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

This Provider Agreement (herein "Provider Agreement" or "Agreement") is entered into this first day of July, 2016, at Columbus, Franklin County, Ohio, between the State of Ohio, The Ohio Department of Medicaid, (hereinafter referred to as ODM) whose principal offices are located in the City of Columbus, County of Franklin, State of Ohio, and _____, Managed Care Plan (hereinafter referred to as MCP), an Ohio corporation, whose principal office is located in the city of _____, County of _____, State of Ohio.

The MCP is licensed as a Health Insuring Corporation by the State of Ohio, Department of Insurance (hereinafter referred to as ODI), pursuant to Chapter 1751 of the Ohio Revised Code (ORC) and is organized and agrees to operate as prescribed by Chapter 5160-26 of the Ohio Administrative Code (OAC), and other applicable portions of the OAC as amended from time to time.

The 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 comprehensive health care services as defined in 42 CFR 438.2 through the managed care program for the Medicaid eligible population described in OAC rule 5160-26-02(B) and any other Medicaid eligible populations authorized by the Centers for Medicare and Medicaid Services (CMS) and described in Ohio's Medicaid State Plan.

ODM, as the single state agency designated to administer the Medicaid program under Section 5162.03 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, the MCP has provided and will continue to provide proof of the MCP's capability to provide quality services, efficiently, effectively and economically during the term of this Agreement.

This Provider Agreement is a contract between ODM and the undersigned MCP, provider of medical assistance, pursuant to the federal contracting provisions of 42 CFR 434.6 and 438.6 in which the MCP agrees to provide comprehensive Medicaid services through the managed care program as provided in Chapter 5160-26 of the OAC, assuming the risk of loss, and at all times complying with federal and state laws and regulations, federal and state Medicaid program requirements, and other requirements as specified by ODM. This includes without limitation Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

ARTICLE I - GENERAL

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

B. The MCP agrees to communicate with the Chief of the Bureau of Managed Care (BMC) (hereinafter referred to as BMC) or his or her designee as necessary in order for the MCP to assure its understanding of the responsibilities and satisfactory compliance with this Provider Agreement.

C. The MCP agrees to furnish its staff and services as necessary for the satisfactory performance of the services as enumerated in this Provider Agreement.

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

ARTICLE II - TIME OF PERFORMANCE

A. Upon approval by the Director of ODM this Provider Agreement shall be in effect from the date executed through June 30, 2016, unless this Provider Agreement is suspended or terminated pursuant to Article VIII prior to the termination date, or otherwise amended pursuant to Article IX.

ARTICLE III - REIMBURSEMENT

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

ARTICLE IV - RELATIONSHIP OF PARTIES

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

these services. If the MCP is a business entity with fewer than five employees, each employee must complete the PEDACKN form.

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

C. ODM retains the right to ensure that the MCP's work is in conformity with the terms and conditions of this Agreement.

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

ARTICLE V - CONFLICT OF INTEREST; ETHICS LAWS

A. In accordance with the safeguards specified in section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423) and other applicable federal requirements, no officer, member or employee of the MCP, the Chief of BMC, or other ODM 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 the MCP is the receipt of services through a health care program offered by the MCP.

B. The MCP represents, warrants, and certifies that it and its employees engaged in the administration or performance of this Agreement are knowledgeable of and understand the Ohio Ethics and Conflicts of Interest laws and Executive Order 2011-03K. The MCP further represents, warrants, and certifies that neither the MCP nor any of its employees will do any act or omit any action that is inconsistent with such laws and Executive Order. The Governor's Executive Orders may be found by accessing the following website: http://governor.ohio.gov/ExecutiveOrders.aspx

C. The MCP hereby covenants that the MCP, its officers, members and employees of the MCP, shall not, prior to the completion of the work under this Agreement, voluntarily acquire any interest, personal or otherwise, direct or indirect, which is incompatible or in conflict with or would compromise in any manner of degree the discharge and fulfillment of his or her functions and responsibilities under this Provider Agreement. The MCP shall periodically inquire of its officers, members and employees concerning such interests.

D. Any such person who acquires an incompatible, compromising or conflicting personal or business interest, on or after the effective date of this Agreement, or who involuntarily acquires any such incompatible or conflicting personal interest, shall immediately disclose his or her interest to ODM in writing. Thereafter, he or she shall not participate in any

action affecting the services under this Provider Agreement, unless ODM shall determine in its sole discretion that, in the light of the personal interest disclosed, his or her participation in any such action would not be contrary to the public interest. The written disclosure of such interest shall be made to: Chief, BMC, ODM.

E. No officer, member or employee of the MCP shall promise or give to any ODM employee anything of value that is of such a character as to manifest a substantial and improper influence upon the employee with respect to his or her duties. The MCP, along with its officers, members and employees, understand and agree to take no action, or cause ODM or its employees to take any action, which is inconsistent with the applicable Ohio ethics and conflict of interest laws including without limitation those provisions found in Chapter 102 and Chapter 2921 of the ORC.

F. The MCP hereby covenants that the 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 ODM in addition to any other required filings.

ARTICLE VI - NONDISCRIMINATION OF EMPLOYMENT

A. The 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, the MCP shall not by reason of race, color, religion, gender, sexual orientation, age, disability, national origin, military status, health status, genetic information or ancestry, discriminate against any individual in the employment of an individual who is qualified and available to perform the services to which the Provider Agreement relates.

B. The MCP agrees that it shall not, in any manner, discriminate against, intimidate, or retaliate against any employee hired for the performance or services under the Provider Agreement on account of race, color, religion, gender, sexual orientation, age, disability, national origin, military status, health status, genetic information or ancestry.

C. In addition to requirements imposed upon subcontractors in accordance with OAC Chapter 5160-26, the MCP agrees to hold all subcontractors and persons acting on behalf of the MCP in the performance of services under this 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 5160-26-05.

ARTICLE VII - RECORDS, DOCUMENTS AND INFORMATION

A. The MCP agrees that all records, documents, writings or other information produced by the MCP under this Provider Agreement and all records, documents, writings or other information used by the MCP in the performance of this Provider Agreement shall be treated in accordance with OAC rule 5160-26-06 and must be provided to ODM, or its

designee, if requested. The MCP must maintain an appropriate record system for services provided to members. The MCP must retain all records in accordance with 45 CFR 74.53.

B. All information provided by the MCP to ODM that is proprietary shall be held to be strictly confidential by ODM. Proprietary information is information which, if made public, would put the MCP at a disadvantage in the market place and trade of which the MCP is a part [see ORC Section 1333.61(D)]. The MCP agrees to expressly indicate by marking the top or bottom of each individual record containing information the MCP deems proprietary or trade secret, regardless of media type (CD-ROM, Excel file etc.) prior to its release to ODM. Upon request from ODM, the MCP agrees to promptly notify ODM in writing of the nature of the proprietary information including all reasonable evidence regarding the nature of the proprietary information in records submitted to ODM. The MCP also agrees to provide for the legal defense of all proprietary information submitted to ODM. ODM shall promptly notify the MCP in writing or via email of the need to legally defend the proprietary information such that the MCP is afforded the opportunity to adequately defend such information. Failure to provide such prior notification or failure to legally defend the proprietary nature of such information is deemed to be a waiver of the proprietary nature of the information, and a waiver of any right of the MCP to proceed against ODM for violation of this Provider 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. ODM 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. The MCP shall not use any information, systems, or records made available to it for any purpose other than to fulfill the duties specified in this Provider Agreement. The MCP agrees to be bound by the same standards of confidentiality that apply to the employees of ODM and the State of Ohio, including without limitation the confidentiality requirements found in 42 CFR Part 431 Subpart F and ORC 5160.45, as well as 42 C.F.R. 2.12 and ORC 5119.27, as applicable. The terms of this section shall be included in any subcontracts executed by the MCP for services under this Provider Agreement. The 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.

D. The MCP agrees, certifies and affirms that HHS, US Comptroller General or representatives will have access to books, documents, and other business records of the MCP.

E. All records relating to performance, under or pertaining to this Provider Agreement will be retained by the MCP in accordance to the appropriate records retention schedule. The appropriate records retention schedule for this Provider Agreement is for a total period of eight (8) years. For the initial three (3) years of the retention period, the records must be stored in a manner and place that provides readily available access. If any records are

destroyed prior to the date as determined by the appropriate records retention schedule, the MCP agrees to pay to ODM all damages, costs, and expenses incurred by ODM associated with any cause, action or litigation arising from such destruction.

F. The MCP agrees to retain all records in accordance with any litigation holds that are provided to them by ODM, and actively participate in the discovery process if required to do so, at no additional charge. Litigation holds may require the MCP to keep the records longer then the approved records retention schedule. The MCP will be notified by ODM when the litigation hold ends and retention can resume based on the approved records retention schedule. If the MCP fails to retain the pertinent records after receiving a litigation hold from ODM, the MCP agrees to pay to ODM all damages, costs and expenses incurred by ODM associated with any cause, action or litigation arising from such destruction.

G. The MCP shall promptly notify ODM of any legal matters and administrative proceedings including, but not limited to, litigation and arbitration, which involve or otherwise pertain to the activities performed pursuant to this Provider Agreement and any third party. In the event that the MCP possesses or has access to information and/or documentation needed by ODM with regard to the above, the MCP agrees to cooperate with ODM in gathering and providing such information and/or documentation to the extent permissible under applicable law.

ARTICLE VIII - NONRENEWAL AND TERMINATION

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

B. Subsequent to receiving a notice of termination from ODM, the MCP beginning on the effective date of the termination, shall cease provision of services on the terminated activities under this Provider Agreement; terminate all subcontracts relating to such terminated activities, take all necessary or appropriate steps to limit disbursements and minimize costs, and comply with the requirements specified in this Provider Agreement, as of the date of receipt of notice of termination describing the status of all services under this Provider Agreement.

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

D. In the event of termination under this Article, MCP shall return all records in their native format relating to cost, work performed, supporting documentation for invoices submitted

to ODM, and copies of all materials produced under or pertaining to this Provider Agreement.

E. ODM may, in its sole discretion, 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 ODM proposes to terminate or refuse to enter into a provider agreement, the provisions of applicable sections of the OAC with respect to ODM's suspension, termination or refusal to enter into a provider agreement shall apply, including the MCP's right to request an adjudication hearing under Chapter 119 of the ORC. The MCP does not have the right to request an adjudication hearing under Chapter 119 of the ORC to challenge any action taken or decision made by ODM with respect to entering into or refusing to enter into a provider agreement with the MCP pursuant to section 5167.10 of the Revised Code.

F. When initiated by the MCP, termination of or failure to renew the Provider Agreement requires written notice to be received by ODM 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 ODM, if the MCP is unable to provide the required number of days of notice to ODM 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 meets the required number of days from the date of the termination notice, and both parties shall, for that time, continue to fulfill their duties and obligations as set forth herein. If the MCP wishes to terminate or not renew their Provider Agreement for a specific region(s), ODM reserves the right to initiate a procurement process to select additional MCPs to serve Medicaid consumers in that region(s). ODM, at its discretion, may use an MCP’s termination or non-renewal of this Provider Agreement as a factor in any future procurement process.

