part of the validation process. A record submittal rate will be calculated as a percentage of all records requested for the study.

Data Quality Standard 1 for Measure 1: For results that are finalized during the contract year, the accuracy rate for encounters generating delivery payments is 100%.

Data Quality Standard 2 for Measure 1: A minimum record submittal rate of 85%.

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

Measure 2 (CFC and ABD combined, if applicable): This accuracy study will compare the accuracy and completeness of payment data stored in MCPs' claims systems during the study period to payment data submitted to and accepted by ODJFS. The measure will be calculated per MCP. Two levels of analysis will be conducted: one to evaluate encounter data completeness for which two rates will be calculated and one to evaluate payment data accuracy. Payment completeness and accuracy rates will be determined by aggregating data across claim types (i.e., professional, institutional, and pharmacy) and stratifying data by file type (i.e., header and detail).

Encounter Data Completeness (Level 1):
Omission Encounter Rate: The percentage of encounters in an MCP's fully adjudicated claims file not present in the ODJFS encounter data files.

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

Payment Data Accuracy (Level 2):
Payment Error Rate: The percentage of matched encounters between the ODJFS encounter data files and an MCP's fully adjudicated claims files where a payment amount discrepancy was identified.

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

Data Quality Standard for Measure 2:

For SFY 2010:
For Level 1: An omission encounter rate and a surplus encounter rate of no more than 11% for both header and detail records.
For Level 2: A payment error rate of no more than 4%.

For SFY 2011:
For Level 1: An omission encounter rate and a surplus encounter rate of no more than 11% for both header and detail records.
For Level 2: A payment error rate of no more than 4%.

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

1.b.ii. Generic Provider Number Usage

This measure is calculated per MCP and includes all Ohio Medicaid members receiving services from the MCP (i.e., ABD and CFC membership, if applicable).

Measure 1: This measure is the percentage of institutional (UB-92) and professional (NSF) encounters with the generic provider number in the Medicaid Provider Number field. Providers submitting claims which do not have an Medicaid Management Information System (MMIS) provider number in the Medicaid Provider Number field must be submitted to ODJFS with the generic provider number (i.e. 9111115). The measure will be calculated per MCP. The report period for this measure is quarterly.

Report Period for Measure 1: For the SFY 2010 and SFY 2011 contract periods, performance will be evaluated using the CFC quarterly report periods listed in 1.a.i., Table 1.

Data Quality Standard for Measure 1: A maximum generic provider number usage rate of 10%.

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

Measure 2: Note: This measure will be revised or rescinded with the amendments made to this Provider Agreement for a February 1, 2010 effective date. This measure is the percentage of pharmacy encounters with the generic provider number in the "Prescribing Provider ID" field. Providers submitting claims which do not have an MMIS provider number in the "Prescribing Provider ID" field must be submitted to ODJFS with the generic provider number (i.e. 9111115). The measure will be calculated per MCP. The report period for this measure is quarterly.

Report Period for Measure 2: For the SFY 2010 and SFY 2011 contract periods, performance will be evaluated using the CFC quarterly report periods listed in 1.a.i., Table 1.

Data Quality Standard for Measure 2: For the SFY 2010 and SFY 2011 contract periods, the data quality standard for this measure is to be determined.

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

1.c. Timely Submission of Encounter Data

1.c.i. Timeliness

ODJFS recommends submitting encounters no later than thirty-five days after the end of the month in which they were paid. ODJFS does not monitor standards specifically for timeliness, but the minimum claims volume (Section 1.a.i.) and the rejected encounter (Section 1.a.iv.) standards are based on encounters being submitted within this time frame.

1.c.ii. Submission of Encounter Data Files in the ODJFS-Specified Medium per Format

Information concerning the proper submission of encounter data may be obtained from the *ODJFS Encounter Data File Submission Specifications* document. The MCP must submit a letter of certification, using the form required by ODJFS, with each encounter data file in the ODJFS-specified medium per format.

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

2. CARE MANAGEMENT DATA

ODJFS designed a Care Management System (CAMS) in order to monitor MCP compliance with program requirements specified in Appendix G, *Coverage and Services*. Each MCP's care management data submissions will be assessed for completeness and accuracy. The MCP is responsible for submitting a care management file every month according to the specifications established in *ODJFS' Care Management File and Submission Specifications*. Failure to do so jeopardizes the MCP's ability to demonstrate compliance with care management requirements.

2.a. Timely Submission of Care Management Files

Data Quality Submission Requirement: The MCP must submit Care Management files on a monthly basis according to the specifications established in *ODJFS' Care Management Files and Submission Specifications.*

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

3. MEMBERS' PCP DATA

The designated PCP is the provider who will manage and coordinate the overall care for members, including those who have care management needs. The MCP must submit a Members' Designated PCP file every month. Specialists may and should be identified as the PCP as appropriate for the member's condition per the specialty types specified for the ABD and CFC populations in *ODJFS Member's PCP Data File and Submission Specifications*; however, no member may have more than one PCP identified for a given month.

3.a. Timely submission of Members' PCP Data

Data Quality Submission Requirement: The MCP must submit a Members' Designated PCP Data file on a monthly basis according to the specifications established in *ODJFS Member's PCP Data File and Submission Specifications*.

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

3.b. Designated PCP for newly enrolled members

This measure is calculated separately for each program (i.e., ABD and CFC) an MCP serves.

Measure: The percentage of MCP's newly enrolled members who were designated a PCP by their effective date of enrollment.

Report Periods: For SFY 2010, MCPs will implement revised data collection and submission processes, if necessary, to align with the updated methodology for this measure. For the SFY 2011 contract period, a baseline level of performance will be set using CY 2010 data. For the SFY 2012 contract period, performance will be evaluated annually using CY 2011.

Data Quality Targets: For the SFY 2012 contract period, a target rate of 85.0% of new members with PCP designation by their effective date of enrollment.

Data Quality Standards: For the SFY 2011 contract period, a baseline level of performance will be set. For the SFY 2012 contract period, the level of improvement must result in at least a 10% decrease in the difference between the target and the previous report period's results.

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

4. APPEALS AND GRIEVANCES DATA

Pursuant to OAC rule 5101:3-26-08.4, MCPs are required to submit information at least monthly to ODJFS regarding appeal and grievance activity. ODJFS requires these submissions to be in an electronic data file format pursuant to the *Appeal File and Submission Specifications* and G*rievance File and Submission Specifications*.

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

MCPs who fail to submit their monthly electronic data files to the ODJFS by the specified due date or who fail to resubmit, by no later than the end of that month, a file which meets the data quality requirements will be subject to penalty as stipulated under the Compliance Assessment System (Appendix N).

APPENDIX M

PERFORMANCE EVALUATION

This appendix establishes performance measures and Minimum Performance Standards for managed care plans (MCPs) in key program areas, under the Agreement. The intent is to maintain accountability for contract requirements. Performance measures and standards are subject to change based on the revision or update of applicable national measures, standards, methods, benchmarks, or other factors as deemed relevant. Performance will be evaluated in the categories of Quality of Care, Access, Consumer Satisfaction, and Administrative Capacity. Each performance measure has an accompanying Minimum Performance Standard. MCPs with performance levels below the Minimum Performance Standards will be required to take corrective action. Selected measures in this appendix will be used to determine incentives as specified in Appendix O, *Pay for Performance (P4P).*

All performance measures, as specified in this appendix, are calculated per MCP. All performance measures in this appendix are calculated separately for each program an MCP serves (i.e., Aged, Blind, or Disabled (ABD), Covered Families and Children (CFC)), with two exceptions. The PCP Turnover measure includes all Ohio members receiving services from the MCP (i.e., ABD and CFC, as applicable). The Independent External Quality Review measure may or may not include all Ohio members receiving services from the MCP (i.e., ABD and CFC, as applicable) depending on the clinical and non-clinical areas of performance under review in any given year.

An MCP's performance is evaluated utilizing statewide results that include all members who meet the criteria specified per the given methodology for each measure. The ABD program has always been evaluated using a statewide approach. The CFC program transitioned to a statewide approach for performance evaluation beginning January 1, 2008. SFY 2010 marks the full implementation of the statewide approach to performance evaluation for the CFC program. Prior to using a statewide approach, MCPs with CFC membership prior to February 1, 2006 were evaluated using a county-based statewide approach.

The Ohio Department of Job and Family Services (ODJFS) reserves the right to revise report periods (and corresponding compliance periods), as needed, due to unforeseen circumstances. Unless otherwise noted, the most recent report or study finalized prior to the end of the contract period will be used in determining the MCP's performance level for that contract period.

1. QUALITY OF CARE

1.a. Independent External Quality Review

In accordance with federal law and regulations, state Medicaid agencies must annually provide for an external quality review of the quality outcomes and timeliness of, and access to, services provided by Medicaid-contracting MCPs [(42 CFR 438.204(d)]. The external review assists the

state in assuring MCP compliance with program requirements and facilitates the collection of accurate and reliable information concerning MCP performance.

Measure: The independent external quality review covers a review of clinical and non-clinical performance as outlined in Appendix K.

Report Period: Performance will be evaluated using the reviews conducted during SFY 2010.

The penalties for noncompliance with this measure are listed in Appendix N, *Compliance Assessment System.*

1.b. Members with Special Health Care Needs (MSHCN)

In order to ensure state compliance with the provisions of 42 CFR 438.208, the Bureau of Managed Health (BMC) established care management basic program requirements as set forth in Appendix G, *Coverage and Services* of the Agreement, and corresponding performance measures and Minimum Performance Standards as described below. The purpose of these measures is to ensure appropriate care management services are provided to MSHCN who have specific diagnoses and/or who require high-cost or extensive services. For detailed methodologies for each measure, see *ODJFS Methods for Members with Special Healthcare Needs Performance Measures for the ABD Program*, and *ODJFS Methods for Members with Special Healthcare Needs Performance Measures for the CFC Program*.

1.b.i. *ABD / CFC* **Care Management of Members** *(applicable to performance evaluation beginning January 2009)*

ABD / CFC *Measure:* The average monthly care management rate for members who have had at least three consecutive months of enrollment in one MCP (including members assigned to low, medium, and high risk stratification levels).

ABD / CFC Report Period: For the SFY 2009 contract period, January – March 2009 (informational only), and April – June 2009 (informational only) report periods. For the SFY 2010 contract period, July-December 2009 (baseline – reporting only), and January – June 2010. For the SFY 2011 contract period, July – December 2010, and January – June 2011 report periods.

ABD / CFC Regional-Based Statewide Approach: MCPs are evaluated using a regional-based statewide result, including all regions in which an MCP has membership. ODJFS used the April – June 2009 report period as the baseline report period to determine a Minimum Performance Standard and target. July- December 2009 will be the baseline report period. January – June 2010 will by the first report period that MCPs will be held accountable to the performance standard and penalties will be applied for noncompliance.

ABD / CFC Interim Regional-Based Statewide Minimum Performance Standard: For SFY 2009, each MCP was required to submit a Quality Improvement Plan (QIP) which addressed the

following: 1) strategies the MCP will implement to identify members eligible for care management services, including low, medium, and high-risk stratification levels; and 2) strategies the MCP will implement to ensure the MCP's information technology system is designed to accept, integrate, and analyze data used to inform and support the MCP's Care Management Program, including the MCP's process for submitting data to CAMS as outlined in the file specifications. The MCP was required to incorporate the QIP into the submission of its Care Management Program for ODJFS review and approval as outlined in Appendix G.

ABD / CFC Regional-Based Statewide Target: For SFY 2010 and SFY 2011, the target is a care management rate of 70% for the ABD population and 15% for the CFC population.

ABD / CFC Regional-Based Statewide Minimum Performance Level: For SFY 2010 and SFY 2011, a care management rate of 27.0% for the ABD population and 5.0% for the CFC population.

ABD / CFC Regional-Based Statewide Minimum Performance Standard: For SFY 2010 and SFY 2011, for the MCP that falls below the minimum performance level, the MCP must meet the minimum performance level. For the MCP that already meets the minimum performance level, the MCP must achieve a level of improvement that is at least a 5.0% decrease in the difference between the target and the previous report period's results.

The penalties for noncompliance with the standards for this measure are listed in Appendix N, *Compliance Assessment System.*

1.b.ii. *ABD / CFC* **Care Management of High Risk Members** *(applicable to performance evaluation beginning January 2009)*

ABD / CFC Measure: The percent of high risk members who have had at least three consecutive months of enrollment in one MCP that are care managed.

ABD / CFC Report Period: For the SFY 2009 contract period, January – March 2009 (informational only), and April – June 2009 (baseline - reporting only) report periods. For the SFY 2010 contract period, July – September 2009, October – December 2009, January – March 2010, and April – June 2010 report periods. For the SFY 2011 contract period, July – September 2010, October – December 2010, January – March 2011, and April – June 2011 report periods.

ABD / CFC Regional-Based Statewide Approach: Performance is evaluated using a regional-based statewide approach for all active regions in which the MCP has membership. ODJFS used the April – June 2009 report period as the baseline report period. July-September 2009 will be the first report period that MCPs will be held accountable to the performance standard and penalties will be applied for noncompliance.

ABD / CFC Interim Regional-Based Statewide Minimum Performance Standard: For SFY 2009, each MCP was required to submit a Quality Improvement Plan (QIP) which addressed the following: 1) strategies the MCP will implement to identify members eligible for care management services, including low, medium, and high-risk stratification levels; and 2) strategies

the MCP will implement to ensure the MCP's information technology system is designed to accept, integrate, and analyze data used to inform and support the MCP's Care Management Program, including the MCP's process for submitting data to CAMS as outlined in the file specifications. The MCP was required to incorporate the QIP into the submission of its Care Management Program for ODJFS review and approval as outlined in Appendix G.

ABD / CFC Regional-Based Statewide Target: For SFY 2010 and SFY 2011, the target is a care management rate of 80% for the ABD population and 70% for the CFC population.