G. The MCP understands that availability of funds to fulfill the terms of this Provider Agreement is contingent on appropriations made by the Ohio General Assembly and the United States government for funding the Medicaid program. If sufficient funds are not available from the Ohio General Assembly or the United States government to make payments on behalf of a specific population (Aged, Blind, Disabled, Modified Adjusted Gross Income, or Adult Extension) to fulfill the terms of this Provider Agreement, the obligations, duties and responsibilities of the parties with respect to that population will be terminated except as specified in Appendix P as of the date funding expires. If the Ohio General Assembly or the United States government fails at any time to provide sufficient funding for ODM or the State of Ohio to make payments due under this Provider Agreement, this Provider Agreement will terminate as of the date funding expires without further obligation of ODM or the State of Ohio.

ARTICLE IX - AMENDMENT AND RENEWAL

A. This writing constitutes the entire Agreement between the parties with respect to all matters herein. This 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. In the event that changes in state or federal law, regulations, an applicable waiver or state plan amendment, or the terms and conditions of any applicable federal waiver or state plan amendment, require ODM to modify this Agreement, ODM shall notify the MCP regarding such changes and this Agreement shall be automatically amended to conform to such changes without the necessity for executing written amendments pursuant to this Article of this Agreement.

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

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

E. If the MCP was not selected as a contractor as a result of a procurement process, the expiration of this Agreement shall not be considered a termination or failure to renew. The MCP will have the ability to protest the award of the contract in accordance with the process that will be described in the Request for Applications.

ARTICLE X - LIMITATION OF LIABILITY

A. The MCP agrees to indemnify and to hold ODM and the state of Ohio harmless and immune from any and all claims for injury or damages resulting from the actions or omissions of the MCP in the fulfillment of this Provider Agreement or arising from this Agreement which are attributable to the MCP's own actions or omissions, or of those of its trustees, officers, employees, agents, subcontractors, suppliers, third parties utilized by the MCP, or joint ventures. Such claims shall include but are not limited to: any claims made under the Fair Labor Standards Act or under any other federal or state law involving wages, overtime, or employment matters and any claims involving patents, copyrights, trademarks and applicable public records laws. The MCP shall bear all costs associated with defending ODM and the state of Ohio against these claims.

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

C. In the event that, due to circumstances not reasonably within the control of the MCP or ODM, a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection occurs, neither ODM nor the MCP will have any liability or obligation

on account of reasonable delay in the provision or the arrangement of covered services; provided that so long as the MCP's Certificate of Authority remains in full force and effect, the MCP shall be liable for the covered services required to be provided or arranged for in accordance with this Agreement.

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

ARTICLE XI - ASSIGNMENT

A. ODM will not allow the transfer of Medicaid members by one MCP to another entity without the express prior written approval of ODM. Even with ODM's prior written approval, ODM reserves the right to offer such members the choice of MCPs outside the normal open enrollment process and implement an assignment process as ODM determines is appropriate. MCPs 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 ODM and subject to such conditions and provisions as ODM may deem necessary. No such approval by ODM of any assignment shall be deemed in any event or in any manner to provide for the incurrence of any obligation by ODM in addition to the total agreed-upon reimbursement in accordance with this Agreement. Any member transfer and/or assignments of interest shall be submitted for ODM's review 120 days prior to the desired effective date. ODM shall use reasonable efforts to respond to any such request for approval within the 120 day period. Failure of ODM to act on a request for approval within the 120 day period does not act as an approval of the request. ODM may require a receiving MCP to successfully complete a readiness review process before the transfer of members or obligations under this Agreement.

B. The 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 ODM and subject to such conditions and provisions as ODM may deem necessary. Any such assignments of subcontracts shall be submitted for ODM's review 30 days prior to the desired effective date. No such approval by ODM of any assignment shall be deemed in any event or in any manner to provide for the incurrence of any obligation by ODM in addition to the total agreed-upon reimbursement in accordance with this Agreement.

ARTICLE XII - CERTIFICATION MADE BY THE MCP

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

B. The MCP certifies that no federal funds paid to the MCP through this or any other Agreement with ODM shall be or have been used to lobby Congress or any federal agency in connection with a particular contract, grant, cooperative agreement or loan. The MCP

further certifies its continuing compliance with applicable lobbying restrictions contained in 31 U.S.C. 1352 and 45 CFR Part 93. If this Agreement exceeds $100,000, the MCP has executed the Disclosure of Lobbying Activities, Standard Form LLL, if required by federal regulations. This certification is material representation of fact upon which reliance was placed when this Provider Agreement was entered into.

C. The MCP certifies that neither the MCP nor any principals of the MCP (i.e., a director, officer, partner, or person with beneficial ownership of more than 5% of the MCP's equity) is presently debarred, suspended, proposed for debarment, declared ineligible, or otherwise excluded from participation in transactions by any Federal agency. The MCP also certifies that it is not debarred from consideration for contract awards by the Director of the Department of Administrative Services, pursuant to either ORC Section 153.02 or ORC Section 125.25. The MCP also certifies that the MCP has no employment, consulting or any other arrangement with any such debarred or suspended person for the provision of items or services or services that are significant and material to the MCP's contractual obligation with ODM. This certification is a material representation of fact upon which reliance was placed when this 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 the MCP knowingly executed this certification erroneously, then in addition to any other remedies, this Provider Agreement shall be terminated pursuant to Article VIII, and ODM must advise the Secretary of the appropriate federal agency of the knowingly erroneous certification.

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

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

F. The MCP certifies and affirms that, as applicable to the MCP, that no party listed or described in Division (I) or (J) of Section 3517.13 of the ORC who was in a listed position at the time of the contribution, has made as an individual, within the two previous calendar years, one or more contributions in excess of one thousand 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 the MCP's certification of this requirement is false or misleading, and not withstanding any criminal or civil liabilities imposed by law, the MCP shall return to ODM all monies paid to the MCP under this Provider Agreement. The provisions of this section shall survive the expiration or termination of this Provider Agreement.

G. The MCP agrees to refrain from promising or giving to any ODM employee anything of value that is of such a character as to manifest a substantial and improper influence upon the employee with respect to his or her duties.

H. The MCP agrees to comply with the false claims recovery requirements of 42 U.S.C 1396a(a)(68) and to also comply with ORC 5162.15.

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

J. The MCP certifies and confirms that any performance of experimental, developmental, or research work shall provide for the rights of the Federal Government and the recipient in any resulting invention.

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

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

ARTICLE XIII - CONSTRUCTION

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

ARTICLE XIV - INCORPORATION BY REFERENCE

A. OAC Chapter 5160-26 is hereby incorporated by reference as part of this Provider Agreement having the full force and effect as if specifically restated herein.

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

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

ARTICLE XV – NOTICES

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

ARTICLE XVI – HEADINGS

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

Intentionally blank.

MCP NAME:

BY: _____ DATE: _____
PRESIDENT & CEO

ADDRESS: _____

THE OHIO DEPARTMENT OF MEDICAID:

BY: _____ DATE: _____
JOHN B. MCCARTHY, MEDICAID DIRECTOR

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

Ohio Department of Medicaid (ODM)
Medicaid Managed Care Provider Agreement
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APPENDIX A

OAC RULES 5160-26

The managed care program rules can be accessed electronically through the Ohio Department of Medicaid's Managed Care webpage.

APPENDIX B

SERVICE AREA SPECIFICATIONS

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

Service Area	
Central/Southeast Region	☒
Northeast Region	☒
West Region	☒

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

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/Southeast Region

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

Counties in the Northeast Region

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

Counties in the West Region

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

APPENDIX C

MCP RESPONSIBILITIES

The following are Managed Care Plan (MCP) responsibilities that are not otherwise specifically stated in OAC rule provisions or elsewhere in the MCP provider agreement, but are required by the Ohio Department of Medicaid (ODM).

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 its Certificate of Authority (COA) to ODM 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 Contract Compliance Officer) who will dedicate a majority of his or her time to the Medicaid product line and coordinate overall communication between ODM and the MCP. ODM may also require the MCP to designate contact staff for specific program areas. The Medicaid Contract Compliance Officer will be responsible for ensuring the timeliness, accuracy, completeness and responsiveness of all MCP submissions to ODM.

    b. A provider relations representative for each service area included in their ODM provider agreement. This provider relations representative can serve in this capacity for only one service area.

4. Communications: The MCP must take all necessary and appropriate steps to ensure that all MCP staff are aware of, and follow, the following communication process:

    a. All MCP employees are to direct all day-to-day submissions and communications to their ODM-designated Contract Administrator within the Bureau of Managed Care (BMC) unless otherwise notified by ODM. If an MCP needs to contact another area of ODM in any other circumstance, the Contract Administrator within the BMC must also be copied or otherwise included in the communication.

    b. Entities that contract with ODM should never be contacted by the MCP unless ODM has specifically instructed the MCP to contact these entities directly.

    c. Because the MCP is ultimately responsible for meeting program requirements, the BMC will not discuss MCP issues with the MCP's subcontractors unless the MCP is also participating in the discussion. MCP delegated entities, with the MCP

participating, should only communicate with the specific Contract Administrator assigned to that MCP.

5. The MCP must be represented at all meetings and events designated by ODM that require mandatory attendance.

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

7. The MCP must have its Ohio Medicaid Managed Care program member call center(s) located in the state of Ohio.

8. The MCP must have the key Ohio Medicaid Managed Care program staff identified below based and working in the state of Ohio. Each key staff person identified below may occupy no more than one of the positions listed below, unless the MCP receives prior written approval from ODM stating otherwise. These key staff are:

   a. **Administrator/CEO/COO** or their designee must serve in a full time (40 hours weekly) position available during ODM working hours to fulfill the responsibilities of the position and to oversee the entire operation of the MCP. The Administrator shall devote sufficient time to the MCP's operations to ensure adherence to program requirements and timely responses to ODM.

   b. **Medical Director/CMO** who is a physician with a current, unencumbered license through the Ohio State Medical Board. The Medical Director must have at least three (3) years of training in a medical specialty. The Medical Director shall devote full time (minimum 32 hours weekly) to the MCP's operations to ensure timely medical decisions, including after-hours consultation as needed. The Medical Director shall be actively involved in all major clinical and quality management components of the MCP. At a minimum, the Medical Director shall be responsible for:
      i. Development, implementation and medical interpretation of medical policies and procedures including, but not limited to, service authorization, claims review, discharge planning, credentialing and referral management, and medical review included in the MCP grievance system;

      ii. Administration of all medical management activities of the MCP; and

      iii. Serve as director of the Utilization Management committee and chairman or co-chairman of the Quality Assessment and Performance Improvement committee.

   c. **Contract Compliance Officer** who will serve as the primary point-of-contact for all MCP operational issues. The primary functions of the Contract Compliance Officer may include but are not limited to coordinating the tracking and submission of all contract deliverables; fielding and coordinating responses to ODM inquiries,

coordinating the preparation and execution of contract requirements, random and periodic audits and site visits.

d. **Provider Services Representatives** who will resolve provider issues, including, but not limited to, problems with claims payment, prior authorizations (PA) and referrals.

e. **Care Management Director** who is an Ohio-licensed registered nurse preferably with a designation as a Certified Case Manager (CCM) from the Commission for Case Manager Certification (CCMC). The Director is responsible for overseeing the day-to-day operational activities of the Care Management Program in accordance with state guidelines. The CM Director is responsible for ensuring the functioning of care management activities across the continuum of care (assessing, planning, implementing, coordinating, monitoring, and evaluating).The CM Director must have experience in the activities of care management as specified in 42 CFR §438.208. Primary functions of the Director position are:
    i. To ensure the implementation of mechanisms for identifying, assessing, and developing a treatment plan for an individual with special health care needs;

    ii. To ensure access to primary care and coordination of health care services for all members; and

    iii. To ensure the coordination of services furnished to the enrollee with the services the enrollee receives from any other health care entity.

f. **Utilization Management Director** who is an Ohio-licensed registered nurse or a physician with a current unencumbered license through the Ohio State Medical Board. This person may have a certification as a Certified Professional in Health Care Quality (CPHQ) by the National Association for Health Care Quality (NAHQ) and/or Certified in Health Care Quality and Management (CHCQM) by the American Board of Quality Assurance and Utilization Review Providers. The Director is responsible for overseeing the day-to-day operational activities of the Utilization Management Program in accordance with state guidelines. The UM Director must have experience in the activities of utilization management as specified in 42 CFR §438.210. Primary functions of the Director of Utilization Management position are:
    i. To ensure that there are written policies and procedures regarding authorization of services and that these are followed;

    ii. To ensure consistent application of review criteria for authorization decisions;

    iii. To ensure that decisions to deny or reduce the amount of services are made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease;

iv. To ensure that notices of adverse action meet the requirements of §438.404; and

v. To ensure that all decisions are made within the specified allowable time frames.

g. **EPSDT/Maternal Child Health Manager** who is an Ohio licensed registered nurse, physician, or physician's assistant; or has a Master's degree in health services, public health, or health care administration or other related field and/or a CPHQ or CHCQM. Staffing under this position should be sufficient to meet quality and performance measure goals. The primary functions of the EPSDT/MCH Manager are:

i. Ensuring receipt of EPSDT services;

ii. Ensuring receipt of maternal and postpartum care;

iii. Promoting family planning services;

iv. Promoting preventive health strategies;

v. Identifying and coordinating assistance for identified member needs specific to maternal/child health and EPSDT; Interfacing with community partners; and

vi. Pregnancy Related Services Coordinator

h. **Quality Improvement Director** who is an Ohio-licensed registered nurse, physician or physician's assistant or is a CPHQ and/or a CHCQM by the American Board of Quality Assurance and Utilization Review Providers. The Quality Improvement Director must have experience in quality management and quality improvement as specified in 42 CFR §438.200 – 438.242. The primary functions of the Quality Improvement Director position are:

i. Ensuring individual and systemic quality of care;

ii. Integrating quality throughout the organization;

iii. Implementing process improvement; and

iv. Resolving, tracking and trending quality of care grievances.

9. Upon request by ODM, the MCP must submit information on the current status of their company's operations not specifically covered under this Agreement unless otherwise excluded by law.

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

11. All employees of the MCP and the MCP's subcontractors who have in-person contact with a member in the member's home must comply with criminal record check requirements as specified by ODM.

12. 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 ODM 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.

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

14. The MCP is responsible for determining medical necessity for services and supplies requested for their members as specified in OAC rule 5160-26-03. Notwithstanding such responsibility, ODM retains the right to make the final determination on medical necessity in specific member situations.

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

16. In addition to the provisions in OAC 5160-26-05(B), the MCP must notify the BMC:

    a. within one working day of becoming aware that a MCP panel provider that served 500 or more of the MCP's members failed to notify the MCP that they are no longer available to serve as a MCP panel provider;

    b. at least 4 months before the effective date of a systemic change in panel. ODM defines a systemic change in panel as an MCP-initiated termination or change in availability of any single provider or combination of providers, that are included in the provider contract termination in question, serving 500 or more of the MCP's members. For example, an MCP terminates ten providers each serving 450 members. This termination must be reported, even though the providers individually do not meet the 500 member requirement. Overall, the group termination impacts 4,500 members and must be reported. ODM reserves the right to require that the MCP align an MCP initiated systemic change in panel to the annual open enrollment month; or

    c. within one working day of becoming aware of a provider-initiated hospital unit closure.

17. Upon ODM's request, the MCP may be required to provide written notice to members of any significant change(s) affecting contractual requirements, member services or access to providers.

18. Additional Benefits: The MCP may elect to provide services that are in addition to those covered under the Ohio Medicaid fee-for-service (FFS) program. Before the MCP notifies potential or current members of the availability of these services, they must first notify ODM and advise ODM that it plans to make such services available. If an MCP elects to provide additional services, the MCP must ensure to the satisfaction of ODM 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 ODM. Additional benefits may not vary by county within a region except out of necessity for transportation arrangements (e.g., bus versus cab). MCPs approved to serve consumers in more than one region may vary additional benefits between regions.

    a. The MCP is **required** to make transportation available to any member requesting transportation when the member **must** travel thirty (30) miles or more from his or her home to receive a medically-necessary Medicaid-covered service provided by the MCP pursuant to OAC rule 5160-26-03 and Appendix G of this Provider Agreement. If the MCP offers transportation to their members as an additional benefit and this transportation benefit only covers a limited number of trips, the required transportation listed above may not be counted toward this trip limit.

    b. The MCP must give ODM and members ninety (90) days prior notice when decreasing or ceasing any additional benefit(s). When an MCP finds that it is impossible to provide 90 days prior notice for reasons beyond its control, as demonstrated to ODM's satisfaction, ODM must be notified within at least one (1) working day.

19. Provision of Transportation Services:

    a. MCPs must ensure transportation pick-up is completed not more than fifteen (15) minutes before or fifteen (15) minutes after the pre-scheduled pick-up time, ensuring the member is on time for their appointment, and no more than thirty (30) minutes after a request for pick-up following a scheduled appointment. The vendor must attempt to contact the member if he/she does not respond at pick-up. The vendor must not leave the pick-up location prior to the pre-scheduled pick-up time. The MCPs must identify and accommodate the special transportation assistance needs of their members (e.g., door-to-door assistance, attendant support, member-specific timeliness requirements). Member-specific needs must be communicated to the transportation vendor and updated as frequently as is needed to support the member's needs. Where applicable, these needs must be documented in the member's care plan.

b. MCPs must submit a plan for the provision of transportation services during winter snow and other weather emergencies, specifying identification, triage, transportation of consumers requiring critical services, notification to consumers of canceled transportation and rescheduling. The plan must specify the snow emergency level and any other weather-related criteria that require a change to scheduled transportation. The MCP must notify the Contract Administrator immediately when transportation is canceled in accordance with the plan.

20. The MCP 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. The MCP shall include a requirement in its contracts with affiliated providers that such providers also adhere to applicable Federal and State laws when providing services to members.

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

22. Marketing Materials and Member Materials

Pursuant to OAC rules 5160-26-08 and 5160-26-08.2, the MCP is responsible for ensuring that all MCP marketing and member materials are prior approved by ODM before being used or shared with members or potential 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 5160-26-08.4. 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 as defined in OAC 5160-26-01.

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. MCP marketing and member materials must not include statements that are inaccurate, misleading, confusing, or otherwise misrepresentative, or which defraud eligible individuals or ODM.

d. MCP marketing materials 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. The MCP 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, the MCP is prohibited from offering gifts to CDJFS offices or Medicaid Consumer Hotline (henceforth referred to as the "Hotline") 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 Hotline.

23. Cultural Competency and Communication Needs

The MCP is responsible for promoting the delivery of services in a culturally competent manner, as solely determined by ODM, to all members, including those with limited English proficiency (LEP) and diverse cultural and ethnic backgrounds. The MCP must make oral interpreter services for all languages available free of charge to all members and eligible individuals pursuant to 42 CFR Section 438.10(c)(4).

The MCP must comply with the requirements specified in OAC rules 5160-26-03.1, 5160-26-05(D), 5160-26-05.1(A), 5160-26-08 and 5160-26-08.2 for providing assistance to LEP members and eligible individuals. In addition, the MCP 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. If ODM identifies prevalent common primary languages other than English in the MCP's service area, the MCP, as specified by ODM, must translate marketing and member materials, including but not limited to HIPAA privacy notices, into the primary languages of those groups and make these marketing and member materials available to eligible individuals free of charge.

b. 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 ODM, the Hotline, 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 primary care provider (PCP) who speaks the primary language of an LEP member, when such a

provider is available. The MCP must share specific communication needs information with its providers [e.g., PCPs, Pharmacy Benefit Managers (PBMs), and Third Party Administrators (TPAs)], as applicable. The MCP must submit to ODM, upon request, information regarding the MCP's members with special communication needs, which could include individual member names, their specific communication need, and any provision of special services to members (i.e., those special services arranged by the MCP as well as those services reported to the MCP which were arranged by the provider).

Additional requirements specific to providing assistance to hearing-impaired, vision-impaired, LRP, and LEP members and eligible individuals are found in OAC rules 5160-26-03.1, 5160-26-05(D), 5160-26-05.1(A), 5160-26-08, and 5160-26-08.2.

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

d. The MCP must participate in ODM's cultural competency initiatives.

e. Person-Centered Language in Communications - The MCP will use person-centered language in all communication with eligible individuals and members consistent with the definition available at: http://www.disabilityisnatural.com/explore/professionals-organizations.