ABD / CFC Minimum Performance Standard: For SFY 2010 and SFY 2011, the standard is a level of improvement that is at least a 5.0% decrease in the difference between the target and the previous report period's results.

The penalties for noncompliance with the standards for this measure are listed in Appendix N, *Compliance Assessment System.*

1.c. Clinical Performance Measures

MCP performance will be assessed based on the analysis of submitted encounter data for each year. For certain measures, standards are established; the identification of these standards is not intended to limit the assessment of other indicators for performance improvement activities. Performance on multiple measures will be assessed and reported to the MCPs and others, including Medicaid consumers.

The clinical performance measures described below closely follow the NCQA HEDIS. Minor adjustments to HEDIS measures are required to account for the differences between the commercial population and Medicaid population, such as shorter and interrupted enrollment periods. NCQA may annually change its method for calculating a measure. These changes can make it difficult to evaluate whether improvement occurred from a prior year. For this reason, ODJFS will use the same methods to calculate the baseline results and the results for the period in which the MCP is being held accountable. For example, the same methods are used to calculate calendar year 2008 results (the baseline period) and calendar year 2009 results. The methods will be updated and a new baseline will be created during 2009 for calendar year 2010 results. These results will then serve as the baseline to evaluate whether improvement occurred from calendar year 2009 to calendar year 2010. Clinical performance measure results will be calculated after a sufficient amount of time has passed after the end of the report period in order to allow for claims runout. For a comprehensive description of the clinical performance measures below, see *ODJFS Methods for Clinical Performance Measures for the ABD Program*, and *ODJFS Methods for Clinical Performance Measures for the CFC Program* . Performance measures and standards are subject to change, based on the revision or update of NCQA methods or other national measures, standards, methods or benchmarks.

1.c.i. Approach

ABD Program

MCPs are evaluated using a statewide result, including all regions in which an MCP has membership. ODJFS used the first calendar year of an MCP's ABD managed care program membership as the baseline year (i.e., CY 2007) for one year measures. The baseline year was used to determine performance standards and targets for one year measures. For those performance measures that require two calendar years of baseline data, the additional calendar year of baseline data (i.e., the calendar year prior to the first calendar year of ABD managed care program membership, i.e., CY 2006) came from FFS claims data. These baseline years were used to determine performance standards and targets for two year measures.

An MCP's second calendar year of ABD managed care program membership (i.e., CY 2008) is the initial report period of evaluation for performance measures that require one calendar year of baseline data (i.e., CY 2007), and for performance measures that require two calendar years of baseline data (i.e., CY 2006 and CY 2007).

For reporting period CY 2008, MCP performance is evaluated using Interim Minimum Performance Standards. ODJFS will use performance targets and Minimum Performance Standards for evaluation for reporting periods CY 2009 and thereafter.

Report Period: For the SFY 2009 contract period, performance will be evaluated using the January - December 2008 report period. For the SFY 2010 contract period, performance will be evaluated using the January - December 2009 report period. For the SFY 2011 contract period, performance will be evaluated using the January – December 2010 report period.

CFC Program

For an MCP which had membership as of February 1, 2006: MCP performance is evaluated using an MCP's county-based statewide result for the counties in which the MCP had membership as of February 1, 2006. For reporting period CY 2008, the county-based statewide targets and performance standards for the CFC Clinical Performance Measures in this Appendix *(1.c.ii.)* are applicable to all counties in which MCPs had membership as of February 1, 2006. The final reporting year (for evaluation) for the counties in which an MCP had membership as of February 1, 2006, for one year measures, is CY 2007. The final reporting year (for evaluation) for the counties in which an MCP had membership as of February 1, 2006, for two year measures, is CY 2008. The final reporting year (for P4P) for the counties in which an MCP had membership as of February 1, 2006, for both one and two year measures, is CY 2008.

For any MCP which did not have membership as of February 1, 2006: MCP Performance is evaluated using an MCP's regional-based statewide result for all active regions in which the MCP has membership. For reporting period CY 2008, MCP performance is evaluated using Interim Regional-Based Statewide Minimum Performance Standards. ODJFS will evaluate MCP

performance using regional-based statewide targets and performance standards beginning with reporting period CY 2009.

For measures requiring one year of baseline data, ODJFS used the first full calendar year of data (CY 2007) from all MCPs serving CFC membership as the baseline. CY 2008 is the first reporting year that MCPs are held accountable to the statewide performance standards for one year measures.

For measures requiring two years of baseline data, ODJFS used the first two full calendar years of data (CY 2007 and CY 2008) from all MCPs serving CFC membership to determine Statewide Minimum Performance Standards. CY 2009 is the first reporting year that MCPs are held accountable to the statewide performance standards for two year measures, and penalties will be applied for noncompliance.

Statewide performance measure results will be calculated after a sufficient amount of time has passed after the end of the report period in order to allow for claims runout.

Report Period: For the SFY 2009 contract period, performance is evaluated using the January - December 2008 report period. For the SFY 2010 contract period, performance will be evaluated using the January – December 2009 report period. For the SFY 2011 contract period, performance will be evaluated using the January – December 2010 report period.

1.c.ii. Measures, Targets, and Standards

ABD Program

MCPs serving the ABD population are held accountable for their performance on the measures listed in Table 1 below. For SFY 2009 (report period CY 2008), MCPs are evaluated using the Interim Minimum Performance Standards listed in Table 1 below. For SFY 2010 (report period CY 2009) and SFY 2011 (report period CY 2010), MCPs will be evaluated using the targets and Minimum Performance Standards listed in Table 1 below. The penalties for noncompliance with the Minimum Performance Standards for these measures are listed in Appendix N, *Compliance Assessment System*.

Table 1. Clinical Performance Measures for the ABD Program

Measure	*Description*	*Int. Min. Perf. Std.*	*Target*	*Minimum Performance Standard*
Inpatient Hospital Discharge Rate	The number of acute inpatient hospital discharges in the reporting year (where the principal diagnosis was Congestive Health Failure [CHF], Coronary Artery Disease [CAD], Hypertension, Diabetes, Chronic Obstructive Pulmonary Disease [COPD], Asthma, Mental Health [SMD], or Substance Abuse [AOD]), per thousand member months, for members who had the same diagnosis in	QIP*	10.8 discharges per 1,000 member months	The level of improvement must result in at least a 10% decrease in the difference between the target and the previous report period's results.

	the year prior to the reporting year. For AOD, members need to have had, in the year prior to the reporting year, a diagnosis of AOD and one of the following: one AOD-related acute inpatient admission or two AOD related emergency department visits.			
Emergency Department (ED) Utilization Rate	The number of emergency department visits in the reporting year (where the primary diagnosis was CHF, CAD, Hypertension, Diabetes, COPD, Asthma, Mental Health [SMD], or Substance Abuse [AOD]), per thousand member months, for members who had the same diagnosis in the year prior to the reporting year. For AOD, members need to have had, in the year prior to the reporting year, a diagnosis of AOD and one of the following: one AOD-related acute inpatient admission or two AOD related emergency department visits.	QIP*	14.7 visits per 1,000 member months	The level of improvement must result in at least a 10% decrease in the difference between the target and the previous report period's results.
Inpatient Hospital Readmission Rate	The number of CHF, CAD, Mental Health [SMD], or Substance Abuse [AOD] related inpatient hospital readmissions in the reporting year for members who had the same diagnosis in the year prior to the reporting year. A readmission is defined as an admission that occurs within 30 days of a prior admission for the same diagnosis. For AOD, members need to have had, in the year prior to the reporting year, a diagnosis of AOD and one of the following: one AOD-related acute inpatient admission or two AOD related emergency department visits.	QIP*	5.9%	The level of improvement must result in at least a 10% decrease in the difference between the target and the previous report period's results.
Coronary Artery Disease (CAD) – Beta Blocker Treatment after Heart Attack**	The percentage of members 35 years of age and older as of December 31st of the reporting year who were hospitalized from January 1 – December 24th of the reporting year with a diagnosis of acute myocardial infarction (AMI) and who received an ambulatory prescription for beta blockers within seven days of discharge.	N/A	N/A	N/A
CAD – Persistence of Beta Blocker Treatment after Heart Attack***	The percentage of members 35 years of age and older as of December 31st of the reporting year who were hospitalized and discharged alive from July 1 of the year prior to the reporting year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.	N/A	82.1% (NCQA HEDIS 2008, 90th Percentile)	The level of improvement must result in at least a 10% decrease in the difference between the target and the previous report period's results.
CAD – Cholesterol Management for Patients with Cardiovascular Conditions/LDL-	The percentage of members who had a diagnosis of CAD in the year prior to the reporting year, who were enrolled for at least 11 months in the reporting year, and who received a lipid profile during the reporting year.	QIP*	86.3% (NCQA HEDIS 2008, 90th Percentile)	The level of improvement must result in at least a 10% decrease in the difference between the target and the previous

C Screening Performed				report period's results.
Diabetes – Eye Exam	The percentage of diabetic members who were enrolled for at least 11 months during the reporting year, and who received one or more retinal or dilated eye exams from an ophthalmologist or optometrist during the reporting year.	QIP*	67.6% (NCQA HEDIS 2008, 90th Percentile)	The level of improvement must result in at least a 10% decrease in the difference between the target and the previous report period's results.
Asthma – Use of Appropriate Medications for People with Asthma	The percentage of members with persistent asthma who received prescribed medications acceptable as primary therapy for long-term control of asthma.	QIP*	91.9% (NCQA HEDIS 2008, 90th Percentile)	The level of improvement must result in at least a 10% decrease in the difference between the target and the previous report period's results.
Follow-up After Hospitalization for Mental Illness	The percentage of discharges for members enrolled from the date of discharge through 30 days after discharge, who were hospitalized for treatment of selected mental health disorders and who had a follow-up visit (i.e., were seen on an outpatient basis or were in intermediate treatment with a mental health provider) within: 1) 30 Days of discharge, and 2) 7 Days of discharge.	QIP*	1)80.3% 2)65.4% (NCQA HEDIS 2008, 90th Percentile)	*For each measure*: The level of improvement must result in at least a 10% decrease in the difference between the target and the previous report period's results.

***** For SFY 2009 each MCP is required to implement a Quality Improvement Plan (QIP) for this measure, which identifies areas needing quality improvement, includes a root-cause analysis of the areas needing improvement, and establishes strategies and implementation activities to achieve continuous quality improvement for this measure.
****** The evaluation report period for this measure is CY 2008 only. For SFY 2009, this measure is reporting only.
***The initial report period of evaluation for this measure is CY 2009. This measure will replace the CAD – Beta Blocker Treatment after Heart Attack measure in the P4P in SFY 2010.

Informational Only Measures for the ABD Program

The clinical performance measures listed in Table 2 below are informational only. Although there are no performance targets or Minimum Performance Standards for these measures, results will be reported and used as one component in assessing the quality of care provided by MCPs to the ABD managed care population.

Table 2. Informational Only Measures for the ABD Program

Condition	Informational Performance Measure
CHF	Inpatient Hospital Discharge rate
	Emergency Department Utilization Rate
	Inpatient Hospital Readmission Rate
CAD	Inpatient Hospital Discharge rate
	Emergency Department Utilization Rate
	Inpatient Hospital Readmission Rate
Hypertension	Inpatient Hospital Discharge rate
	Emergency Department Utilization Rate
Diabetes	Inpatient Hospital Discharge rate
	Emergency Department Utilization Rate
	Comprehensive Diabetes Care (CDC)/HbA1c testing
	CDC/kidney disease monitored
	CDC/LDL-C screening performed
COPD	Inpatient Hospital Discharge rate
	Emergency Department Utilization Rate
	Use of Spirometry Testing in the Assessment and Diagnosis of COPD
Asthma	Inpatient Hospital Discharge rate
	Emergency Department Utilization Rate
Mental Health (SMD)	Inpatient Hospital Discharge rate
	Emergency Department Utilization Rate
	Inpatient Hospital Readmission Rate
	Antidepressant Medication Management
Substance Abuse (AOD)	Inpatient Hospital Discharge rate
	Emergency Department Utilization Rate
	Inpatient Hospital Readmission Rate
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

CFC Program

MCPs serving the CFC population are held accountable for their performance on the measures listed in Table 3 below.

For SFY 2009 (report period CY 2008):
MCPs that did not have CFC membership as of February 1, 2006 are evaluated using the Interim Regional-Based Statewide Minimum Performance Standards listed in Table 3 below.

MCPs with CFC membership as of February 1, 2006 are evaluated using the Interim Regional-Based Statewide Minimum Performance Standards for the following (one-year) measures listed in Table 3 below: *Postpartum Care, Preventive Care for Children 3-6 Years Old, Preventive Care for Children 12-21 Years Old,* and *Annual Dental Visits.* These MCPs are evaluated using the county-based statewide targets and Minimum Performance Standards for the following (two-year) measures listed in Table 3 below: *Frequency of Ongoing Prenatal Care, Initiation of Prenatal*

Care, Preventive Care for Children Who Turn 15 Months Old, Use of Appropriate Medications for People with Asthma, and *Lead Screening for 1 and 2 Year Olds.*

For SFY 2010 (report period CY 2009) and SFY 2011 (report period CY 2010):
All MCPs serving the CFC population will be evaluated using the regional-based statewide targets and Minimum Performance Standards listed in Table 3 below.

The penalties for noncompliance with the County-Based and Regional-Based Statewide Minimum Performance Standards for these measures are listed in Appendix N, *Compliance Assessment System*.