24. New Member Materials

Pursuant to OAC rule 5160-26-08.2(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, provider panel information, and information on advance directives, as specified by ODM.

a. The MCP must use the model language specified by ODM for the new member letter.

b. The ID card, new member letter, and, if applicable, provider directory request postcard 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 MCP must provide access to provider panel information to members via the MCP's website and printed provider directories.

    i. MCPs may mail ODM prior-approved postcards to new members in lieu of mailing printed directories. At a minimum, the postcards must advise members to call the MCP or return the postcards to request a printed provider directory. MCPs must automatically send a printed provider

directory to members that voluntarily enroll and request a printed provider directory, as reflected on the Consumer Contact Record (CCR), with the new member materials as specified in 24.d. of this Appendix.

ii. MCPs that do not use an ODM prior-approved postcard must mail printed provider directories to all new members as specified in 24.d. of this Appendix except printed provider directories do not need to be mailed to new members that voluntarily enroll and request to not receive printed provider directories as reflected on the CCR.

iii. If requested, a printed provider directory must be sent to a member within seven (7) calendar days of the request.

d. The MCP may mail the member handbook, provider directory, if applicable, and advance directives information to the member separately from the ID card, new member letter, and provider directory request postcard if applicable. An MCP will meet the timeliness requirement for mailing these materials if they are mailed to the member within twenty-four (24) hours of the MCP receiving the ODM produced monthly full-membership roster, which is the HIPAA 834 FU, and if the materials are mailed via a method with an expected delivery date of no more than five (5) days. If the MCP mails the member handbook, provider directory (if applicable), and advance directives information separately from the ID card, new member letter, and postcard (if applicable), but the MCP is unable to mail these materials within twenty-four (24) hours of receiving the HIPAA 834 F, the MCP must mail the member handbook, provider directory (if applicable), and advance directives information via a method that will ensure receipt by no later than the effective date of coverage. If the MCP mails the ID card, new member letter, and postcard (if applicable), with the other materials (e.g., member handbook, provider directory, and advance directives), the MCP must ensure that all materials are mailed via a method that will ensure their receipt prior to the member's effective date of coverage.

e. The MCP 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.

f. The MCP ID card must contain pharmacy information, as prescribed by ODM.

25. Healthchek Services

a. Informing Members About Healthchek - In addition to the Healthchek requirements specified in OAC rules 5160-26-03(H) and 5160-26-08.2(B)(4)(i), the MCP must:

i. Inform each member under the age of 21 within 7 calendar days of their effective date of enrollment in the MCP about the Healthchek program as prescribed by ODM and as specified by 42 C.F.R. Section 441.56. An MCP may meet this requirement by including information with the new member materials as specified in paragraph 24.d of this Appendix. In addition, the MCP may be required to communicate with the member's local County Department of Job and Family Services agency any requests made by the member for County coordinated services and/or supports (e.g. social services).

ii. Provide members with accurate information in the member handbook regarding Healthchek, Ohio's early and periodic screening, diagnostic, and treatment (EPSDT) benefit. The MCP's member handbooks must be provided to members within the time frames specified in 24.d of this Appendix, and must include verbatim the model language developed by ODM. The model language at a minimum will include:

a. A description of the types of screening and treatment services covered by Healthchek;

b. A list of the intervals at which individuals under age 21 should receive screening examinations, as indicated by the most recent version of the document entitled "Recommendations for Preventive Pediatric Health Care," published by Bright Futures/American Academy of Pediatrics;

c. Information that Healthchek services are provided at no additional cost to the member; and

d. Information that providers may request prior authorization for coverage of services that have limitations and/or are not covered for members age 21 and older if the services are medically necessary EPSDT services.

iii. Provide the above Healthchek information in 25.a.ii on the MCP's member website specified in 41.b. of this Appendix.

iv. Deliver Healthchek information as provided, or as approved, by ODM to its members at the following intervals:
a. When the member is 9 months old;
b. When the member is 18 months old;
c. When the member is 30 months old;
d. January of each calendar year to all members under the age of 21; and

e. At the beginning of each school year in the month of July for members from age 4 to under 21.

v. Use the mailing templates provided by ODM that will not exceed two (2) 8x11 pages for each mailing with most mailings being one (1) page or less in length. The MCP must populate the materials with appropriate Healthchek information as required (e. g. type of service, rendering provider, date of service and age of member on the date of service).

b. Informing Members about Pregnancy Related Services (PRS)

i. Upon the identification of a member as pregnant, the MCP must deliver to the member within 14 calendar days a PRS form as designated by ODM. The MCP may be required to communicate with the member's local County Department of Job and Family Services agency any requests made by the member for County coordinated services and supports (e.g. social services).

c. Informing Providers about Healthchek -- In addition to the Healthchek requirements specified in OAC rule 5160-26-05.1(A)(13), the MCP must:

i. Provide Healthchek education to all contracted providers on an annual basis which must include, at a minimum, the following:

a. The required components of a Healthchek exam as specified in Ohio Administrative Code Chapter 5160-14-3;

b. A list of the intervals at which individuals under age 21 should receive screening examinations, as indicated by the most recent version of the document "Recommendations for Preventive Pediatric Health Care" published by Bright Futures/American Academy of Pediatrics;

c. A statement that Healthchek includes a range of medically necessary screening, diagnosis and treatment services; and

d. A list of common billing codes and procedures related to the Healthchek services (e.g., immunizations, well child exams, laboratory tests, and screenings).

ii. Provide the above information on the MCP's provider website as specified in 41.c. of this Appendix.

d. MCPs must maintain documentation that it informed members and providers of Healthchek and Pregnancy Related Services as specified by ODM.

26. 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 (42 CFR 489.100—489.104).

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 ODM-approved information to all adult members concerning:

a. The member's rights under state law to make decisions concerning his or her medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

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.

27. Call Center Standards

The MCP must provide assistance to members through a member services toll-free call-in system pursuant to OAC rule 5160-26-08.2(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 ODM 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 request prior approval from ODM of any extended hours of operation of the member services line that is outside the required days and time specified above.

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 5160-26-03.1(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).

The MCP 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. At least semi-annually, the MCP must self-report its monthly and semi-annual performance in these three areas for their member services and 24/7 hour toll-free call-in systems to ODM as specified. If

an MCP has separate telephone lines for different Medicaid populations, the MCP must report performance for each individual line separately. MCPs must report their July through December performance to ODM by January 10 and their January through June performance by July 10. ODM reserves the right to require more frequent reporting by a MCP if it becomes aware of an egregious access issue or consecutive months of non-compliance with URAC standards. ODM will inform the MCPs of any changes/updates to these URAC call center standards.

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, without prior approval by ODM. With the exception of transportation vendors, MCPs are prohibited from publishing a delegated entity's general call center number.

28. Notification of Voluntary MCP Membership

In order to comply with the terms of the ODM State Plan Amendment for the managed care program (i.e., 42 CFR 438.50), the MCP must inform new members that MCP membership is voluntary for the following population. Specifically, the MCP must inform any applicable member(s) that Indians who are members of federally-recognized tribes, except as permitted under 42 CFR 438.50(d)(2) 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 be a member of an MCP:

Until January 1, 2017, the MCP must inform any applicable member(s) that the following populations are not required to select an MCP in order to receive their Medicaid healthcare benefits, and describe what steps the member must take if he or she does not wish to become a member of an MCP:
-Children under 19 years of age who are:

- 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.

29. Privacy Compliance Requirements

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations at 45 CFR.164.502(e) and 164.504(e) require ODM to enter into agreements with MCPs as a means of obtaining satisfactory assurance that the MCPs will appropriately safeguard all "protected health information" (PHI), which means information received from or on behalf of ODM that meets the definition of PHI as defined by HIPAA and the regulations

promulgated by the United States Department of Health and Human Services, specifically 45 C.F.R. 160.103, 45 CFR 164.501 and any amendments thereto.

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

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

a. **Permitted Uses and Disclosures.** The MCP will not use or disclose PHI except as provided in this Agreement or as otherwise required under HIPAA regulations or other applicable law.

b. **Safeguards.** The MCP shall implement sufficient safeguards, and comply with Subpart C of 45 CFR Part 164 pertaining to electronic PHI to prevent the use or disclosure of PHI other than as provided for under this Agreement. Safeguards will be implemented for all paper and electronic PHI created, received, maintained, or transmitted on behalf of ODM.

c. **Reporting of Disclosures.** The MCP agrees to promptly report to ODM any inappropriate use or disclosure of PHI that is not in accordance with this Agreement or applicable law, including a breach of unsecured PHI as required at 45 CFR 164.410 and any security incident the MCP has knowledge of or reasonably should have knowledge of under the circumstances.

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

e. **Incidental Costs.** The MCP shall bear the sole expense of all costs to mitigate any harmful effect, of any breaches or security incidents which were caused by the MCP, or its subcontractors, in violation of the terms of this Agreement. These costs will include, but are not limited to, the cost of investigation, remediation and assistance to the affected individuals, entities or other authorities.

f. **Agents and Subcontractors.** The MCP, in compliance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2) as applicable, must ensure that all its agents and subcontractors that create, receive, maintain, or transmit PHI from or on behalf of MCP and/or ODM agree to have, in a written agreement, the same restrictions, conditions, and requirements that apply to MCP with respect to the use or disclosure of PHI.

g. **Accessibility of Information.** The MCP must make available to ODM such information as ODM may require to fulfill its obligations to provide access to, provide a copy of any information or documents with respect to PHI pursuant to HIPAA and regulations promulgated by the United States Department of Health and Human Services, including, but not limited to, 45 CFR 164.524 and 164.528 and any amendments thereto.

h. **Amendment of Information.** The MCP shall make any amendment(s) to PHI as directed by, or agreed to, by ODM pursuant to 45 CFR 164.526, or take other steps as necessary to satisfy ODM's obligations under 45 CFR 164.526. In the event that the MCP receives a request for amendment directly from an individual, agent, or subcontractor, the MCP must notify ODM prior to making any such amendment(s). The MCP's authority to amend information is explicitly limited to information created by the MCP.

i. **Accounting for Disclosure.** The MCP shall maintain and make available to ODM or individuals requesting the information as appropriate, records of all disclosures of PHI in a Designated Record Set as necessary to satisfy ODM's obligations under 45 CFR 164.528. For every disclosure, the record must include, at a minimum, the name of the individual who is the subject of the disclosure, the date of the disclosure, reason for the disclosure if any, and the name and address of the recipient to which the PHI was disclosed.

j. **Obligations of ODM.** When the MCP is required to carry out an obligation of ODM under Subpart E of 45 CFR Part 164, the MCP agrees to comply with all applicable requirements of Subpart E that would apply to ODM in the performance of such obligation.

k. **Access to Books and Records.** The MCP shall make available to ODM and to the Secretary of the U.S. Department of Health and Human Services any and all internal practices, documentation, books, and records related to the use and disclosure of PHI received from ODM, or created or received on behalf of ODM. Such access is for the purposes of determining compliance with the HIPAA Rules.

l. **Material Breach.** In the event of material breach of the MCP's obligations under this Article, ODM may immediately terminate this Agreement as set forth in ARTICLE VI, Section B. Termination of this Agreement will not affect any provision of this Agreement, which, by its wording or its nature, is intended to remain effective and to continue to operate after termination.

m. **Return or Destruction of Information.** Upon termination of this Agreement and at the request of ODM, the MCP will return to ODM or destroy all PHI in MCP's possession stemming from this Agreement as soon as possible but no later than 90 days, and will not keep copies of the PHI except as may be requested by ODM or required by law, or as otherwise allowed for under this Agreement. If the MCP, its agent(s), or subcontractor(s) destroy any PHI, then the MCP will provide to ODM documentation evidencing such destruction. Any PHI retained by the MCP will continue to be extended the same protections set forth in this Section, HIPAA regulations and this Agreement for as long as it is maintained.

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

30. Electronic Communications

The MCP is required to purchase/utilize Transport Layer Security (TLS) for all e-mail communication between ODM 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.

31. MCP Membership Acceptance, Documentation and Reconciliation

a. Medicaid Consumer Hotline Contractor - The MCP shall provide to the Hotline ODM prior-approved MCP materials and directories for distribution to eligible individuals who request additional information about the MCP.

b. Enrollment and Capitation Reconciliation

i. The MCP shall maintain the integrity of its membership data through reconciliation of the daily HIPAA 834C (Daily Benefit Enrollment and Maintenance File) and the monthly HIPAA 834F (Monthly Benefit Enrollment and Maintenance File) transactions. The monthly cycle is based on state cut-off dates (e.g., June 2012 enrollment reflects changes from that occurred April 19, 2012 – May 21, 2012). Please reference the Processing Dates for Calendar Year memo issued annually. Discrepancies between the HIPAA 834C and 834F that have a negative impact on a member's access to care must be reported to ODM within one (1) business day.

ii. The HIPAA 820 (Monthly Remittance Advice) will contain the following: a capitation payment for each member listed on the HIPAA 834F, a capitation payment/recoupment for changes listed in the daily HIPAA 834C, any other capitation payment/recoupment, and delivery payment/recoupment from the previous calendar month. Reconciliation for any discrepancies between the HIPAA 834 and HIPAA 820 is due and

must be submitted, as instructed by ODM, no later than sixty (60) days after the issuance of the HIPAA 834F. Please reference the Processing Dates for Calendar Year memo that is issued annually. In the event of changes in the processing dates, the due date will be adjusted accordingly.

iii. All reconciliation requests must be submitted in the format specified by ODM. ODM may reject reconciliation requests that are submitted after the due date. Reconciliation requests submitted after the due date will be processed at the discretion of ODM. Recoupments, date of death, duplicative payments made to the same plan due to multiple IDs will always be processed.

iv. MCP-Initiated Nursing Facility (NF) disenrollment requests: Excluding Adult Extension, pursuant to OAC rule 5160-26-02.1, NF disenrollment requests for MAGI and ABD must be submitted to ODM on an ODM designated form. See disenrollment table below:

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

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

- The admission date is 3 months or less prior to the initial enrollment month, and the MCP disenrollment request must align with the Disenrollment Table dates; or

- The admission date is more than 3 months prior to the initial enrollment month, and the MCP disenrollment request must be

submitted during the initial enrollment month to disenroll the member the last day of the month prior to the initial enrollment.

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

In all cases, MCPs are responsible for coverage through the disenrollment date.

c. Change in Enrollment During Hospital/Inpatient Facility Stay - When an MCP learns of a currently hospitalized member's intent to disenroll through the CCR or the HIPAA 834, the disenrolling MCP must notify the hospital/inpatient facility and treating providers as well as the enrolling MCP, if applicable, 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 or ODM as applicable to facilitate the discharge, transfer and authorization of services as needed.

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

When 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 MCP shall notify the hospital/inpatient facility and treating providers that the MCP is responsible for the professional charges effective on the date of enrollment, and shall work to ensure that discharge planning

provides continuity using MCP-contracted or authorized providers.

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

e. Newborn Notifications – MCP membership for newborns will be in accordance with rule OAC 5160-26-02.

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.

The MCP must notify the CDJFS and provide at a minimum the mother's name, social security number, eligibility system 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 ODM of a newborn's MCP membership via the membership roster(s).

f. Eligible Individuals (pursuant to OAC 5160-26-01)- 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, the MCP 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.

g. Pending Member - If a pending member (i.e., an eligible individual subsequent to MCP selection or assignment to an MCP, but prior to their membership effective date) contacts the selected MCP, the MCP must provide any membership information requested, including but not limited to explaining how to access services as an MCP member and assistance in determining whether current services require prior authorization. The MCP 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.

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

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

33. Transition of Care for Members Moving from Medicaid Fee for Service (FFS) to Managed Care:

a. Retroactive Coverage Requirements – The MCP must pay for claims for covered services provided to members during retroactive enrollment periods. For services provided during retroactive enrollment periods that require FFS prior authorization as documented in Appendix DD of OAC 5160-1-60, OAC 5160-9-12 (regarding pharmacy claims), and all other FFS regulations that set forth prior authorization policy, MCPs may conduct a medical necessity review for payment. However, if the service was already reviewed and approved by FFS, the MCP must also approve the service.

b. New Populations Enrolling in Managed Care (i.e., after July 1, 2016: Adult Extension members who can access waiver services and January 1, 2017: Foster Care, Adoption Assistance, Bureau for Children with Medical Handicaps, 1915(i), and the DD waiver) - 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 relationship with providers and existing care plans, is critical for members transitioning from FFS to managed care. The MCP must develop and implement processes that include the following provisions:

1. Pre-enrollment planning – The MCP must implement a comprehensive transition of care process prior to the effective enrollment date that will:

i. Utilize information and data provided by ODM (prior authorizations, FFS claims, MCP encounters, consumer contact records, etc.) and/or collected by the MCP through assessments, new member outreach in advance of the member's enrollment effective date, etc;

ii. Create a new member profile based on the information and data referenced in 1.i to identify existing health care needs:

- Existing sources of care (i.e., primary physicians, specialists, case managers, behavioral health providers, ancillary, and other providers),
- Current provision of services for all aspects of health care services, including scheduled health care appointments, planned and/or approved (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
- Needed/approved transportation arrangements; and
- Services received through other state sub-recipient agencies [e.g., Ohio Department of Mental Health and Addiction Services (MHAS) , the

Ohio Department of Developmental Disabilities (DODD) and the Ohio Department (ODA)]; and

iii. Assure each new member will obtain needed services that are, at a minimum, specified in Section 3.

2. Provision of Care Management - In accordance with Appendix K, the MCP must assure that each member is in a care management arrangement where the MCP (or its delegate) or a patient-centered medical home (PCMH) is the designated primary care management entity. In the event ODM is unable to identify which members are assigned/attributed to a PCMH, the MCP will identify if the member has an existing relationship (i.e., attribution, assignment) with a patient centered medical home (PCMH) and, if not, connect the member to a PCMH, as applicable. There must be a clear delineation of roles and responsibilities between the MCP and other entities (PCMH, community partners, etc.) that are responsible for, or are contributing to, care management in order to assure no duplication of, or gaps in, services. Members under the age of 21 must be initially assigned to the intensive or high risk level until an assessment can be completed to confirm or adjust the initial risk level.

3. Continuation of Services – The MCP must allow a new member who is transitioning from FFS to an MCP to continue to receive services from network and out-of-network providers as per the following:

Transition Requirements	Members who are 21 years of age and older	Members who are under 21 years of age
Physician Services	Must allow the member to continue with out of network physician or specialist for the first month of enrollment.	Must allow the member to continue with out of network physician or specialist for the first three months of enrollment.
Durable Medical Equipment	Honor Medicaid FFS prior authorizations (PAs) for no less than 90 days from the enrollment effective date. After the 90 days has expired, the MCP can conduct a medical necessity review pursuant to OAC rule 5160-26-03.1.	Unless noted as an exception below, the MCP must honor Medicaid FFS PAs for no less than 90 days from the enrollment effective date. After the 90 days has expired, the MCP can conduct a medical necessity review pursuant to OAC rule 5160-26-03.1. The MCP must honor the Medicaid FFS PA for 90 days or the duration of the PA, whichever is longer, for the

		following items: enteral feeding supply kits, hearing aids, synthesized speech generating devices, and parenteral nutritional supply kits.
Home Care and Private Duty Nursing (PDN) Services	Maintain current service level with current provider until the MCP conducts a medical necessity review and renders an authorization decision pursuant to OAC rule 5160-26-03.1	Maintain current service level with current provider pursuant to OAC rule 5160-12-01 for 90 days after initial MCP enrollment. After 90 days of enrollment and prior to transitioning to a participating provider or proposing a change in the service amount, the MCP must make a home visit, and observe the home care or PDN service being provided, to assess the current need for continued services.
Medicaid Community Behavioral Health Services	Make referral and linkage to, and follow up with, the Community Behavioral Health Centers for requested/needed services.	Make referral and linkage to, and follow up with, the Community Behavioral Health Centers for requested/needed services.
Prescription Drugs	Must cover prescription refills during the first three months of membership for prescriptions covered by Ohio Medicaid during the prior FFS enrollment period. Thereafter, the MCP may not require PA of these prescriptions until the MCP has educated the member that further dispensation will require the prescribing provider to request PA. If applicable, the MCP must offer the member the option of using an alternative medication that may be available without PA. Written member education notices must use ODM-specified model language. Verbal member education may be done in place of written education but must contain the same information as a written notice. MCP member notices and, if applicable, call scripts used for verbal education, must be prior approved by ODM. For antidepressant and antipsychotic medications, the MCP must abide by the restrictions on PA described in Appendix G.2.b.vi. of this Agreement.	
Scheduled Surgeries	Must allow the member to receive scheduled inpatient or outpatient surgery if it has been prior approved and/or pre-	

	certified pursuant to OAC rule 5160-2-40 (surgical procedures would also include follow up care as appropriate).
Chemotherapy or Radiation	Must allow the member to continue to receive the entire course of treatment if initiated prior to enrollment with the MCP.
Organ, Bone Marrow, Hematopoietic Stem Cell Transplants	Must honor current FFS prior authorizations for organ, bone marrow, or hematopoietic stem cell transplant pursuant to OAC rule 5160-2-07.1 and 2.b.vii of Appendix G. MCPs must receive prior approval from ODM prior to transferring services to a network provider.
Vision and Dental	Must honor current FFS prior authorizations for any vision and dental services that have not yet been received.
Hospital Discharge	Must continue with treatment if the member was discharged 30 days prior to the MCP enrollment effective date.
Pregnancy Care	Must allow a member who is in her third trimester of pregnancy to continue a relationship with her out of network obstetrician and/or delivery hospital.