Table 3. Clinical Performance Measures for the CFC Program

Measure	*Description*	*County-Based Statewide Target*	*County-Based Statewide Minimum Performance Standard*	*Interim Regional-Based Statewide Minimum Perf. Std.*	*Regional-Based Statewide Target*	*Regional-Based Statewide Minimum Perf. Std.*
Perinatal Care-Frequency of Ongoing Prenatal Care	The percentage of enrolled women with a live birth during the year who received the expected number of prenatal visits. The number of observed versus expected visits will be adjusted for length of enrollment.	At least 80.0% of the eligible population must receive 81.0% or more of the expected number of prenatal visits.	The level of improvement must result in at least a 10.0% decrease in the difference between the target and the previous report period's results.	QIP*	80.7% (NCQA HEDIS 2008, 90th Percentile)	The level of improvement must result in at least a 10% decrease in the difference between the target and the previous report period's results.
Perinatal Care - Timeliness of Prenatal Care	The percentage of enrolled women with a live birth during the year who had a prenatal visit within 42 days of enrollment or by the end of the first trimester for those women who enrolled in the MCP during the early stages of pregnancy.	At least 90.0% of the eligible population initiates prenatal care within the specified time.	The level of improvement must result in at least a 10.0% decrease in the difference between the target and the previous report period's results.	QIP*	91.4% (NCQA HEDIS 2008, 90th Percentile)	The level of improvement must result in at least a 10% decrease in the difference between the target and the previous report period's results.
Perinatal	The percentage of	At least 80.0%	The level of	QIP*	70.6%	The level of

Care - Postpartum Care	women who delivered a live birth who had a postpartum visit on or between 21 days and 56 days after delivery.	of the eligible population must receive a postpartum visit.	improvement must result in at least a 5.0% decrease in the difference between the target and the previous report period's results.		(NCQA HEDIS 2008, 90th Percentile)	improvement must result in at least a 10% decrease in the difference between the target and the previous report period's results.
Preventive Care - (three measures)	The percentage of children who received the expected number of well-child visits adjusted by age and enrollment. The expected number of visits are as follows: 1) Children who turn 15 months old: six or more well-child visits; 2) Children who were 3, 4, 5, or 6, years old: one or more well-child visits; 3) Children who were 12 through 21 years old: one or more well-child visits.	At least 80.0% of the eligible children receive the expected number of well-child visits.	The level of improvement must result in at least a 10.0% decrease in the difference between the target and the previous report period's results.	QIP*	1)73.7% 2)78.9% 3)56.7% (NCQA HEDIS 2008, 90th Percentile)	The level of improvement must result in at least a 10% decrease in the difference between the target and the previous report period's results.
Use of Appropriate Medications for People with Asthma	The percentage of members with persistent asthma who were enrolled for at least 11 months with the plan during the year and who received prescribed medications acceptable as primary therapy for long-term control of asthma.	At least 95.0% of the eligible population must receive the recommended medications.	The level of improvement must result in at least a 10.0% decrease in the difference between the target and the previous report period's results.	QIP*	91.9% (NCQA HEDIS 2008, 90th Percentile)	The level of improvement must result in at least a 10% decrease in the difference between the target and the previous report period's results.
Annual	The percentage of	At least 60.0%	The level of	QIP*	61.3%	The level of

Dental Visits	enrolled members age 4 through 21 who were enrolled for at least 11 months with the plan during the year and who had at least one dental visit during the year.	of the eligible population receives a dental visit.	improvement must result in at least a 10.0% decrease in the difference between the target and the previous report period's results.		(NCQA HEDIS 2008, 90th Percentile)	improvement must result in at least a 10% decrease in the difference between the target and the previous report period's results.
Lead Screening for 1 and 2 Year Olds (two measures)**	The percentage of one and two year olds who received a blood lead screening by age group.	At least 80.0% of the eligible population receives a blood lead screening.	The level of improvement must result in at least a 10.0% decrease in the difference between the target and the previous report period's results.	N/A	N/A	N/A
Lead Screening in Children***	The percentage of children who have turned two years of age during the reporting year who have received one lead test on or before their second birthday.	N/A	N/A	N/A	84.0% (NCQA HEDIS 2008, 90th Percentile)	The level of improvement must result in at least a 10% decrease in the difference between the target and the previous report period's results.

***** MCPs required to implement a Quality Improvement Plan (QIP) for this measure must submit a QIP which identifies areas needing quality improvement, includes a root-cause analysis of the areas needing improvement, and establishes strategies and implementation activities to achieve continuous quality improvement for this measure.
** The final report period for these measures is CY 2008 (SFY 2009).
***The initial report period for this measure is CY 2009 (SFY 2010). This measure will replace the Lead Screening for 1 year olds and for 2 year olds in the P4P system (Appendix O) in SFY 2010.

2. ACCESS

Performance in the Access category will be determined by the following measures: PCP Turnover, Children's Access to Primary Care (CFC program only), Adults' Access to Preventive/Ambulatory Health Services, and Adults' Access to Designated PCP. For a comprehensive description of the access performance measures below, see *ODJFS Methods for*

Access Performance Measures for the ABD Program, and *ODJFS Methods for Access Performance Measures for the CFC Program*.

2.a. PCP Turnover *(applicable to performance evaluation and P4P through SFY 2009; this measure will be eliminated effective SFY 2010)*

A high PCP turnover rate may affect continuity of care and may signal poor management of providers. However, some turnover may be expected when MCPs end contracts with providers who are not adhering to the MCP's standard of care. Therefore, this measure is used in conjunction with the children and adult access and designated PCP measures to assess performance in the access category. This measure is calculated per MCP and includes all Ohio members receiving services from the MCP (i.e., ABD and CFC, as applicable).

Measure: The percentage of primary care providers (PCPs) affiliated with the MCP as of the beginning of the measurement year who were not affiliated with the MCP as of the end of the measurement year.

Report Period: For the SFY 2009 contract period, performance will be evaluated using the CY 2008 report period. For SFY 2009, the CY 2008 report period is informational only.

Regional-Based Statewide Approach: MCPs will be evaluated statewide using results for all regions in which the MCP has membership.

Interim Regional-Based Statewide Minimum Performance Standard: For SFY 2009, each MCP must submit a Quality Improvement Plan (QIP) which identifies areas needing quality improvement, includes a root-cause analysis of the areas needing improvement, and establishes strategies and implementation activities to achieve continuous quality improvement for this measure.

This measure is included in the P4P system through SFY 2009, as established in Appendix O, *Pay-for-Performance (P4P)*. For the SFY 2009 CFC P4P system determination, participating plans will be evaluated on this measure using a county-based statewide result for the counties in which the MCP had membership as of February 1, 2006. The County-Based Statewide Minimum Performance Standard for the SFY 2009 CFC P4P determination is a maximum PCP turnover rate of 18.0% for the CFC population. For the SFY 2009 ABD P4P system determination, participating plans will be evaluated on this measure using the Interim Regional-Based Statewide Minimum Performance Standard listed above.

2.b. CFC Children's Access to Primary Care *(applicable to performance evaluation through SFY 2010 for the CFC program only)*

This measure indicates whether children aged 12 months to 11 years are accessing PCPs for sick or well-child visits.

CFC Measure: The percentage of members age 12 months to 11 years who had a visit with an MCP PCP-type provider.

CFC Report Period: For the SFY 2009 contract period, performance will be evaluated using the January - December 2008 report period. For the SFY 2010 contract period, performance will be evaluated using the January – December 2009 report period.

For an MCP which had membership as of February 1, 2006: MCP performance will be evaluated using an MCP's county-based statewide result for the counties in which the MCP had membership as of February 1, 2006. The Minimum Performance Standard in this Appendix will be applicable to the MCP's county-based statewide result for the counties in which the MCP had membership as of February 1, 2006. The last reporting year using the MCP's county-based statewide result for the counties in which the MCP had membership as of February 1, 2006 is CY 2008.

*CFC County-Based Statewide Minimum Performance Standard**s***:
CY 2008 report period – 74.0% of children must receive a visit

For any MCP which did not have membership as of February 1, 2006: Performance will be evaluated using a regional-based statewide approach for all active regions in which the MCP has membership.

CFC Regional-Based Statewide Approach: MCPs will be evaluated statewide, using results for all active regions in which the MCP has membership. ODJFS will use the first two full calendar years of data (CY 2007 and CY 2008) from all MCPs serving CFC membership as a baseline to determine a Statewide Minimum Performance Standard. CY 2009 will be the first reporting year that MCPs will be held accountable to the Statewide Minimum Performance Standard for statewide reporting, and penalties will be applied for noncompliance. Statewide performance measure results will be calculated after a sufficient amount of time has passed after the end of the report period in order to allow for claims run out.

CFC Regional-Based Statewide Minimum Performance Standards:
CY 2009 report period – 84%

The penalties for noncompliance with the standards for this measure are listed in Appendix N, *Compliance Assessment System.*

2.b.i. CFC Children's Access to Primary Care *(applicable to performance evaluation as of SFY 2011 for the CFC program only)*

This measure indicates whether children aged 12 months to 19 years are accessing PCPs for sick or well-child visits.

CFC Measure: The percentage of members age 12 months to 19 years who had a visit with an MCP PCP-type provider.

CFC Report Period: For the SFY 2011 contract period, performance will be evaluated using the January - December 2010 report period.

CFC Regional-Based Statewide Approach: MCPs will be evaluated statewide, using results for all active regions in which the MCP has membership. ODJFS will use CY 2008 and CY 2009 data from all MCPs serving CFC membership as a baseline to determine a Statewide Minimum Performance Standard. CY 2010 will be the first reporting year that MCPs will be held accountable to the Statewide Minimum Performance Standard for statewide reporting, and penalties will be applied for noncompliance. Statewide performance measure results will be calculated after a sufficient amount of time has passed after the end of the report period in order to allow for claims run out.

CFC Regional-Based Statewide Minimum Performance Standard:
CY 2010 report period – To be determined (in Spring, 2010).

The penalties for noncompliance with the standards for this measure are listed in Appendix N, *Compliance Assessment System.*

2.c. ABD Member²s'/CFC Adults' Access to Preventive/Ambulatory Health Services

This measure indicates whether ABD members and CFC adult members are accessing health services.

ABD / CFC Measure: For the ABD program, this measure is the percentage of members who had an ambulatory or preventive care visit. For the CFC program, this measure is the percentage of members age 20 and older who had an ambulatory or preventive care visit.

ABD / CFC Report Period: For the SFY 2009 contract period, performance will be evaluated using the January - December 2008 report period. For the SFY 2010 contract period, performance will be evaluated using the January - December 2009 report period. For the SFY 2011 contract period, performance will be evaluated using the January - December 2010 report period.

ABD / CFC Regional-Based Statewide Approach: MCPs will be evaluated statewide using results for all regions in which the MCP has membership. For the ABD program, MCPs are held accountable to the Regional-Based Statewide Minimum Performance Standard beginning CY 2009. For the CFC program, MCPs are held accountable to the Regional-Based Statewide Minimum Performance Standard beginning CY 2009. Statewide performance measure results will be calculated after a sufficient amount of time has passed after the end of the report period in order to allow for claims run out.

ABD / CFC Interim Regional-Based Statewide Minimum Performance Standard: For SFY 2009, each MCP must implement a Quality Improvement Plan (QIP) which identifies areas needing quality improvement, includes a root-cause analysis of the areas needing improvement, and establishes strategies and implementation activities to achieve continuous quality improvement for this measure.

ABD / CFC Regional-Based Statewide Minimum Performance Standard:
CY 2009 report period –
For the CFC Program, 75% of adults must receive a visit.
For the ABD Program, 78% of members must receive a visit.

The penalties for noncompliance with the standards for this measure are listed in Appendix N, *Compliance Assessment System.*

This measure is included in the P4P system, as established in Appendix O, *Pay-for-Performance (P4P)*. For the SFY 2009 CFC P4P system determination, participating plans will be evaluated on this measure using a county-based statewide result for the counties in which the MCP had membership as of February 1, 2006. The *County-Based Statewide Minimum Performance Standard* for the SFY 2009 CFC P4P determination is: at least 63% of CFC adults receive a visit. For the SFY 2009 ABD P4P system determination, participating plans will be evaluated on this measure using the Interim Regional-Based Statewide Minimum Performance Standard listed above.

2.d. Members' Access to Designated PCP

The MCP must encourage and assist members without a designated primary care provider (PCP) to establish such a relationship, so that a designated PCP can coordinate and manage a member's health care needs. This measure is used to assess MCPs' performance in the access category.

ABD / CFC Measure: The percentage of members who had a visit through the members' designated PCPs.

ABD / CFC Report Period: For the SFY 2009 contract period, performance will be evaluated using the January - December 2008 report period. For SFY 2010, MCPs will implement revised data collection and submission processes, if necessary, to align with the updated methodology for this measure. For the SFY 2011 contract period, performance will be evaluated using the January - December 2010 report period (baseline - reporting only). For the SFY 2012 contract period, performance will be evaluated using the January – December, 2011 report period.

ABD / CFC Regional-Based Statewide Approach: MCPs will be evaluated statewide using results for all regions in which the MCP has membership. For the ABD and CFC programs, MCPs are held accountable to the Regional-Based Statewide Minimum Performance Standard beginning CY 2011. CY 2010 data will be used as a baseline. Statewide performance measure results will be calculated after a sufficient amount of time has passed following the end of the report period in order to allow for claims run out.

ABD / CFC Interim Regional-Based Statewide Minimum Performance Standard: For SFY 2009, each MCP must implement a Quality Improvement Plan (QIP) which identifies areas needing quality improvement, includes a root-cause analysis of the areas needing improvement, and establishes strategies and implementation activities to achieve continuous quality improvement for this measure.

ABD / CFC Regional-Based Statewide Performance Target:
CY 2011 – 80.0% of members must have one or more visits with their designated PCPs.

ABD / CFC Regional-Based Statewide Minimum Performance Standard:
CY 2011 report period – The level of improvement must result in at least a 10% decrease in the difference between the target and the previous report period's results.

The penalties for noncompliance with the standards for this measure are listed in Appendix N, *Compliance Assessment System.*

3. CONSUMER SATISFACTION

In accordance with federal requirements and in the interest of assessing enrollee satisfaction with MCP performance, ODJFS conducts an annual independent consumer satisfaction survey. Results are used to assist in identifying and correcting MCP performance overall and in the areas of access to care, quality of care, and member services. The results of this measure are reported annually. For a comprehensive description of the consumer satisfaction performance measure, see *ODJFS Methods for the Consumer Satisfaction Performance Measure for the CFC Program.* Consumer satisfaction performance measure methods for the ABD Program will be available in Winter, 2009.

Measure: For the CFC program, for SFY 2009, this measure is the average rating of the respondents to the consumer satisfaction survey who were asked to rate their overall satisfaction with their MCP.

For the CFC program, for SFY 2010 and SFY 2011, this measure is the overall average rating of the respondents to the consumer satisfaction survey who were asked to rate how often they were satisfied with their MCPs' customer service.

For the ABD program, for SFY 2010 and SFY 2011, this measure is the overall average rating of the respondents to the consumer satisfaction survey who were asked to rate how often they were satisfied with their MCPs' customer service.

ABD / CFC Report Period: For the SFY 2009 contract period, performance will be evaluated using the results from the CY 2009 consumer satisfaction survey. For the SFY 2010 contract period, performance will be evaluated using the results from the CY 2010 consumer satisfaction survey. For the SFY 2011 contract period, performance will be evaluated using the results from the CY 2011 consumer satisfaction survey.

ABD / CFC Regional-Based Statewide Approach: MCPs will be evaluated annually using a statewide result, including all regions in which an MCP has membership.

For the CFC Program, the first year that MCPs will be held accountable to the Regional-Based Statewide Minimum Performance Standard for evaluation is SFY 2009, using CY 2009 data. The

first year that MCPs will be held accountable to the Regional-Based Statewide Minimum Performance Standard for P4P (Appendix O) is SFY 2010, using CY 2010 data.

For the ABD Program, the first year that MCPs will be held accountable to the Regional-Based Statewide Minimum Performance Standard for evaluation and P4P (Appendix O) is SFY 2010, using CY 2010 data.

ABD / CFC Regional-Based Statewide Minimum Performance Standard:
CY 2009 report period –
For the ABD Program: N/A.
For the CFC Program: an average score of no less than 7.0.

CY 2010 report period –
For the ABD Program: an overall average score of no less than 2.0.
For the CFC Program: an overall average score of no less than 2.0.

The penalties for noncompliance with the standards for this measure are listed in Appendix N, *Compliance Assessment System.*

This measure is included in the P4P system, as established in Appendix O, *Pay-for-Performance (P4P)*. For the SFY 2009 CFC P4P system determination, participating plans will be evaluated on this measure using a county-based statewide result for the counties in which the MCP had membership as of February 1, 2006. The County-Based Statewide Minimum Performance Standard for the SFY 2009 CFC P4P determination is an average score of no less than 7.0. This measure is not used in the SFY 2009 ABD P4P system determination.

4. ADMINISTRATIVE CAPACITY

The ability of an MCP to meet administrative requirements has been found to be both an indicator of current plan performance and a predictor of future performance. Deficiencies in administrative capacity make the accurate assessment of performance in other categories difficult, with findings uncertain. Performance in this category will be determined by the Compliance Assessment System, and the Emergency Department Diversion measure described below. For a comprehensive description of the emergency department diversion measure, see *ODJFS Methods for the Administrative Capacity Performance Measure for the ABD Program*, and *ODJFS Methods for the Administrative Capacity Performance Measure for the CFC Program*.

4.a. Compliance Assessment System

ABD / CFC Measure: The number of points accumulated during a rolling 12-month period through the *Compliance Assessment System* (Appendix N).

ABD / CFC Report Period: For the SFY 2010 contract period, performance will be evaluated using a rolling 12-month report period.

ABD / CFC Performance Standard: A maximum of 15 points.

The penalties associated with accumulated points are outlined in Appendix N, *Compliance Assessment System.*

4.b. Emergency Department Diversion

Managed care plans must provide access to services in a way that assures access to primary and urgent care in the most effective settings and minimizes inappropriate utilization of emergency department (ED) services. MCPs are required to identify high utilizers of targeted ED services and implement action plans designed to minimize inappropriate, preventable, and/or primary care sensitive ED utilization.

ABD / CFC Measure: The percentage of members who had two or more *targeted* ED visits during the twelve month reporting period.

ABD / CFC Report Period:
For the SFY 2009 contract period, results will be calculated for the reporting period of CY 2008 and compared to the CY 2007 baseline results. An Interim Regional-Based Statewide Minimum Performance Standard will be used for this evaluation period. For the SFY 2010 contract period, results will be calculated for the reporting period of CY 2009 and compared to the CY 2008 baseline results to determine if the regional-based Statewide Minimum Performance Standard is met.

ABD / CFC Regional-Based Statewide Approach:
MCPs will be evaluated statewide, using results for all active regions in which the MCP has membership. ODJFS used CY 2007 as a baseline to determine a regional-based statewide target and Minimum Performance Standard. (The number of ABD members with an ED visit used to calculate the measure for the baseline year was adjusted based on the number of months of ABD managed care membership in the baseline year.)

ABD / CFC Interim Regional-Based Statewide Minimum Performance Standard:
For SFY 2009, each MCP must implement a Quality Improvement Plan (QIP) which identifies areas needing quality improvement, includes a root-cause analysis of the areas needing improvement, and establishes strategies and implementation activities to achieve continuous quality improvement for this measure.

ABD / CFC Regional-Based Statewide Target:
SFY 2010 –
For the ABD Program: a maximum of 5.00% of the eligible population will have two or more targeted ED visits during the reporting period.
For the CFC Program: a maximum of 3.00% of the eligible population will have two or more targeted ED visits during the reporting period.

ABD / CFC Regional-Based Statewide Minimum Performance Standard:
For SFY 2010, the level of improvement must result in at least a 10% decrease in the difference

between the target and the baseline period results.

The penalties for noncompliance with the standards for this measure are listed in Appendix N, *Compliance Assessment System.*

APPENDIX N

COMPLIANCE ASSESSMENT SYSTEM

I. General Provisions of the Compliance Assessment System

A. The Compliance Assessment System (CAS) is designed to improve the quality of each MCP's performance through actions taken by the ODJFS to address identified failures to meet program requirements. This appendix applies to the MCP specified in the baseline of this Agreement.

B. The CAS assesses progressive remedies with specified values (e.g., points, fines, etc.) assigned for certain documented failures to satisfy the deliverables required by OAC rule or the Agreement. Remedies are progressive based upon the severity of the violation, or a repeated pattern of violations. The CAS allows the accumulated point total to reflect patterns of less serious violations as well as less frequent, more serious violations.

C. The CAS focuses on clearly identifiable deliverables and sanctions/remedial actions are only assessed in documented and verified instances of noncompliance. The CAS does not include categories which require subjective assessments or which are not within the MCP's control.

D. The CAS does not replace ODJFS' ability to require CAPs and program improvements, or to impose any of the sanctions specified in OAC rule 5101:3-26-10, including the proposed termination, amendment, or nonrenewal of the MCP's Provider Agreement.

E. As stipulated in OAC rule 5101:3-26-10(F), regardless of whether ODJFS imposes a sanction, MCPs are required to initiate corrective action for any MCP program violations or deficiencies as soon as they are identified by the MCP or ODJFS.

F. If ODJFS determines that an MCP has violated any of the requirements of sections 1903(m) or 1932 of the Social Security Act which are not specifically identified within the CAS, ODJFS may, pursuant to the provisions of OAC rule 5101:3-26-10(A), notify the MCP's members that they may disenroll from the MCP without cause and/or suspend any further new member enrollments.

G. For purposes of the CAS, the date that ODJFS first becomes aware of an MCP's program violation is considered the date on which the violation occurred. Therefore, program violations that technically reflect noncompliance from the previous compliance term will be subject to remedial action under CAS at the time that ODJFS first becomes aware of this noncompliance.

H. In cases where an MCP contracted healthcare provider is found to have violated a program requirement (e.g., failing to provide adequate contract termination notice, marketing to potential members, inappropriate member billing, etc.), ODJFS will not assess points if: (1) the MCP can document that they provided sufficient notification/ education to providers of applicable program requirements and prohibited activities; and (2) the MCP takes immediate and appropriate action to correct the problem and to ensure that it does not happen again to the satisfaction of ODJFS.

Repeated incidents will be reviewed to determine if the MCP has a systemic problem in this area, and if so, sanctions/remedial actions may be assessed, as determined by ODJFS.

I. All notices of noncompliance will be issued in writing to the identified MCP contact.

II. Types of Sanctions/Remedial Actions

ODJFS may impose the following types of sanctions/remedial actions, including, but not limited to, the items listed below. The following are examples of program violations and their related penalties. This list is not all inclusive. As with any instance of noncompliance, ODJFS retains the right to use their sole discretion to determine and apply the most appropriate penalty based on the severity of the offense, pattern of repeated noncompliance, and number of consumers affected. Additionally, if an MCP has received any previous written correspondence regarding their duties and obligations under OAC rule or the Agreement, such notice may be taken into consideration when determining penalties and/or remedial actions.

A. Corrective Action Plans (CAPs) – A CAP is a structured activity/process implemented by the MCP to improve identified operational deficiencies.

MCPs may be required to develop CAPs for any instance of noncompliance, and CAPs are not limited to actions taken in this Appendix. All CAPs requiring ongoing activity on the part of an MCP to ensure their compliance with a program requirement remain in effect for twenty-four months.

In situations where ODJFS has already determined the specific action which must be implemented by the MCP or if the MCP has failed to submit a CAP, ODJFS may require the MCP to comply with an ODJFS-developed or "directed" CAP.

In situations where a penalty is assessed for a violation in which an MCP has previously been assessed a CAP (or any penalty or any other related written correspondence), the MCP may be assessed escalating penalties.

B. Quality Improvement Directives (QIDs) – A QID is a general instruction that directs the MCP to implement a quality improvement initiative to improve identified administrative or clinical deficiencies. All QIDs remain in effect for twelve months from the date of implementation. MCPs may be required to develop QIDs for any instance of noncompliance. In situations where ODJFS has already determined the specific action which must be implemented by the MCP or if the MCP has failed to submit a QID, ODJFS may require the MCP to comply with an ODJFS-developed or "directed" QID.
In situations where a penalty is assessed for a violation an MCP has previously been assessed a QID (or any penalty or any other related written correspondence), the MCP may be assessed escalating penalties.

C. Quality Improvement Plan (QIP) – A QIP is a written description of a MCP's process to improve access and quality of care in a clinical or administrative area. A QIP consists of three

components: data analysis, root cause analysis, and the resulting quality improvement initiative, including the implementation and completion timeline. QIPs will be required when an MCP must comply with interim performance measure standards as specified by ODJFS.

D. Points – Each MCP will start the SFY 2010 Agreement with zero points. Points will accumulate over a rolling 12-month schedule. Each month, points that are more than 12-months old will expire.

No points will be assigned for any violation where an MCP is able to document that the precipitating circumstances were completely beyond their control and could not have been foreseen (e.g., a construction crew severs a phone line, a lightning strike blows a computer system, etc.).

D.1. 5 Points - Failures to meet program requirements, including but not limited to, actions which could impair the member's ability to obtain correct **information** regarding services or which could impair a consumer's or member's rights, as determined by ODJFS, will result in the assessment of 5 points. Examples include, but are not limited to, the following:

- Violations which result in a member's MCP selection or termination based on inaccurate provider panel information from the MCP.
- Failure to provide member materials to new members in a timely manner.
- Failure to comply with appeal, grievance**,** or state hearing requirements, including the failure to notify a member of their right to a state hearing when the MCP proposes to deny, reduce, suspend or terminate a Medicaid-covered service.
- Failure to staff 24-hour call-in system with appropriate trained medical personnel.
- Failure to meet the monthly call-center requirements for either the member services or the 24-hour call-in system lines.
- Provision of false, inaccurate or materially misleading information to health care providers, the MCP's members, or any eligible individuals.
- Use of unapproved marketing or member materials.
- Failure to appropriately notify ODJFS or members of provider panel terminations.
- Failure to update website provider directories as required.
- Failure to comply with a CAP or QID.

D.2. 10 Points - Failures to meet program requirements, including but not limited to, actions which could affect the ability of the MCP to deliver or the **consumer to access** covered services, as determined by ODJFS. Examples include, but are not limited to, the following:

- Discrimination among members on the basis of their health status or need for health care services (this includes any practice that would reasonably be expected to encourage termination or discourage selection by individuals whose medical condition indicates probable need for substantial future medical services).
- Failure to assist a member in accessing needed services in a timely manner after request from the member.
- Failure to provide medically-necessary Medicaid covered services to members.

- Failure to process prior authorization requests within the prescribed time frames.
- Repeated failure to comply with a CAP or QID.

E. Fines – Refundable or nonrefundable fines may be assessed as a penalty separate to or in combination with other sanctions/remedial actions.

E.1. Unless otherwise stated, all fines are nonrefundable.

E.2. Pursuant to procedures as established by ODJFS, refundable and nonrefundable monetary sanctions/assurances must be remitted to ODJFS within thirty (30) days of receipt of the invoice by the MCP. In addition, per ORC Section 131.02, payments not received within forty-five (45) days will be certified to the Attorney General's (AG's) office. MCP payments certified to the AG's office will be assessed the appropriate collection fee by the AG's office.

E.3. Monetary sanctions/assurances imposed by ODJFS will be based on the most recent premium payments in the month of the cited deficiency.

E.4. Any monies collected through the imposition of a refundable fine will be returned to the MCP (minus any applicable collection fees owed to the AG's Office if the MCP has been delinquent in submitting payment) after they have demonstrated full compliance, as determined by ODJFS, with the particular program requirement.

E.5. MCPs are required to submit a written request for refund to ODJFS at the time they believe is appropriate before a refund of monies will be considered.

F. Combined Remedies - Notwithstanding any other action ODJFS may take under this Appendix, ODJFS may impose a combined remedy which will address many areas of noncompliance if ODJFS determines, in its sole discretion, that (1) one systemic problem is responsible for multiple areas of noncompliance and/or (2) that there are a number of repeated instances of noncompliance with the same program requirement. The total fines assessed in any one month will not exceed 15% of one month's payment from ODJFS to the MCP.