c. Continuation of Services for Members not identified in 33.b of this Appendix who Transition from Fee for Service to Managed Care – The MCP must allow a member transitioning from FFS to an MCP to receive services from network and out of network providers, if any of the following applies:
    1. If the MCP confirms that the Adult Extension member is currently receiving care in a nursing facility on the effective date of enrollment with the MCP, the MCP must cover NF care at the same facility until a medical necessity review has been completed and if applicable a transition to an alternative placement has been documented in the member's care plan.
    2. Upon learning, or receiving notification, of a pregnant woman's enrollment with the MCP, the MCP must identify the member's maternal risk and must facilitate connection to services and supports in accordance with ODM's *Guidance for Managed Care Plans for the Provision of Enhanced Maternal Care Services*. These services and supports include delivery at an appropriate facility and continuation of progesterone therapy covered by Medicaid FFS for the duration of the pregnancy. In addition, the MCP must allow the pregnant member to continue with an out of network provider if she is in her third trimester of pregnancy and/or has an established relationship with an obstetrician and/or delivery hospital.
    3. For all consumers, the MCP must honor any current FFS prior authorizations and/or to allow its new members to continue to receive the following services as provided by Medicaid FFS, regardless of whether the authorized/treating provider is in or out-of-network with the MCP:

i. The member has been scheduled for an inpatient or outpatient surgery and has been prior-approved and/or pre-certified pursuant to OAC rule OAC rule 5160-2-40 (surgical procedures would also include follow-up care as appropriate);
ii. The member is receiving ongoing chemotherapy or radiation treatment;
iii. The member has been released from the hospital within thirty (30) days prior to MCP enrollment and is following a treatment plan.
iv. An organ, bone marrow, or hematopoietic stem cell transplant pursuant to OAC rule 5160-2-07.1 and 2.b.vii of Appendix G;
v. Dental services, as previously authorized, that have not yet been received;
vi. Vision services, as previously authorized, that have not yet been received;
vii. Durable medical equipment (DME), as previously authorized, 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 5160-26-03.1.
viii. Private duty nursing and home care services must be covered at the same level with the same provider as approved and/or covered by Medicaid FFS until the MCP conducts a medical necessity review and renders an authorization decision pursuant to OAC rule 5160-26-03.1.
ix. Prescription drugs must be covered without PA for at least one refill for the first 30 days of membership. The MCP may not require PA, for these prescription drugs filled without PA during the first 30 days of membership, until the MCP has educated the member that further dispensation will require the prescribing provider to request PA. If applicable, the MCP must offer the member the option of using an alternative medication that may be available without PA. Written member education notices must use ODM-specified model language. Verbal member education may be done in place of written education but must contain the same information as a written notice. MCP member notices and, if applicable, call scripts used for verbal education, must be prior approved by ODM.

x. For antidepressant and antipsychotic medications, the MCP must abide by the restrictions on PA described in Appendix G.2.b.vi of this Agreement.

d. Out-of-Panel Provider Reimbursement – The MCP must reimburse 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 33 (a, b, and c) of this Appendix.

e. Documentation of services – The MCP must document the provision of transition of services identified in 33 (a, b, and c) of this Appendix as follows:

i. The MCP must seek confirmation from a non-panel provider that the provider agrees to provide the service and accept 100% of the current Medicaid FFS rate as payment. If the provider agrees, the MCP shall distribute its materials to the non-panel provider as outlined in Appendix G.3 of this Agreement.

ii. If the non-panel provider does not agree to provide the service and accept 100% of the Medicaid FFS rate, the MCP must notify the member of the MCP's availability to assist with locating a provider as expeditiously as the member's health condition warrants.

iii. If the service will be provided by a panel provider, the MCP must notify the panel provider and the member to confirm the MCP's responsibility to cover the service.

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

34. Transition of Care Requirements for Members of an Exiting MCP

When the enrolling MCP is informed by ODM, or its designee, of a member transitioning from the exiting MCP, the enrolling MCP must follow the transition of care requirements as set forth in Appendix C.33, above.

35. Health Information System Requirements

The ability to develop and maintain information management systems capacity is crucial to successful plan performance. ODM 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), the 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), the 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), the 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), the MCP must make all collected data available upon request by ODM or CMS.

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

a. Before the MCP may submit production files;

b. Whenever the MCP changes the method or preparer of the electronic media; and/or

c. When ODM determines that the MCP's data submissions have an unacceptably high error rate.

When the MCP changes or modifies information systems that are involved in producing any type of electronically submitted files, either internally or by changing vendors, it is required to submit to ODM for review and approval a transition plan that includes the submission of test files in the ODM-specified formats. Once an acceptable test file is submitted to ODM, as determined solely by ODM, the MCP can return to submitting production files. ODM will inform the MCP in writing when a test file is acceptable. Once the MCP's new or modified information system is operational, 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. ODM 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 this Agreement, *Compliance Assessment System*.

b. Electronic Data Interchange, Claims Adjudication and Payment Processing Requirements

i. 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. The MCP 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 by the MCP or its designee. Such notification may be in the form of a claim payment/remittance advice produced on a routine monthly, or more frequent, basis.

ii. The MCP is prohibited from recovering back or adjusting any payments that are beyond two years from the date of payment of the claim due to the MCP member's retroactive termination of coverage from the MCP, unless the MCP is directed to do so by CMS, ODM, or applicable state or federal law and regulation. However, the preceding sentence does not prohibit the MCP or ODM from initiating a recovery or adjustment more than two years after the payment of a claim in the event of fraud, abuse, or as otherwise provided by applicable state or federal law and regulation.

iii. The MCP must have policies providing that, upon discovery of claims payment systemic errors that resulted in incorrectly underpaying or denying claims, the MCP is required to reprocess and correctly pay such claims, from the date of identification of the error retroactively through the

period specified in the contract between the MCP and the provider for claims payment corrective activity. A claims payment systemic error is defined as involving more than five providers, or involving a significant number of payment errors if five or fewer providers are affected. If a claims payment systemic error occurs, the MCP shall notify ODM of the error and shall specify its process and timeline for corrective action, unless the MCP corrects the payments within 60 days from the date of identification of the error. The MCP's policies must include how corrective action will be taken on behalf of all affected providers, regardless of whether the claims payment systemic error is identified by the MCP or by any provider. If the error is not a claims payment systemic error, the MCP shall correct the payments within 60 days from the date of identification of the error.

iv. The MCP is prohibited from engaging in practices that unfairly or unnecessarily delay the processing or payment of any claim for MCP members.

v. 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 ODM consistent with EDI processing specifications in the transaction implementation guides and in conformance with the 820 and 834 Transaction Companion Guides issued by ODM:

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.

vi. 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 ODM, as outlined below.

vii. 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 (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)

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 (ASCX12N 834)

f. Health Care Payment and Remittance Advice (ASC X12N 835)

g. Health Plan Premium Payments (ASC X12N 820)

h. Coordination of Benefits

viii. Trading Partner Agreement with ODM

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

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

c. Encounter Data Submission Requirements

General Requirements

Each MCP must collect data on services furnished to members through a claims system and must report encounter data to the ODM. The MCP is required to submit this data electronically to ODM as specified in Appendix L.

Acceptance Testing

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

Acceptance testing of encounter data is required as specified in 35.a.v. of this Appendix.

Encounter Data File Submission Procedures

A certification letter must accompany the submission of an encounter data file in the ODM-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.

d. IDSS Data Submission and Audit Report Requirements

In accordance with 42 CFR 438.606, the MCP must submit a signed data certification letter to ODM attesting to the accuracy and completeness of its audited HEDIS IDSS

data submitted to ODM. Each MCP must also submit to ODM a signed data certification letter attesting to the accuracy and completeness of its final HEDIS audit report (FAR) submitted to ODM.

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

e. Information Systems Review

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

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

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

ii. Review the completed ISCA and accompanying documents;

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

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

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

vi. Examine MCP processes for data transfers;

vii. If 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.

36. Delivery (Childbirth) Payments – MAGI and Adult Extension Members Only

The MCP will be reimbursed for paid MAGI and Adult Extension member deliveries that are identified in the submitted encounters using the methodology outlined in the *ODM 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 ODM and is not entitled to receive payment for the delivery. Delivery encounters submitted by the MCP must be received by ODM no later than four hundred sixty (460) days after the last date of service (pending ODM IT capacity). Delivery encounters which are received by ODM after this time will be denied payment. Prior to the implementation of the 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. The MCP 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 are found for the same delivery, only one payment will be made. The same is true for multiple births; if multiple delivery encounters are submitted, only one payment will be made.

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

Timing of Delivery Payments
The MCP will be paid monthly for deliveries. For example, payment for a delivery encounter submitted with the required encounter data submission in March, will be reimbursed in May.

This payment will be a part of the weekly update (adjustment payment) 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 can be found in the Modified Adjusted Gross Income (MAGI) and Adult Extension Delivery Payment Reporting Procedures and Specifications for ODM Managed Care Plans (MITS version - draft) document.

Auditing of Delivery Payments
A delivery payment audit will be conducted periodically. If medical records do not substantiate that a delivery (at least 22 weeks gestation) occurred related to the payment that was made, then ODM will recoup the delivery payment from the MCP. Also, if it is determined that the encounter which triggered the delivery payment was not a paid encounter, then ODM will recoup the delivery payment.

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

38. The MCP must receive prior written approval from ODM before adding any information to its website that would require ODM prior approval in hard copy form (e.g., provider listings, member handbook information).

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

40. In the event of an insolvency of an MCP, the MCP, as directed by ODM, 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.

41. Information Required for MCP Websites

a. On-line Provider Directory – The MCP must have an internet-based provider directory or link to the Medicaid Consumer Hotline's online provider directory available in the same format as its ODM-approved provider directory, that allows members to electronically search for the MCP panel providers based on name, provider type and geographic proximity (as specified in Appendix H). MCP provider

directories must include all MCP-contracted providers (except as specified by ODM) as well as certain ODM non-contracted providers.

b. On-line Member Website – The MCP 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 response by return e-mail or phone call. The MCP's responses to questions or comments must be made within one working day of receipt. The MCP's responses to grievances and appeals must adhere to the timeframes specified in OAC rule 5160-26-08.4. The member website must be regularly updated to include the most current ODM-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 must make a copy of its Authorized Representative request form available to members through its online member portal located on the MCP's website.

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 listing of the counties the MCP serves unless the MCP serves the entire state in which case the MCP may indicate it services the entire state; (3) the ODM-approved MCP member handbook, recent newsletters and announcements; (4) the MCP's on-line provider directory as referenced in section 41.a. of this appendix; (5) a list of services requiring PA; (6) the MCP's preferred drug list (PDL), including an explanation of the list and identification of any preferred drugs that require PA, the MCP's list of drugs that require PA, including an explanation of the list, identification of first line drugs for drugs that require PA for step therapy, how to initiate a PA, and the MCP's policy for coverage of generic versus brand name drugs; (7) the toll-free telephone number for the 24/7 medical advice call-in system specified in OAC rule 5160-26-03.1 (A) (6); and (8) contact information to schedule non-emergency transportation assistance, including an explanation of the available services and how to contact member services for transportation services complaints. The MCP must publish a thirty (30) days advance notice of changes to the MCP list of drugs requiring prior authorization via their website. The toll-free member services, 24/7 medical advice and transportation scheduling telephone numbers must be easily identified on with the MCP's website home page or a page that is a direct link from a contact button on the home page. ODM may require the MCP to include additional information on the member website as needed.

Provide all Healthchek information as specified in 25.a.i. of this Appendix.

c. On-line Provider Website – The MCP 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 listing of the counties the MCP serves unless the MCP serves the entire state in which case the MCP may indicate it services the entire state; (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 policies and procedures for out-of-network providers to seek payment of claims for emergency, post-stabilization and any other services authorized by the MCP; (5) the MCP's on-line provider directory as referenced in section 41.a. of this appendix; and (6) the MCP's PDL, including an explanation of the list and identification of any preferred drugs that require PA, the MCP's list of drugs that require PA, including an explanation of the list, identification of first line drugs for drugs that require PA for step therapy, how to initiate a PA, and the MCP's policy for coverage of generic versus brand name drugs. The MCP must publish a thirty (30) days advance notice of changes to the MCP list of drugs requiring prior authorization via their website. ODM may require the MCP to include additional information on the provider website as needed.