G. Progressive Remedies - Progressive remedies will be based on the number of points accumulated at the time of the most recent incident. Unless specifically otherwise indicated in this appendix, all fines are nonrefundable. The designated fine amount will be assessed when the number of accumulated points falls within the ranges specified below:

0 -15 Points	CAP
16-25 Points	CAP + $5,000 fine
26-50 Points	CAP + $10,000 fine
51-70 Points	CAP + $20,000 fine

71-100 Points	CAP + $30,000 fine
100+ Points	Proposed Contract Termination

H. New Enrollment Freezes - Notwithstanding any other penalty or point assessment that ODJFS may impose on the MCP under this Appendix, ODJFS may prohibit an MCP from receiving new enrollment through consumer initiated selection or the assignment process if: (1) the MCP has accumulated a total of 51 or more points during a rolling 12-month period; or (2) the MCP fails to fully implement a CAP within the designated time frame; or (3) circumstances exist which potentially jeopardize the MCP's members' access to care; or (4) the MCP is found to have a pattern of repeated or ongoing noncompliance. Examples of circumstances that ODJFS may consider as jeopardizing member access to care include:

- the MCP has been found by ODJFS to be noncompliant with the prompt payment or the non-contracting provider payment requirements;
- the MCP has been found by ODJFS to be noncompliant with the provider panel requirements specified in Appendix H of the Agreement;
- the MCP's refusal to comply with a program requirement after ODJFS has directed the MCP to comply with the specific program requirement; or
- the MCP has received notice of proposed or implemented adverse action by the ODI.

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

I. Reduction of Assignments – ODJFS has sole discretion over how member auto-assignments are made. ODJFS may reduce the number of assignments an MCP receives to assure program stability within a region or if ODJFS determines that the MCP lacks sufficient capacity to meet the needs of the increased enrollment volume. Examples of circumstances which ODJFS may determine demonstrate a lack of sufficient capacity include, but are not limited to an MCP's failure to: maintain an adequate provider network; repeatedly provide new member materials by the member's effective date; meet the minimum call center requirements; meet the minimum performance standards for identifying and assessing children with special health care needs and members needing care management services; and/or provide complete and accurate appeal/grievance, member's PCP and CAMS data files.

J. Termination, Amendment, or Nonrenewal of MCP Provider Agreement - ODJFS can at any time move to terminate, amend or deny issuance of a provider agreement. Upon such termination, nonrenewal, or denial of an MCP provider agreement, all previously collected monetary sanctions will be retained by ODJFS. The at-risk amount paid to the MCP under the

current provider agreement will be returned to ODJFS in accordance with Appendix P, *Terminations*, of the provider agreement.

K. Specific Pre-Determined Penalties

K.1. Adequate network-minimum provider panel requirements - Compliance with provider panel requirements will be assessed quarterly. Any deficiencies in the MCP's provider network as specified in Appendix H of the Agreement or by ODJFS, will result in the assessment of a $1,000 nonrefundable fine for each category (practitioners, PCP capacity, hospitals), for each county, and for each population (e.g., ABD, CFC). For example if the MCP did not meet the following minimum panel requirements, the MCP would be assessed (1) a $3,000 nonrefundable fine for the failure to meet CFC panel requirements; and, (2) a $1,000 nonrefundable fine for the failure to meet ABD panel requirements).

- practitioner requirements in Franklin county for the CFC population
- practitioner requirements in Franklin county for the ABD population
- hospital requirements in Franklin county for the CFC population
- PCP capacity requirements in Fairfield county for the CFC population

In addition to the pre-determined penalties, ODJFS may assess additional penalties pursuant to this Appendix (e.g. CAPs, points, fines) if member specific access issues are identified resulting from provider panel noncompliance.

K.2. GIS - Compliance with the GIS requirements may be assessed semi-annually. Any failure to meet GIS requirements as specified in Appendix H of the Agreement will result a $1,000 nonrefundable fine for each county and for each population (e.g., ABD, CFC, etc.). For example if the MCP did not meet GIS requirements in the following counties, the MCP would be assessed (1) a nonrefundable $2,000 fine for the failure to meet GIS requirements for the CFC population and (2) a $1,000 nonrefundable fine for the failure to meet GIS requirements for the ABD population.

- GIS requirements in Franklin county for the CFC population
- GIS requirements in Fairfield county for the CFC population
- GIS requirements in Franklin county for the ABD population

K.3. Late Submissions - All required submissions/data and documentation requests must be received by their specified deadline and must represent the MCP in an honest and forthright manner. Failure to provide ODJFS with a required submission or any data/documentation requested by ODJFS will result in the assessment of a nonrefundable fine of $100 per day, unless the MCP requests and is granted an extension by ODJFS. Assessments for late submissions will be done monthly. Examples of such program violations include, but are not limited to:

- Late required submissions
  - Annual delegation assessments
  - Call center report
  - State hearing notifications

- Late required data submissions
  - Appeals and grievances, care management, or PCP data
- Late required information requests
  - Automatic call distribution reports
  - Information/resolution regarding consumer or provider complaint
  - Just cause or other coordination care request from ODJFS
  - Failure to provide ODJFS with a required submission after ODJFS has notified the MCP that the prescribed deadline for that submission has passed

If an MCP determines that they will be unable to meet a program deadline or data/documentation submission deadline, the MCP must submit a written request to its Contract Administrator for an extension of the deadline, as soon as possible, but no later than 3 PM EST on the date of the deadline in question. Extension requests should only be submitted in situations where unforeseeable circumstances have occurred which make it impossible for the MCP to meet an ODJFS-stipulated deadline and all such requests will be evaluated upon this standard. Only written approval as may be granted by ODJFS of a deadline extension will preclude the assessment of compliance action for untimely submissions.

K.4. Noncompliance with Claims Adjudication Requirements - If ODJFS finds that an MCP is unable to (1) electronically accept and adjudicate claims to final status and/or (2) notify providers of the status of their submitted claims, as stipulated in Appendix C of the Agreement, ODJFS will assess the MCP with a monetary sanction of $20,000 per day for the period of noncompliance.

If ODJFS has identified specific instances where an MCP has failed to take the necessary steps to comply with the requirements specified in Appendix C of the Agreement for (1) failing to notify non-contracting providers of procedures for claims submissions when requested and/or (2) failing to notify contracting and non-contracting providers of the status of their submitted claims, the MCP will be assessed 5 points per incident of noncompliance.

K.5. Noncompliance with Financial Performance Measures and/or the Submission of Financial Statements - Failure to meet any standard for 2.a., 2.b., or 2.c. of Appendix J will result in ODJFS requiring the MCP to complete a CAP and specifying the date by which compliance must be demonstrated. Failure to meet the standard or otherwise comply with the CAP by the specified date will result in a new enrollment freeze unless ODJFS determines that the deficiency does not potentially jeopardize access to or quality of care or affect the MCP's ability to meet administrative requirements (e.g., prompt pay requirements). Justifiable reasons for noncompliance may include one-time events (e.g., MCP investment in information system products).

If Financial Statements are not submitted to ODI by the due date, the MCP continues to be obligated to submit the report to ODJFS by ODI's originally specified due date unless the MCP requests and is granted an extension by ODJFS.

Failure to submit complete quarterly and annual Financial Statements on a timely basis will be deemed a failure to meet the standards and will be subject to the noncompliance penalties listed above for indicators 2.a., 2.b., and 2.c., including the imposition of a new enrollment freeze. The new enrollment freeze will take effect at the first of the month following the month in which the determination was made that the MCP was non-compliant for failing to submit financial reports timely.

K.6. Noncompliance with Reinsurance Requirements - If it is determined that an MCP failed to have reinsurance coverage as specified in Appendix J, that an MCP's deductible exceeds $75,000.00 without approval from ODJFS, or that the MCP's reinsurance for non-transplant services covers less than 80% of inpatient costs in excess of the deductible incurred by one member for one year without approval from ODJFS, then the MCP will be required to pay a monetary penalty to ODJFS. The amount of the penalty will be the difference between the estimated amount, as determined by ODJFS, of what the MCP would have paid in premiums for the reinsurance policy if it had been in compliance and what the MCP did actually pay while it was out of compliance plus 5%. For example, if the MCP paid $3,000,000.00 in premiums during the period of non-compliance and would have paid $5,000,000.00 if the requirements had been met, then the penalty would be $2,100,000.00.

If it is determined that an MCP's reinsurance for transplant services covers less than 50% of inpatient costs incurred by one member for one year, the MCP will be required to develop a CAP.

K.7. Noncompliance with Prompt Payment: - Noncompliance with the prompt pay requirements as specified in Appendix J of the Agreement will result in progressive penalties. The first violation during a rolling 12-month period will result in the submission of quarterly prompt pay and monthly status reports to ODJFS until the next quarterly report is due. The second violation during a rolling 12-month period will result in the submission of monthly status reports and a refundable fine equal to 5% of the MCP's monthly premium payment or $300,000, whichever is less. The refundable fine will be applied in lieu of a nonrefundable fine and the money will be refunded by ODJFS only after the MCP complies with the required standards for two (2) consecutive quarters. Subsequent violations will result in an enrollment freeze.

If an MCP is found to have not been in compliance with the prompt pay requirements for any time period for which a report and signed attestation have been submitted representing the MCP as being in compliance, the MCP will be subject to an enrollment freeze of not less than three (3) months duration.

K.8. Noncompliance with Clinical Laboratory Improvement Amendments (CLIA)- Noncompliance with CLIA requirements as specified by ODJFS will result in the assessment of a nonrefundable $1,000 fine for each violation.

K.9. Noncompliance with Abortion and Sterilization Payment - Noncompliance with abortion and sterilization requirements as specified by ODJFS will result in the assessment of a

nonrefundable $2,000 fine for each documented violation. Additionally, MCPs must take all appropriate action to correct each ODJFS-documented violation.

K.10. Refusal to Comply with Program Requirements - If ODJFS has instructed an MCP that they must comply with a specific program requirement and the MCP refuses, such refusal constitutes documentation that the MCP is no longer operating in the best interests of the MCP's members or the state of Ohio and ODJFS will move to terminate or non-renew the MCP's provider agreement.

K.11. Data Quality Measures (as specified in Appendix L) - The MCP must submit to ODJFS, by the specified deadline and according to ODJFS' specifications, all required data files and requested documentation needed to calculate each measure listed under K.11. below. If an MCP fails to comply with this requirement for any measure listed under K.11. below, the MCP will be considered noncompliant with the standard(s) for that measure. ODJFS reserves the right to withhold an assessment of noncompliance under this section due to unforeseeable circumstances.

The monetary penalty for each measure listed under K.11. below shall not exceed $300,000 during each evaluation period.

K.11.a. Measures Assessed Separately By Program – For the following measures, performance is monitored and reported separately for each program (i.e., ABD, CFC) the MCP serves, as specified in Appendix L. Penalties for non-compliance are assessed separately for each program the MCP serves.

K.11.a.i. Encounter Data Volume - Performance is monitored once every quarter for the entire report period for each program the MCP serves. If the standard is not met for every service category in all quarters of the report period, then the MCP will be determined to be noncompliant for the report period.

The first time an MCP is noncompliant with a standard for this measure for a given population, ODJFS will issue a Sanction Advisory informing the MCP that any future noncompliance instances with the standard for this measure will result in ODJFS imposing a monetary sanction. Upon all subsequent measurements of performance, if an MCP is again determined to be noncompliant with the standard, ODJFS will impose a monetary sanction of two percent of the current month's premium payment. Monetary sanctions will not be levied for consecutive quarters that an MCP is determined to be noncompliant. If an MCP is noncompliant for three consecutive quarters, membership will be frozen. Once the MCP is determined to be compliant with the standard and the violations/ deficiencies are resolved to the satisfaction of ODJFS, the penalties will be lifted, if applicable, and monetary sanctions will be returned.

K.11.a.ii. Incomplete Data for LMP (CFC Program Only) - The first time an MCP is noncompliant with a standard for this measure, ODJFS will issue a Sanction Advisory informing the MCP that any future noncompliance instances with the standard for this measure will result in ODJFS imposing a monetary sanction. Upon all subsequent measurements of performance, if an MCP is again determined to be noncompliant with the standard, ODJFS will impose a

monetary sanction of one percent of the current month's premium payment. Once the MCP is performing at standard levels and violations/deficiencies are resolved to the satisfaction of ODJFS, the money will be refunded.

K.11.a.iii. Designated PCP for Newly Enrolled Members - If an MCP is noncompliant with the standard, ODJFS will impose a monetary sanction of one-half of one percent the current month's premium payment. However, no monetary sanctions will be imposed if the MCP is in its first contract year of Medicaid program participation. Once the MCP is performing at standard levels and violations/deficiencies are resolved to the satisfaction of ODJFS, the money will be refunded. As stipulated in OAC rule 5101:3-26-08.2, each new member must have a designated PCP prior to their effective date of coverage. Therefore, MCPs will be subject to additional corrective action measures under this Appendix, for failure to meet this requirement.

K.11.a.iv. Encounter Data Accuracy Study

Delivery Payment Measure – Compliance with this measure is only assessed for MCPs serving the CFC program. The MCP must participate in a detailed review of delivery payments made for deliveries during the report period. The accuracy rate for encounters generating delivery payments is 100%; therefore, any duplicate delivery payments or delivery payments that are not validated must be returned to ODJFS. For all encounter data accuracy studies that are completed during this contract period, if an MCP does not meet the minimum record submittal rate of 85%, ODJFS will impose a non-refundable $10,000 monetary sanction. However, no monetary sanctions will be imposed if the MCP is in its first contract year of Medicaid program participation.

K.11.b Data Quality Measures Assessed For All Programs An MCP Serves - For the following measures, performance is monitored and reported for all programs (i.e., ABD, CFC) the MCP serves, as specified in Appendix L. Penalties for noncompliance are assessed at the MCP level per measure and apply to all programs an MCP serves.

K.11.b.i. Incomplete Outpatient Hospital Data - Performance is monitored once every quarter for all report periods. For quarterly reports that are issued on or after July 1, 2007, an MCP will be determined to be noncompliant for the quarter if the standard is not met in any report period and the initial instance of noncompliance in a report period is determined on or after July 1, 2007. An initial instance of noncompliance means that the result for the applicable report period was in compliance as determined in the prior quarterly report, or the instance of noncompliance is the first determination for an MCP's first quarter of measurement.

The first time an MCP is noncompliant with a standard for this measure, ODJFS will issue a Sanction Advisory informing the MCP that any future noncompliance instances with the standard for this measure will result in ODJFS imposing a monetary sanction. Upon all subsequent quarterly measurements of performance, if an MCP is again determined to be noncompliant with the standard, ODJFS will impose a monetary sanction of one percent of the current month's premium payment. However, no monetary sanctions will be imposed if the MCP is in its first contract year of Medicaid program participation. Once the MCP is performing

at standard levels and violations/deficiencies are resolved to the satisfaction of ODJFS, the money will be refunded.

K.11.b.ii. Rejected Encounters - Performance is monitored once every quarter for Measure 1 and once every month for Measure 2. Compliance determination with the standard applies only to the period under consideration and does not include performance in previous quarters. Files in the ODJFS-specified medium per format that are totally rejected will not be considered in the determination of noncompliance.

The first time an MCP is noncompliant with a standard for this measure, ODJFS will issue a Sanction Advisory informing the MCP that any future noncompliance instances with the standard for this measure will result in ODJFS imposing a monetary sanction. Upon all subsequent measurements of performance, if an MCP is again determined to be noncompliant with the standard, ODJFS will impose a monetary sanction of one percent of the current month's premium payment. The monetary sanction will be applied for each file type in the ODJFS-specified medium per format that is determined to be out of compliance. Once the MCP is performing at standard levels and violations/deficiencies are resolved to the satisfaction of ODJFS, the money will be refunded. Special consideration will be made for MCPs with less than 1,000 members.

K.11.b.iii. Acceptance Rate - Performance is monitored once every month. Compliance determination with the standard applies only to the month under consideration and does not include performance in previous months.

If the MCP is determined to be noncompliant with the standard, ODJFS will impose a monetary sanction of one percent of the MCP's current month's premium payment. The monetary sanction will be applied for each file type in the ODJFS-specified medium per format that is determined to be out of compliance. The monetary sanction will be applied only once per file type per compliance determination period and will not exceed a total of two percent of the MCP's current month's premium payment. Once the MCP is performing at standard levels and violations/deficiencies are resolved to the satisfaction of ODJFS, the money will be refunded. Special consideration will be made for MCPs with less than 1,000 members.

K.11.b.iv. Encounter Data Accuracy Study

Payment Accuracy Measure - Beginning SFY 2010, if an MCP is noncompliant with the standard for either level 1 or level 2 for this measure, the MCP must implement a CAP which identifies interventions and a timeline for resolving data quality issues related to payments. Additional reports to ODJFS addressing targeted areas of deficiencies and progress implementing data quality improvement activities may be required. Upon all subsequent measurements of performance, if an MCP is again determined to be noncompliant with the standard, ODJFS will impose a monetary sanction of one percent of the current month's premium payment. However, no monetary sanctions will be imposed if the MCP is in its first contract year of Medicaid program participation. -Once the MCP is performing at standard levels

and violations/deficiencies are resolved to the satisfaction of ODJFS, the money will be refunded.

K.11.b.v. Generic Provider Number Usage

Measure 1 - Performance is monitored once every quarter for all report periods. For quarterly reports that are issued on or after July 1, 2007, an MCP will be determined to be noncompliant for the quarter if the standard is not met in any report period and the initial instance of noncompliance in a report period is determined on or after July 1, 2007. An initial instance of noncompliance means that the result for the applicable report period was in compliance as determined in the prior quarterly report, or the instance of noncompliance is the first determination for an MCP's first quarter of measurement.

The first time an MCP is noncompliant with a standard for this measure, ODJFS will issue a Sanction Advisory informing the MCP that any future noncompliance instances with the standard for this measure will result in ODJFS imposing a monetary sanction. Upon all subsequent measurements of performance, if an MCP is again determined to be noncompliant with the standard, ODJFS will impose a monetary sanction of three percent of the current month's premium payment. Once the MCP is performing at standard levels and violations/deficiencies are resolved to the satisfaction of ODJFS, the money will be refunded.

Measure 2 - Performance is monitored once every quarter for all report periods on or after July 1, 2008. An initial instance of noncompliance means that the result for the applicable report period was in compliance as determined in the prior quarterly report, or the instance of noncompliance is the first determination for an MCP's first quarter of measurement.

The first time an MCP is noncompliant with a standard for this measure, ODJFS will issue a Sanction Advisory informing the MCP that any future noncompliance instances with the standard for this measure will result in ODJFS imposing a monetary sanction. Upon all subsequent measurements of performance, if an MCP is again determined to be noncompliant with the standard, ODJFS will impose a monetary sanction of three percent of the current month's premium payment. Once the MCP is performing at standard levels and violations/deficiencies are resolved to the satisfaction of ODJFS, the money will be refunded.

K.12. Performance Evaluation Measures (as specified in Appendix M) - The MCP must submit to ODJFS, by the specified deadline and according to ODJFS' specifications, all required data files and requested documentation needed to calculate each measure listed under K.12. below. If an MCP fails to comply with this requirement for any measure listed under K.12. below, the MCP will be considered noncompliant with the standard(s) for that measure. ODJFS reserves the right to withhold an assessment of noncompliance under this section due to unforeseeable circumstances.

The monetary penalty for each measure listed under K.12. below shall not exceed $300,000 during each evaluation period.

K.12.i. ABD / CFC Independent External Quality Review - For these review studies, performance will either be monitored and reported separately for each program, or together across all programs, (i.e., ABD, CFC), the MCP serves. Penalties will be assessed per study. For all reviews conducted during the contract period, if the EQRO cites a deficiency in performance the MCP will be required to complete a Corrective Action Plan or Quality Improvement Directive, depending on the severity of the deficiency. Serious deficiencies may result in immediate termination or non-renewal of the Agreement.

K.12.ii. ABD / CFC Care Management of Members - For these two measures, performance is monitored and reported for each program (i.e., ABD, CFC) the MCP serves. Penalties will be assessed by program. Beginning SFY 2010, the first time an MCP is noncompliant with a standard for this measure, ODJFS will issue a Sanction Advisory. If an MCP is again determined to be noncompliant with the standard in a subsequent report period, the MCP must implement a CAP which identifies interventions and a timeline for resolving care management issues. Additional reports to ODJFS addressing targeted areas of deficiencies and progress implementing quality improvement activities may be required. Upon all subsequent measurements of performance, ODJFS will impose a monetary sanction of two percent of the current month's premium payment per applicable program. Monetary sanctions will not be levied for consecutive report periods that an MCP is determined to be noncompliant. If an MCP is noncompliant for a subsequent report period, new member enrollment freezes or a reduction of assignments will occur as outlined in this Appendix. Once the MCP is determined to be compliant with the standard and the violations/deficiencies are resolved to the satisfaction of ODJFS, the penalties will be lifted, if applicable, and monetary sanctions will be returned.

K.12.iii. ABD / CFC Care Management of High Risk Members - For these two measures, performance is monitored and reported for each program (i.e., ABD, CFC) the MCP serves. Penalties will be assessed by program. Beginning SFY 2010, the first time an MCP is noncompliant with a standard for this measure, ODJFS will issue a Sanction Advisory informing the MCP that any future noncompliance instances with the standard for this measure will result in ODJFS imposing a monetary sanction. Upon all subsequent measurements of performance, if an MCP is again determined to be noncompliant with the standard, ODJFS will impose a monetary sanction of two percent of the current month's premium payment per applicable program. Monetary sanctions will not be levied for consecutive quarters that an MCP is determined to be noncompliant. If an MCP is noncompliant for a subsequent quarter, new member enrollment freezes or a reduction of assignments will occur as outlined in this Appendix. Once the MCP is determined to be compliant with the standard and the violations/deficiencies are resolved to the satisfaction of ODJFS, the penalties will be lifted, if applicable, and monetary sanctions will be returned.

K.12.iv. Clinical Performance Measures

K.12.iv.a. ABD Clinical Performance Measures

For measures one through three in Table 1 below, if the MCP fails to meet the standard for the measure, the MCP will be required to take the following action:

1) If the MCP's results are greater than the percentage stated in Table 1 below, the MCP will be required to complete a CAP to address the area of noncompliance.
2) If the MCP's results are less than or equal to the percentage stated in Table 1 below, the MCP will be required to submit a QID that outlines the steps the MCP will take to improve the results.

For measures four through nine in Table 1 below, if the MCP fails to meet the standard for the measure, the MCP will be required to take the following action:

1) If the MCP's results are less than the percentage stated in Table 1 below, the MCP will be required to complete a CAP to address the area of noncompliance.
2) If the MCP's results are greater than or equal to the percentage stated in Table 1 below, the MCP will be required to submit a QID that outlines the steps the MCP will take to improve the results.

Table 1. Results that Determine Penalties for ABD Clinical Performance Measures

Measure	Results that Determine Penalty
1. Inpatient Hospital Discharge Rate	20 discharges/1,000 MM
2. Emergency Department Utilization Rate	21 visits/1,000 MM
3. Inpatient Hospital Readmission Rate	19%
4. Coronary Artery Disease – Persistence of Beta Blocker Treatment after Heart Attack	50% (NCQA HEDIS 2008, 25th Percentile)
5. Coronary Artery Disease – Cholesterol Management for Patients with Cardiovascular Conditions/LDL-C Screening Performed	74% (NCQA HEDIS 2008, 25th Percentile)
6. Diabetes – Eye Exam	40% (NCQA HEDIS 2008, 25th Percentile)
7. Asthma – Use of Appropriate Medications	86% (NCQA HEDIS 2008, 25th Percentile)
8. Follow Up after Hospitalization for Mental Illness (within 30 days)	66% (NCQA HEDIS 2008, 50th Percentile)
9. Follow Up after Hospitalization for Mental Illness (within 7 days)	43% (NCQA HEDIS 2008, 50th Percentile)

K.12.iv.b. CFC Clinical Performance Measures

For SFY 2009, MCPs with membership as of February 1, 2006 are held accountable to the county-based statewide targets and minimum performance standards for two year measures (*Frequency of Ongoing Prenatal Care, Initiation of Prenatal Care, Preventive Care - 15 Month Old Age Group, Use of Appropriate Medications for People with Asthma, Lead Screening for 1 Year Olds, and Lead Screening for 2 Year Olds*).

Beginning SFY 2010, all MCPs are held accountable to the regional-based statewide targets and minimum performance standards for both one and two year measures.

For each measure listed in Table 2 below, if the MCP fails to meet the standard for the measure, the MCP will be required to take the following action:

1) Complete a CAP to address the area of noncompliance if the MCP's results are below the percentage stated in Table 2 below; or
2) Submit a QID that outlines the steps the MCP will take to improve the results, if the MCP's results are equal to or greater than the percentage stated in Table 2 below.

Table 2. Results that Determine Penalties for CFC Clinical Performance Measures

Measure	SFY 2009 County-Based Results that Determine Penalty	SFY 2010 Regional-Based Results that Determine Penalty
Perinatal Care – Frequency of Ongoing Prenatal Care	44%	51% (NCQA HEDIS 2008, 25th Percentile)
Perinatal Care – Timeliness of Prenatal Care	74%	77% (NCQA HEDIS 2008, 25th Percentile)
Perinatal Care – Postpartum Care	N/A	54% (NCQA HEDIS 2008, 25th Percentile)
Preventive Care – 15 Month Old Age Group	42%	45% (NCQA HEDIS 2008, 25th Percentile)
Preventive Care – 3 – 6 Year Old Age Group	N/A	60% (NCQA HEDIS 2008, 25th Percentile)
Preventive Care – 12 – 21 Year Old Age Group	N/A	36% (NCQA HEDIS 2008, 25th Percentile)
Use of Appropriate Medications for People with Asthma	84%	86% (NCQA HEDIS 2008, 25th Percentile)
Annual Dental Visits	N/A	36% (NCQA HEDIS 2008, 25th Percentile)
Lead Screening – 1 Year Olds	45%	N/A
Lead Screening – 2 Year Olds	28%	N/A
Lead Screening in Children	N/A	49% (NCQA HEDIS 2008, 25th Percentile)

K.12.v. CFC Children's Access to Primary Care - If an MCP is noncompliant with the minimum performance standard, the MCP must develop and implement a corrective action plan.

K.12.vi. ABD Members' / CFC Adults' Access to Preventive/Ambulatory Health Services - For these two measures, performance is monitored and reported for each program (i.e., ABD, CFC) the MCP serves. Penalties will be assessed by program. If an MCP is noncompliant with the minimum performance standard, then the MCP must develop and implement a corrective action plan.

K.12.vii. ABD / CFC Members' Access to Designated PCP - For these two measures, performance is monitored and reported for each program (i.e., ABD, CFC) the MCP serves. Penalties will be assessed by program. If an MCP is noncompliant with the minimum performance standard, then the MCP must develop and implement a corrective action plan.

K.12.viii. ABD / CFC Consumer Satisfaction - For these two measures, performance is monitored and reported for each program (i.e., ABD, CFC) the MCP serves. Penalties will be assessed by program. If an MCP is determined noncompliant with the minimum performance standard, then the MCP must develop a corrective action plan and provider agreement renewals may be affected.

K.12.ix. ABD / CFC Emergency Department Diversion - For these two measures, performance is monitored and reported for each program (i.e., ABD, CFC) the MCP serves. Penalties will be assessed by program. If the standard is not met, then the MCP must develop a corrective action plan, for which ODJFS may direct the MCP to develop the components of their targeted EDD program as specified by ODJFS. If the standard is not met and the results are at or below a percentage (to be determined), then the MCP must develop a QID.