The MCP must provide prescribers with in-office access to their preferred drug and PA lists via the availability of at least one hand-held software application.

Provide all Healthchek information as specified in 25.b.i. of this Appendix.

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

43. 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.

44. Third Party Liability (TPL) –

a. Coordination of Benefits - When a claim is denied due to TPL, 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 TPL information received from ODM.

b. Recovery - ODM reserves the right to collect and retain any recovery of third party resources for individuals assigned to the MCPs for collection to the extent that the third party resources remain uncollected from one year from the payment date of the claim.

45. MCP Submission Due Dates - Unless otherwise indicated, MCP submissions with due dates that fall on a weekend or holiday are due the next business day.

46. Trial Member Level Incentive Programs - The MCP must submit a description of a proposed trial member-level incentive program to ODM for review and approval prior to implementation. A trial member level incentive program is defined as a time limited monetary or non-monetary reward offered to a member who complies with the intended goals of the program as outlined by the MCP (e.g., recommended health screenings) in the submission. The incentive 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.

47. The MCP must subscribe to the appropriate 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. The MCP is solely responsible for submitting its names and email addresses to the appropriate distribution lists and is also responsible for ensuring the validity of any e-mail addresses maintained on those distribution lists.

48. Pursuant to O.R.C. 5167.14, MCPs must enter into a data security agreement with the State of Ohio's Board of Pharmacy that governs the MCP's use of the Board's drug database established and maintained under O.R.C. 4729.75.

49. Upon request by ODM, the MCP must share data with ODM's actuary.ODM and the MCP are covered entities under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). ODM represents and warrants that separate from this Provider Agreement, a Business Associate agreement that complies fully with HIPAA and the Health Information Technology for Economic and Clinical Health Act ("HITECH") and the implementing federal regulations under both Acts, has been executed by ODM's actuary, is currently in effect, and will remain in effect for the Term of this Agreement.

50. As outlined in OAC rule 5160-26-05(D), MCP subcontractors and referral providers may not bill enrollees any amount greater than would be owed if the entity provided the services directly (i.e., no balance billing by providers).

51. The MCP must comply with Executive Order 2011-12K. A copy of Executive Order 2011-12K can be found at http://governor.ohio.gov/MediaRoom/ExecutiveOrders.aspx. This Executive Order prohibits the use of public funds to purchase services that will be provided outside of the United States except under certain circumstances. Such services include the use of offshore programming or call centers. Additionally, the MCP must not transfer PHI to any location outside the United States or its territories.

52. The MCP must hold and maintain, or must be actively seeking and working towards, accreditation by the National Committee for Quality Assurance (NCQA) for the Ohio Medicaid line of business.

    The MCP must achieve and/or maintain an Excellent, Commendable or Accredited status. If the MCP receives a Provisional or Denied status from NCQA, the MCP will be subject to sanctions as noted in Appendix N. Compliance will be assessed annually based on the MCP's accreditation status as of September 15th of each year.

    For the purposes of meeting this accreditation requirement, ODM will only accept the use of the NCQA Corporate Survey Process to the extent deemed allowable by NCQA.

    Upon completion of the accreditation survey, the MCP must submit to ODM a copy of the "Final Decision Letter" no later than 10 calendar days upon receipt from NCQA. Thereafter and on an annual basis between accreditation surveys, the MCP must submit a copy of the "Accreditation Summary Report" issued as a result of the Annual HEDIS Update no later than 10 calendar days upon receipt from NCQA. Upon ODM's request, the MCP must provide any and all documents related to achieving accreditation.

53. MCP Family Advisory Council

    The MCP must convene an MCP Family Advisory Council at least quarterly in each region that the MCP serves consisting of the MCP's current members. The purpose of the Council is to engage members in such a way as to elicit meaningful input related to the MCP's strengths and challenges with respect to serving members. The composition of the group must be diverse and representative of the MCP's current membership throughout the region with respect to the members' race, ethnic background, primary language, age, Medicaid eligibility category (Adult Extension, MAGI and ABD), and health status.

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

    - A list of attending members during the prior quarter for each regional Advisory Council;

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

- Improvement recommendations developed by each Council.

54. MCP must participate in the development, implementation, and operation of initiatives for early managed care enrollment and care coordination for inmates to be released from state prisons or state psychiatric hospitals and youths in Department of Youth Services custody.

55. If the MCP uses a Diagnosis Related Grouper (DRG) to pay for inpatient hospital claims, then the MCP must use the All-Patient Refined (APR) DRG that is the same version that ODM uses.

56. **Nursing Facility Services:**

For Medicaid covered nursing facility stays, the MCP must evaluate the member's need for the level of services provided by a nursing facility. To make this decision, the MCP must use the criteria for nursing facility-based level of care pursuant to OAC rules 5160-3-08 and 5160-1-01. The MCP must maintain a written record that the criteria were met, or if not met, the MCP must maintain documentation that a Notice of Action was issued in accordance with OAC 5160-26-08.4.

The MCP must ensure accurate claims payment to nursing facility (NF) providers by appropriately modifying payment when a member has patient liability obligations or lump sum amount(s) pursuant to 5160-3-39.1.The MCP is prohibited from paying for NF services during restricted Medicaid coverage periods (RMCP). The MCP must accept provider documentation of determinations made by County Department of Job and Family Services (CDJFS) for patient liability obligations, lump sum amounts, and RMCPs.

57. <u>Payment/Adjustment to Capitation in Consideration of the ACA Section 9010 Health Insurance Providers Fee</u>

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

Beginning in calendar year 2014, the ACA requires the MCP to pay the Annual Fee no later than September 30th (as applicable to each relevant year, the "Fee Year") with

respect to premiums paid to the MCP in the preceding calendar year (as applicable to each relevant year, the "Data Year"), and continuing similarly in each successive year.

In order to satisfy the requirement for actuarial soundness set forth in 42 CFR 438.6(c) with respect to amounts paid by ODM under this Agreement, the parties agree that ODM shall make a payment or an adjustment to capitation to the MCP for the full amount of the Annual Fee allocable to this Agreement, as follows:

Amount and method of payment: For each Fee Year, ODM shall make a payment or an adjustment to capitation to the MCP for that portion of the Annual Fee that is attributable to the premiums paid by ODM to the MCP (the "Ohio Medicaid-specific Premiums") for risks in the applicable Data Year under the Agreement, less any applicable exclusions and appropriate credit offsets. These payments or adjustments to be made by ODM will include the following:

- The amount of the Annual Fee attributable to this Agreement;
- The corporate income tax liability, if any, that the MCP incurs as a result of receiving ODM's payment for the amount of the Annual Fee attributable to this Agreement; and
- Any Ohio state and local Sales and Use taxes and Health Insuring Corporation taxes.

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

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

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

Payment by ODM is intended to put the MCP in the same position as the MCP would have been in had no Annual Fee been imposed upon the MCP.

This provision shall survive the termination of the Agreement.

58. Hepatitis C Risk Pool Arrangement

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

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

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

The MCP must participate in ODM sanctioned workgroups and processes to establish a state-level emergency response plan which will include a provision for Medicaid consumers, and will comply with the resulting procedures.

During the time of an emergency or a natural, technological, or man-made disaster, the MCP must be able to generate a current list of members for whom an individual disaster plan, according to the specifications below, has been developed, including the risk and the individual-level plan, and distribute to local and state emergency management authorities according to the protocol established by ODM.

Individual Disaster/Emergency Response Plan
The MCP must identify members who are at risk for harm, loss, or injury during any potential natural, technological, or manmade disaster. The MCP must ensure that every member who is technology and/or service dependent, with no known reasonable means to access services, is known and documented as part of the plan's Comprehensive Disaster/Emergency Response Plan. For these members, the MCP must develop an individual-level plan with the member if appropriate. The member-level plan must: 1) include a provision for the continuation of critical services appropriate for the member's needs in the event of a disaster including, but not

limited to access to medication/prescriptions; 2) identify how and when the plan will be activated; 3) be documented in the member record maintained by the MCP; and 4) be provided to the member.

The MCP must ensure that staff, including care managers, are prepared to respond to and implement the plans in the event of an emergency or disaster.

APPENDIX D

ODM RESPONSIBILITIES

The following are the Ohio Department of Medicaid (ODM) responsibilities or clarifications that are not otherwise specifically stated in OAC Chapter 5160-26 or elsewhere in the ODM-MCP Provider Agreement.

General Provisions

1. ODM 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 and the provider agreement.

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

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

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

5. ODM will provide MCP's linkages to organization that can provide guidance on the development of effective strategies to eliminate health disparities.

6. ODM will conduct an annual analysis of Medicaid eligible individuals to identify whether there are any prevalent common primary languages, other than English, in the MCP service areas. ODM will notify the MCP of any languages that are identified as prevalent for the purpose of translating marketing and member materials (See Appendix C.22).

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

8. ODM will identify contact staff, including the Contract Administrator (CA), selected for each MCP.

9. ODM will provide MCPs with an electronic Provider Master File containing all the Ohio Medicaid fee-for-service (FFS) providers, which includes their Medicaid Provider Number, as well as all providers who have been assigned a provider reporting number for current encounter data purposes. This file also includes NPI information when available.

10. Service Area Designation

ODM will implement a mandatory managed care program in service areas wherever choice and capacity allow and the criteria in 42 CFR 438.50(a) are met.

11. Consumer Information

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

b. ODM will notify members or ask 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, ODM will provide coverage and reimbursement for these services for the MCP's members.

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

12. Membership Selection and Premium Payment

a. The Medicaid Consumer Hotline (henceforth referred to as the "Hotline") - The ODM-contracted Hotline is responsible for providing unbiased education and selection services for the Medicaid managed care program. The Hotline operates a statewide toll-free telephone center to assist eligible individuals in selecting an MCP or choosing a health care delivery option.

b. Auto-Assignment Eligible individuals that fail to select a plan will be assigned to an MCP in accordance with 42 CFR 438.50 and at the discretion of ODM.

c. Consumer Contact Record (CCR): ODM or their designated entity shall provide 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 Hotline initiated MCP assignment processed through the Hotline.

d. ODM verifies MCP enrollment via a membership roster. ODM or its designated entity provides a full member roster (F) and a change roster (C) via HIPAA 834 compliant transactions.

e. Monthly Premiums - ODM will remit payment to the MCPs via an electronic funds

transfer (EFT), or at the discretion of ODM, by paper warrant.

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

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

14. ODM 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.

15. Communications - The Bureau of Managed Care (BMC) is responsible for the oversight of the MCPs' provider agreements with ODM. 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 Managed Care Contract Administration Section.