III. Request for Reconsiderations

MCPs may request a reconsideration of remedial action taken under the CAS for penalties that include points, fines, reductions in assignments and/or enrollment freezes. Requests for reconsideration must be submitted on the ODJFS required form as follows:

A. MCPs notified of ODJFS' imposition of remedial action taken under the CAS will have ten (10) working days from the date of receipt of the notification to request reconsideration, although ODJFS will impose enrollment freezes based on an access to care concern concurrent with initiating notification to the MCP. Any information that the MCP would like reviewed as part of the reconsideration request must be submitted at the time of submission of the reconsideration request, unless ODJFS extends the time frame in writing.

B. All requests for reconsideration must be submitted by either email to the designated Contract Administrator (CA) or overnight mail to the Bureau of Managed Care (BMC), and received by ODJFS by the tenth business day after receipt of the notification of the imposition of the remedial action by ODJFS.

C. The MCP will be responsible for verifying timely receipt of all reconsideration requests. All requests for reconsideration must explain in detail why the specified remedial action should not be imposed. The MCP's justification for reconsideration will be limited to a review of the written material submitted by the MCP. The Bureau Chief will review all correspondence and materials related to the violation in question in making the final reconsideration decision.

D. Final decisions or requests for additional information will be made by ODJFS within ten (10) business days of receipt of the request for reconsideration.

E. If additional information is requested by ODJFS, a final reconsideration decision will be made within three (3) business days of the due date for the submission. Should ODJFS require additional time in rendering the final reconsideration decision, the MCP will be notified of such in writing.

F. If a reconsideration request is decided, in whole or in part, in favor of the MCP, both the penalty and the points associated with the incident, will be rescinded or reduced, in the sole discretion of ODJFS. The MCP may still be required to submit a CAP if ODJFS, in its sole discretion, believes that a CAP is still warranted under the circumstances.

APPENDIX O

PAY-FOR-PERFORMANCE (P4P)

This Appendix establishes a pay-for-performance (P4P) incentive system for MCPs to improve performance in specific areas important to the Medicaid MCP members. P4P includes the at-risk amount included with the monthly premium payments (see Appendix F), and possible additional monetary rewards up to $250,000 per program (i.e., ABD, CFC).

To qualify for consideration of any P4P, MCPs must meet Minimum Performance Standards established in Appendix M, *Performance Evaluation* on selected measures, and achieve P4P standards established for selected clinical performance measures, as set forth herein. For qualifying MCPs, higher performance standards for three measures must be reached to be awarded a portion of the at-risk amount and any additional P4P. An excellent and superior standard is set in this Appendix for each of the three measures. Qualifying MCPs will be awarded a portion of the at-risk amount for each excellent standard met. If an MCP meets all three excellent and superior standards, they may be awarded additional P4P.

1. ABD PROGRAM

All MCPs will be included in the statewide P4P system. The at-risk amount included in the statewide P4P system is calculated separately for each region that an MCP serves.

1.a. SFY 2009 ABD Program P4P

1.a.i. Incentive Measures

Performance will be evaluated on the measures listed in Table 1 below to determine the status of the at-risk amount for the SFY 2009 P4P determination.

Table 1. SFY 2009 Incentive Measures

Incentive Measures
1. ABD Care Management of High-Risk Members
2. ABD Care Management of Members
3. PCP Turnover
4. ABD Members Access to Preventive/Ambulatory Health Services
5. ABD Members Access to Designated PCP
6. ABD Emergency Department Diversion
7. ABD Use of Appropriate Medications for People with Asthma
8. ABD Inpatient Hospital Discharge Rate
9. ABD Emergency Department Utilization Rate
10. ABD Inpatient Hospital Readmission Rate
11. ABD CAD - Cholesterol Management/LDL-C Screening Performed
12. ABD Diabetes - Eye Exam
13. ABD Follow Up After Hospitalization for Mental Illness

1.a.ii. Determining SFY 2009 P4P

MCPs which meet the Interim Minimum Performance Standards set in Appendix M, *Performance Evaluation*, for all of the measures listed in Table 1 above may retain one hundred percent of their at-risk amount. MCPs which do not meet the Interim Minimum Performance Standards set in Appendix M, *Performance Evaluation*, for all of the measures listed in Table 1 above must return one hundred percent of their at-risk amount to ODJFS. No additional P4P will be awarded in SFY 2009.

1.b. <u>SFY 2010 ABD Program P4P</u>

1.b.i. Qualifying Performance Levels

To qualify for consideration of the SFY 2010 P4P, an MCP's performance level must meet the Minimum Performance Standards set in Appendix M, *Performance Evaluation*, for the measures listed below. A detailed description of the methodologies for each measure can be found on the BMC page of the ODJFS website.

Measures for which the Minimum Performance Standard for SFY 2010 established in Appendix M, *Performance Evaluation*, must be met to qualify for consideration of incentives are as follows:

1. ABD Members' Access to Preventive/Ambulatory Health Services (Appendix M, Section 2.c.)

Report Period: CY 2009

2. ABD Overall Satisfaction with MCP Customer Service (Appendix M, Section 3.)

Report Period: CY 2010.

For each ABD clinical performance measure listed below, the MCP must meet the P4P standard to be considered for SFY 2010 P4P. The MCP meets the P4P standard if one of two criteria is met. The P4P standard is a performance level of either:

1) The Minimum Performance Standard established in Appendix M, *Performance Evaluation*, for four of the six ABD clinical performance measures listed in Table 2 below; or

2) The Medicaid Minimum Performance Level for four of the six ABD clinical performance measures listed in Table 2 below. The Medicaid Minimum Performance Levels are subject to change based on the revision or update of applicable national standards, methods or benchmarks.

Table 2. Medicaid Minimum Performance Levels

ABD Clinical Performance Measure	Medicaid Minimum Performance Level
1. Inpatient Hospital Discharge Rate	20 discharges/ 1,000 MM
2. CAD: Persistence of Beta-Blocker Treatment after Heart Attack (AMI -related admission)	50% (NCQA HEDIS 2008, 25th Percentile)
3. CAD: Cholesterol Management for Patients with Cardiovascular Conditions/ LDL-C screening performed	74% (NCQA HEDIS 2008, 25th Percentile)
4. Diabetes: Comprehensive Diabetes Care (CDC)/Eye exam	40% (NCQA HEDIS 2008, 25th Percentile)
5. Asthma: Use of Appropriate Medications for People with Asthma	86% (NCQA HEDIS 2008, 25th Percentile)
6. Mental Health: Follow-up After Hospitalization for Mental Illness within 7 Days of Discharge	43% (NCQA HEDIS 2008, 50th Percentile)

1.b.ii. Excellent and Superior Performance Levels

For qualifying MCPs as determined by Section 1.b.i. herein, performance will be evaluated on the measures listed below to determine the status of the at-risk amount and any additional P4P that may be awarded. Excellent and superior standards are set for the three measures described below. The standards are subject to change based on the revision or update of applicable national standards, methods or benchmarks.

A brief description of these measures is provided in Appendix M, *Performance Evaluation*. A detailed description of the methodologies for each measure can be found on the BMC page of the ODJFS website.

1. ABD Care Management of High Risk Members (Appendix M, Section 1.b.ii.)

Report Period: April – June 2010

Excellent Standard: 46.7%

Superior Standard: 61.3%

2. ABD Comprehensive Diabetes Care (CDC)/Eye exam (Appendix M, Section 1.c.ii.)

Report Period: CY 2009

Excellent Standard: 39.7%

Superior Standard: 53.8%

3. ABD Members' Access to Preventive/Ambulatory Health Services (Appendix M, Section 2.c.)

Report Period: CY 2009

Excellent Standard: 81%

Superior Standard: 87%

1.b.iii. Determining SFY 2010 P4P

MCPs that do not meet the Minimum Performance Standards described in section 1.b.i. herein, will not be considered for P4P and must return to ODJFS one hundred percent of their at-risk amount used in the SFY 2010 P4P determination. MCPs reaching the Minimum Performance Standards described in Section 1.b.i. herein, will be considered for P4P including retention of the at-risk amount and any additional P4P. For each excellent standard established in Section 1.b.ii. herein, that an MCP meets, one-third of the at-risk amount may be retained. For MCPs meeting all of the excellent and superior standards established in Section 1.b.ii. herein, additional P4P may be awarded. For MCPs receiving additional P4P, the amount in the P4P fund will be divided equally, up to the maximum additional amount, among all MCPs' ABD and/or CFC programs receiving additional P4P. The maximum additional amount to be awarded per plan, per program, per contract year is $250,000. An MCP may receive up to $500,000 should both of the MCP's ABD and CFC programs achieve the superior performance levels.

2. CFC PROGRAM

The county-based statewide P4P system will transition to a regional-based statewide P4P system in SFY 2010. The last county-based statewide P4P system determination will be made for SFY 2009. The first regional-based statewide P4P system determination will be made for SFY 2010. The regional-based statewide P4P system has been modeled after the county-based statewide system with adjustments to performance standards where appropriate.

2.a. <u>SFY 2009 CFC Program P4P – County-Based P4P System</u>

The last county-based statewide P4P system determination will be made for SFY 2009. For SFY 2009, MCPs with membership as of February 1, 2006 will be included in the county-based statewide P4P system determination. These MCPs will be put at-risk for a portion of the premiums received for members in counties they are serving as of February 1, 2006.

2.a.i. Qualifying Performance Levels

To qualify for consideration of the SFY 2009 P4P, an MCP's performance level must meet the Minimum Performance Standards set in Appendix M, *Performance Evaluation*, for the measures listed below. A detailed description of the methodologies for each measure can be found on the BMC page of the ODJFS website.

Measures for which the Minimum Performance Standard for SFY 2009 established in Appendix M, *Performance Evaluation*, must be met to qualify for consideration of P4P are as follows:

1. PCP Turnover (Appendix M, Section 2.a.)

Report Period: CY 2008

2. CFC Children's Access to Primary Care (Appendix M, Section 2.b.)

Report Period: CY 2008

3. CFC Adults' Access to Preventive/Ambulatory Health Services (Appendix M, Section 2.c.)

Report Period: CY 2008

4. CFC Overall Satisfaction with MCP (Appendix M, Section 3.)

Report Period: The most recent consumer satisfaction survey completed prior to the end of SFY 2009.

For each CFC clinical performance measure listed below, the MCP must meet the P4P standard to be considered for SFY 2009 P4P. The MCP meets the P4P standard if one of two criteria is met. The P4P standard is a performance level of either:

1) The Minimum Performance Standard established in Appendix M, *Performance Evaluation*, for seven of the nine CFC clinical performance measures listed in Table 3 below; or

2) The Medicaid Minimum Performance Level for seven of the nine CFC clinical performance measures listed in Table 3 below. The Medicaid Minimum Performance Levels are subject to change based on the revision or update of applicable national standards, methods or benchmarks.

Table 3. Medicaid Minimum Performance Levels

CFC Clinical Performance Measure	Medicaid Minimum Performance Level
1. Perinatal Care - Frequency of Ongoing Prenatal Care	44%
2. Perinatal Care - Timeliness of Prenatal Care	74%
3. Perinatal Care - Postpartum Care	50%
4. Well-Child Visits – Children who turn 15 months old	42%
5. Well-Child Visits - 3, 4, 5, or 6, years old	57%
6. Well-Child Visits - 12 through 21 years old	33%
7. Use of Appropriate Medications for People with Asthma	84%
8. Annual Dental Visits	42%
9. Blood Lead – 1 year olds	45%

2.a.ii Excellent and Superior Performance Levels

For qualifying MCPs as determined by section 2.a.i. of this appendix, performance will be evaluated on the measures listed below to determine the status of the at-risk amount. The standards are subject to change based on the revision or update of applicable national standards, methods or benchmarks.

A brief description of these measures is provided in Appendix M, *Performance Evaluation*. A detailed description of the methodologies for each measure can be found on the BMC page of the ODJFS website.

1. CFC Care Management of High Risk Members (Appendix M, Section 1.b.ii.)

Excellent Standard: The Interim Minimum Performance Standard established in Appendix M, Section 1.b.ii.

Superior Standard: N/A

2. CFC Use of Appropriate Medications for People with Asthma (Appendix M, Section 1.c.ii.)

Report Period: CY 2008

Excellent Standard: 86%

Superior Standard: 88%

3. CFC Adults' Access to Preventive/Ambulatory Health Services (Appendix M, Section 2.c.)

Report Period: CY 2008

Excellent Standard: 77%

Superior Standard: 84%

2.a.iii. Determining SFY 2009 P4P

MCPs that do not meet the Minimum Performance Standards described in section 2.a.i. herein will not be considered for P4P and must return to ODJFS one hundred percent of their at-risk amount used in the SFY 2009 P4P determination. MCPs reaching the Minimum Performance Standards described in section 2.a.i. herein will be considered for P4P (retention of the at-risk amount). For each excellent standard established in section 2.a.ii. herein, that an MCP meets, one-third of the at-risk amount used in the SFY 2009 P4P determination may be retained. No additional P4P will be awarded in SFY 2009.

2.b. SFY 2010 CFC Program P4P - Regional-Based Statewide P4P System
All MCPs will be included in the regional-based statewide P4P system. The at-risk amount included in the statewide P4P system is calculated separately for each region an MCP serves.

The first regional-based statewide P4P determination will be SFY 2010 and will include at-risk amounts from July, 2009 through June, 2010.

For MCPs with membership in the NEC region, this determination will include at-risk dollars from Columbiana county from March, 2010 through June, 2010 and at-risk dollars from Mahoning and Trumbull counties from July, 2009 through June, 2010.

2.b.i. Qualifying Performance Levels

To qualify for consideration of the SFY 2010 P4P, an MCP's performance level must meet the Minimum Performance Standards set in Appendix M, *Performance Evaluation*, for the measures listed below. A detailed description of the methodologies for each measure can be found on the BMC page of the ODJFS website.

Measures for which the Minimum Performance Standard for SFY 2010 established in Appendix M, *Performance Evaluation*, must be met to qualify for consideration of P4P are as follows:

1. CFC Children's Access to Primary Care (Appendix M, Section 2.b.)

Report Period: CY 2009

2. CFC Adults' Access to Preventive/Ambulatory Health Services (Appendix M, Section 2.c.)

Report Period: CY 2009

3. CFC Overall Satisfaction with MCP Customer Service (Appendix M, Section 3.)

Report Period: The most recent consumer satisfaction survey completed prior to the end of SFY 2010.

For each CFC clinical performance measure listed below, the MCP must meet the P4P standard to be considered for SFY 2010 P4P. The MCP meets the P4P standard if one of two criteria is met. The P4P standard is a performance level of either:

1) The Minimum Performance Standard established in Appendix M, *Performance Evaluation*, for seven of the nine CFC clinical performance measures listed in Table 4 below; or

2) The Medicaid Minimum Performance Level for seven of the nine CFC clinical performance measures listed in Table 4 below. The Medicaid Minimum Performance Levels are subject to change based on the revision or update of applicable national standards, methods or benchmarks.

Table 4. Medicaid Minimum Performance Levels

CFC Clinical Performance Measure	Medicaid Minimum Performance Level
1. Perinatal Care - Frequency of Ongoing Prenatal Care	51% (NCQA HEDIS 2008, 25th Percentile)
2. Perinatal Care - Initiation of Prenatal Care	77% (NCQA HEDIS 2008, 25th Percentile)
3. Perinatal Care - Postpartum Care	54% (NCQA HEDIS 2008, 25th Percentile)
4. Well-Child Visits – Children who turn 15 months old	45% (NCQA HEDIS 2008, 25th Percentile)
5. Well-Child Visits - 3, 4, 5, or 6, years old	60% (NCQA HEDIS 2008, 25th Percentile)
6. Well-Child Visits - 12 through 21 years old	36% (NCQA HEDIS 2008, 25th Percentile)
7. Use of Appropriate Medications for People with Asthma	86% (NCQA HEDIS 2008, 25th Percentile)
8. Annual Dental Visits	36% (NCQA HEDIS 2008, 25th Percentile)
9. Lead Screening in Children	49% (NCQA HEDIS 2008, 25th Percentile)

2.b.ii. Excellent and Superior Performance Levels

For qualifying MCPs as determined by section 2.b.i. of this appendix, performance will be evaluated on the measures listed below to determine the status of the at-risk amount. The standards are subject to change based on the revision or update of applicable national standards, methods or benchmarks.

A brief description of these measures is provided in Appendix M, *Performance Evaluation*. A detailed description of the methodologies for each measure can be found on the BMC page of the ODJFS website.

1. CFC Care Management of High Risk Members (Appendix M, Section 1.b.ii.)

Report Period: April – June, 2010

Excellent Standard: 26.1%

Superior Standard: 32.4%

2. CFC Use of Appropriate Medications for People with Asthma (Appendix M, Section 1.c.ii.)

Report Period: CY 2009

Excellent Standard: 86.1%

Superior Standard: 88.7%

3. CFC Adults' Access to Preventive/Ambulatory Health Services (Appendix M, Section 2.c.)

Report Period: CY 2009

Excellent Standard: 79%

Superior Standard: 85%

2.b.iii. Determining SFY 2010 P4P

MCPs that do not meet the Minimum Performance Standards described in section 2.b.i. herein will not be considered for P4P and must return to ODJFS one hundred percent of their at-risk amount used in the SFY 2010 P4P determination. MCPs reaching the Minimum Performance Standards described in section 2.b.i. herein will be considered for P4P (retention of the at-risk amount). For each excellent standard, established in section 2.b.ii. herein, that an MCP meets, one-third of the at-risk amount used in the SFY 2010 P4P determination may be retained.

2.c. CFC Program P4P – Determination of Regional Premium Payments At-Risk for Months Prior to July, 2009, for Counties Not Included in the SFY 2009 County-Based Statewide P4P Determination

Regional premium payments at-risk for months prior to July, 2009, for counties not included in the SFY 2009 county-based statewide P4P determination, will not be included in the first (SFY 2010) regional-based statewide P4P determination, but rather will be determined as follows:

MCPs which meet the SFY 2009 CFC Interim Minimum Performance Standards set in Appendix M, *Performance Evaluation*, for all of the measures listed in Table 5 below may retain one hundred percent of their at-risk amount for months prior to July, 2009, for counties not included in the county-based statewide P4P determination. MCPs which do not meet the Interim Minimum Performance Standards set in Appendix M, *Performance Evaluation*, for all of the measures listed in Table 5 below must return to ODJFS one hundred percent of their at-risk amount for months prior to July, 2009, for counties not included in the county-based statewide P4P determination. This determination will be made by December 31, 2009.

Table 5. Measures Used to Determine the Status of the At-Risk Amount for Months Prior to July, 2009, for Counties Not Included in the County-Based Statewide P4P System.

Measures
1. CFC Care Management of High Risk Members
2. CFC Care Management of Members
3. PCP Turnover
4. CFC Adults' Access to Preventive/Ambulatory Health Services
5. CFC Members' Access to Designated PCP
6. CFC Emergency Department Diversion
7. CFC Perinatal Care - Frequency of Ongoing Prenatal Care
8. CFC Perinatal Care - Initiation of Prenatal Care
9. CFC Perinatal Care - Postpartum Care
10. CFC Well Child Visits - 15 Months Old
11. CFC Well Child Visits - 3, 4, 5, or 6 Years Old
12. CFC Well Child Visits - 12 through 21 Years Old
13. CFC Annual Dental Visits
14. CFC Use of Appropriate Medications for People with Asthma

3. NOTES

3.a. Initiation of the At-Risk Amount

3.a.i. ABD P4P Program

The status of the at-risk amount will not be determined for the first twenty-four months of regional membership, because compliance with many of the standards in the ABD program cannot be determined in an MCP's first two contract years. In addition, MCPs in their first two (2) contract years in the ABD program are not eligible for the additional P4P amount awarded for superior performance.

Starting with the twenty-fifth month of regional membership in the Ohio Medicaid ABD Managed Care Program, an MCP's at-risk amount will be included in the P4P system. The determination of the status of this at-risk amount will be made after at least two full calendar years of ABD regional membership, as many of the performance standards used in the ABD P4P system require two full calendar years of ABD regional membership to determine an MCP's performance level. Because of this requirement, the number of months of at-risk dollars to be included in an MCP's first ABD at-risk status determination may vary depending on when ABD regional membership starts relative to the calendar year.

3.a.ii. CFC P4P Program

CFC County-Based Statewide P4P Program - Applicable to MCPs with CFC membership as of February 1, 2006.

Compliance with many of the performance standards used in the P4P system cannot be determined in an MCP's first two contract years. Therefore, the at-risk amount for an MCP's first twenty-four months of Ohio Medicaid CFC Managed Care Program participation will not be included in the P4P system. In addition, MCPs in their first two contract years are not eligible for the additional P4P amount awarded for superior performance.

Starting with the twenty-fifth month of Ohio Medicaid CFC Managed Care Program participation, an MCP's at-risk amount will be included in the P4P system. The determination of the status of this at-risk amount will be made after at least three full calendar years of CFC membership, as many of the performance standards used in the CFC P4P system require three full calendar years of CFC membership to determine an MCP's performance level. Because of this requirement, more than 12 months of at-risk dollars may be included in an MCP's first at-risk status determination depending on when an MCP starts with the program relative to the calendar year.

CFC Regional-Based Statewide P4P Program - Applicable to all MCPs with CFC membership.

Starting with the twenty-fifth month of regional membership in the Ohio Medicaid CFC Managed Care Program, an MCP's at-risk amount will be included in the P4P system. The determination of the status of this at-risk amount will be made after at least three full calendar years of CFC regional membership, as many of the performance standards used in the CFC P4P system require three full calendar years of regional membership to determine an MCP's performance level. Because of this requirement, more than 12 months of at-risk dollars may be included in an MCP's first at-risk status determination depending on when an MCP starts with the program relative to the calendar year.

3.b. Determination of At-Risk Amounts and Additional P4P Payments

Given that unforeseen circumstances (e.g., revision or update of measure(s), applicable national standards, methods or benchmarks, or issues related to program implementation) may impact the determination of the status of an MCP's at-risk amount and any additional P4P payments, ODJFS reserves the right to calculate an MCP's at-risk amount (the status of which is determined in accordance with this appendix) using a lesser percentage than that established in Appendix F and to award additional P4P in an amount lesser than that established in this appendix.

For MCPs that have participated in the Ohio Medicaid Managed Care Program long enough to calculate performance levels for all of the performance measures included in the P4P system, determination of the status of an MCP's at-risk amount may occur within six months of the end of the contract period. Where applicable, determination of additional P4P payments will be made at the same time the status of an MCP's at-risk amount is determined. Given that unforeseen circumstances may impact the determination of the status of an MCP's at-risk amount and any additional P4P payments, ODJFS reserves the right to revise the time frame in which the determination will be made (i.e., the determination may be made more than six months after the end of the contract period).

3.c. Contract Termination, Nonrenewals, or Denials

Upon termination, nonrenewal or denial of an MCP contract, the at-risk amount paid to the MCP under the current provider agreement will be returned to ODJFS in accordance with Appendix P, *Terminations/Non-renewals/Amendments*, of the provider agreement.

Additionally, in accordance with Article XI of the provider agreement, the return of the at-risk amount paid to the MCP under the current provider agreement will be a condition necessary for ODJFS' approval of a provider agreement assignment.

3.d. Measures and Report Periods

The report period used in determining the MCP's performance levels varies for each measure depending on the frequency of the report and the data source. ODJFS reserves the right to revise P4P measures and report periods, as needed, due to unforeseen circumstances. Unless otherwise noted, the most recent report or study finalized prior to the end of the contract period will be used in determining the MCP's overall performance level for that contract period.

APPENDIX P

MCP TERMINATIONS/NONRENEWALS/AMENDMENTS

Upon termination either by the MCP or ODJFS, nonrenewal or denial of an MCP's provider agreement, all previously collected refundable monetary sanctions will be retained by ODJFS.

1 . MCP-INITIATED TERMINATIONS/NONRENEWALS

If an MCP provides notice of the termination/nonrenewal of their provider agreement to ODJFS, pursuant to Article VIII of the agreement, the MCP will be required to submit the following to ODJFS:

a. Refundable Monetary Assurance and the At-Risk Amount

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

The MCP must also return to ODJFS the at-risk amount paid to the MCP under the current provider agreement. The amount to be returned will be based on actual MCP membership for preceding months and estimated MCP membership through the end date of the contract. MCP membership for each month between the month the termination/nonrenewal is issued and the end date of the provider agreement will be estimated as the MCP membership for the month the termination/nonrenewal is issued. Any over payment will be determined by comparing actual to estimated MCP membership and will be returned to the MCP following the end date of the provider agreement.

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

If the monetary assurance and the at-risk amount are not received as specified above, ODJFS will withhold the MCP's next month's capitation payment until such time that

ODJFS receives documentation that the monetary assurance and the at-risk amount are received by the Treasurer of State. If within one year of the date of issuance of the invoice, an MCP does not submit all outstanding monies owed and required submissions, including, but not limited to, grievance, appeal, encounter and cost report data related to time periods through the final date of service under the MCP's provider agreement, the monetary assurance will not be refunded to the MCP.

b. Data Files

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

c. Notification

i. Provider Notification - The MCP must notify contracted providers at least 55 days prior to the effective date of termination. The provider notification must be approved by ODJFS prior to distribution.

ii. Member Notification - The MCP must notify their members of the termination at least 45 days in advance of the effective date of termination. The member notification must be approved by ODJFS prior to distribution.

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

2. ODJFS-INITIATED TERMINATIONS

If ODJFS initiates the proposed termination, nonrenewal or amendment of an MCP's provider agreement pursuant to OAC rule 5101:3-26-10 and the MCP appeals that proposed action, the MCP's provider agreement will be extended through the issuance of an adjudication order in the MCP's appeal under the ORC Chapter 119.

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

Pursuant to OAC rule 5101:3-26-10(H), if ODJFS has proposed the termination, nonrenewal, denial or amendment of a provider agreement, ODJFS may notify the MCP's members of this proposed action and inform the members of their right to immediately terminate their membership with that MCP without cause. If ODJFS has proposed the termination, nonrenewal, denial or amendment of a provider agreement and access to medically-necessary covered services is jeopardized, ODJFS may propose to terminate the membership of all of the MCP's members. The appeal process for reconsideration of the proposed termination of members is as follows:

- All notifications of such a proposed MCP membership termination will be made by ODJFS via certified or overnight mail to the identified MCP Contact.

- MCPs notified by ODJFS of such a proposed MCP membership termination will have three working days from the date of receipt to request reconsideration.

- All reconsideration requests must be submitted by either facsimile transmission or overnight mail to the Deputy Director, Office of Ohio Health Plans, and received by 3PM Eastern Time on the third working day following receipt of the ODJFS notification of termination. The address and fax number to be used in making these requests will be specified in the ODJFS notification of termination document.

- The MCP will be responsible for verifying timely receipt of all reconsideration requests. All requests must explain in detail why the proposed MCP membership termination is not justified. The MCP’s justification for reconsideration will be limited to a review of the written material submitted by the MCP.

- A final decision or request for additional information will be made by the Deputy Director within three working days of receipt of the request for reconsideration. Should the Deputy Director require additional time in rendering the final reconsideration decision, the MCP will be notified of such in writing.

- The proposed MCP membership termination will not occur while an appeal is under review and pending the Deputy Director’s decision. If the Deputy Director denies the appeal, the MCP membership termination will proceed at the first possible effective date. The date may be retroactive if the ODJFS determines that it would be in the best interest of the members.