APPENDIX E

Rate Methodology

Calendar Year 2016 Medicaid Managed Care Provider Agreement Rate Summary

January 1, 2016 through December 31, 2016

Ohio Department of Medicaid

Prepared for:
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Deputy Director Rate Setting
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December 11, 2015

July 2016 Medicaid Managed Care Provider Agreement Rate Amendment Summary

July 1, 2016 through December 31, 2016

Ohio Department of Medicaid

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Appendix 1: July 2016 Rate Change Summaries

I. INTRODUCTION

This document is an abridged version of the file titled "July 2016 Medicaid Managed Care Capitation Rate Amendment" dated June 3, 2016. Please refer to the July amendment to the certified calendar year 2016 capitation rates for a complete version of the July Medicaid Managed Care capitation rate amendment documentation.

Background

Milliman, Inc. (Milliman) has been retained by the Ohio Department of Medicaid (ODM) to provide actuarial and consulting services related to the development of capitation rates for its Medicaid Managed Care (MMC) program. This report provides a summary of the methodology used in the development of an amendment to the certified calendar year (CY) 2016 capitation rates for effective dates beginning July 1, 2016.

This report is an amendment to the documentation of the capitation rate developed for CY 2016. The previously certified capitation rates and the documentation of the development were published in the following correspondence provided by Milliman:

- *CY 2016 Medicaid Managed Care Certification* dated December 8, 2015 (Original)

We have updated the capitation rates provided in the Original certification to reflect Ohio's conversion from the status of a 209(b) to a 1634 state, Nursing Facility policy changes, and an increase to enhanced maternal program amounts. **Unless otherwise stated, the methodology and assumptions utilized is consistent with the capitation certification documentation included in the Original report.** The amendment to the CY 2016 certified capitation rates for the Medicaid managed care program are effective from July 1, 2016 through December 31, 2016.

General Information

The capitation rates provided with this certification are "actuarially sound" for purposes of 42 CFR 438.6(c), according to the following criteria:

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

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

- Actuarial standards of practice applicable to Medicaid managed care rate setting which have been enacted as of the capitation rate certification date, including: ASOP 1 (Introductory Actuarial Standard of Practice); ASOP 5 (Incurred Health and Disability Claims); ASOP 23 (Data Quality); ASOP 25 (Credibility Procedures); ASOP 41 (Actuarial Communications); ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies); and ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification).
- Federal regulation 42 CFR §438.6(c).
- *2016 Medicaid Managed Care Rate Development Guide* published by CMS on September 23, 2015.
- Throughout this document, the term "actuarially sound" will be defined in ASOP 49:

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

II. EXECUTIVE SUMMARY

Summary of Methodology

The methodology used in developing the July 1, 2016 amendment to the certified CY 2016 capitation rates is outlined below.

Step 1: Base Experience

We used the projected claims data underlying the calendar year CY 2016 MMC capitation rates, as outlined in the Original certification, as base experience for developing the July 1, 2016 capitation rates. These projected claims costs are inclusive of all retrospective, prospective, trend, managed care efficiency, and other claims cost adjustments made to the data as outlined in the Original certification.

Step 2: Adjustments for prospective program and policy changes

The base experience is adjusted for known policy and program changes that are expected to be implemented in July through December 2016. This includes Ohio's conversion from the status of a 209(b) to a 1634 state and a Nursing Facility policy change for the CFC and ABD populations. Documentation of items requiring the calculation of adjustment factors is provided in this report. Adjustments were applied to the base experience data to reflect program changes not included in the Original certification. The resulting values establish the adjusted claim cost by population rate cell for the contract period.

Step 3: Incorporate non-claims items and adjustments

The adjusted claim cost is modified to include the impact of certain non-benefit items, such as an administrative allowance. The July 2016 capitation rate amendment includes an annualized amount of $26.8 million across four female CFC rate cells, before fees and taxes, for the enhanced maternal program. ODM has indicated managed care plans (MCPs) will receive an additional $6.7 million in funding for the enhanced maternal program during the July through December 2016 rate period. For the CY 2016 time period after the July 1st rate amendment, the MMC rates will include $20.1 million for the enhanced maternal program. This amount represents an increase from the $13.4 million annual amount included in the Original certification.

Additionally, administrative expense allowance for the ABD <21 and ABD 21+ populations reflects an increase of 0.12% from the Original certification. This increase is intended to provide MCPs with the same aggregate administrative expense allowance as the Original certification after reflecting 1634 conversion population movement. No other changes were made to non-claims assumptions from the values included in the Original certification.

Step 4: Development and issuance of actuarial certification

An actuarial certification is included and signed by Jeremy D. Palmer, FSA, a Principal and Consulting Actuary in the Indianapolis office of Milliman, Inc. Mr. Palmer meets the qualification standards established by the American Academy of Actuaries and follows the practice standards established by the Actuarial Standards Board, in order to certify that the final rates meet the standards in 42 CFR §438.6(c).

Appendix 1 of this report contains a summary of July 2016 capitation rate changes.

III. PROSPECTIVE DATA ADJUSTMENTS

Program Adjustments – July 2016

Adjustment factors for the July 1, 2016 rate amendment were developed for the following policy and program changes, known as of the date of this report, that affect the MMC program during July through December 2016.

209(b) to 1634 Conversion

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

Additionally, on July 31, 2016, ODM will eliminate the existing Medicaid spend down program. A 1915(i) state plan option will create a special benefit program for adults with serious and persistent mental illness (SPMI) with income up to 225% of the federal poverty level.

To ensure that impacted members have sufficient time to transition to other coverage sources, ODM has requested a waiver of ABD redeterminations. This pause in redetermination will result in existing ABD members not being subject to the 1634 eligibility criteria until after eligibility redetermination resumes on January 1, 2017. This rate amendment assumes that the Centers for Medicare and Medicaid Services (CMS) will approve this waiver.

We estimated the morbidity impact associated with the 209(b) to 1634 conversion for the July through December 2016 time period considering the timing of population movements. Based on discussions with ODM, it is our understanding the following population movements are expected to occur during the July through December 2016 time period:

- Individuals with SSI currently enrolled in the CFC and Extension populations will be transitioned to the ABD population on their next redetermination on or after August 1, 2016.
- Individuals currently receiving SSI that are newly enrolled in Medicaid due to the 1634 conversion will be enrolled on a fee-for-service (FFS) basis until their next redetermination.
- New 1915(i) eligible recipients will be enrolled in MMC on or after January 1, 2017.
- Those enrolled in the Medicaid spend down program that remain eligible for Medicaid under 1634 will be transitioned to MMC on January 1, 2018.

Nursing Facility Policy Change

For the ABD and CFC populations, nursing facility stays are currently required to be covered by MCPs for the month of admission and the next consecutive month. After this point in time, a member is transitioned out of the MMC program and receives Medicaid services on a fee-for-service basis. Effective July 1, 2016, nursing facility stays in the ABD and CFC populations will be required to cover the month of admission and two consecutive months.

We estimated the increase in nursing facility utilization associated with this policy change. We developed this estimate by adding up to one month of nursing facility utilization for every CFC and ABD nursing facility stay with a duration of three or more months in the historical data, where the third month of the stay was covered under fee-for-service after the recipient exited managed care. For the Extension population, MCPs will continue to cover nursing facility stays as long as medically necessary and therefore no rate adjustment was required.

IV. NON-BENEFIT EXPENSES

Administrative Expense Cost Allowance

The administrative expense allowance for the ABD <21 and ABD 21+ populations reflect an increase of 0.12% from the Original certification. This increase is intended to provide MCPs with the same aggregate administrative expense allowance as the Original certification, after reflecting population movement from Ohio's conversion from the status of a 209(b) to a 1634 state. No other changes were made to non-claims assumptions from the values included in the Original certification.

State Taxes and Fees

The development of the actuarially sound capitation rates for July 2016 includes a Sales and Use tax and Health Insuring Corporation (HIC) tax component. These taxes will be consistent with the values included in the Original certification.

Health Insurer Provider Fee (HIPF)

The Consolidated Appropriations Act of 2016, signed on December 18, 2015, includes a moratorium of the ACA Health Insurer Provider Fee (HIPF) for 2017. As a result, 2016 MMC certified capitation rates are no longer expected to be adjusted for the HIPF.

V. OTHER ITEMS

Enhanced Maternal Program

ODM implemented an enhanced maternal program to target geographic areas with high infant mortality rates. Funding to support MCP initiatives for the program is included in the applicable regions and female rate cells.

Based on guidance provided by ODM, the July 2016 capitation rate amendment reflects $13.4 million being allocated to MCPs during the six month period for four female CFC rate cells, before fees and taxes, for the enhanced maternal program. The rate cells assumed to be included in the program are HF/HST 14-18 F, HF 19-44 F, HF 45+ M+F, and HST 19-64 F. The regions assumed to be included in the program are North Central, Southwest, South Central, Northeast, and Northeast Central. The total amount of available funding for the enhanced maternal program was allocated based on the assumed percent of targeted membership in each region and rate cell.

The Original certification includes an annualized amount of $13.4 million for the enhanced maternal program, of which a total of $6.7 million is estimated to be paid during the January through June 2016 time period. Based on July 2016 capitation rate amendment payments of $13.4 million, we estimate total payments of approximately $20.1 million for the enhanced maternal program during CY 2016.

Hepatitis C Risk Pool

Because of uncertainty associated with Hepatitis C pharmaceutical expenditures, the July 2016 rate structure will maintain a high risk pool for expenditures related to Hepatitis C prescription drugs. The development of risk pool payments by MCP used a process consistent with the methodology outlined in the Original certification. Further, the underlying data, list of drugs, methodology, and aggregate risk pool expenditures is consistent with the Original certification.

Due to the 209(b) to 1634 Conversion, we have amended the statewide Hepatitis C risk pools to reflect the projected impact of population movement on estimated 2016 Hepatitis C expenditures by rate cell during CY 2016. It should be noted this had no impact on total estimated expenditures, only the distribution of expenditures by rate cell. The expected timeline for implementation of the CY 2016 hepatitis C drug risk pool is consistent with the Original certification.

VI. RISK ADJUSTMENT

Aged, Blind, and Disabled

Risk adjustment will be applied to the ABD population using CDPS + Rx. Risk adjustment is performed on a budget neutral basis at the region level, separately between disabled children (under age 21) and adults (age 21+). The risk adjustment methodology is consistent with the January 1, 2016 through June 30, 2016 rate period. The July 1, 2016 through December 31, 2016 rate period will be risk adjusted based on a diagnosis and prescription drug collection period based on incurred (dispensed) dates from July 1, 2014 through June 30, 2015. Consistent with the January 1, 2016 through June 30, 2016 rate period, the risk adjustment diagnosis base will exclude diagnosis codes associated with diagnostic testing and certain medical supply codes.

Extension

Risk adjustment will be applied to the Extension population using CDPS + Rx. Risk adjustment is performed on a budget neutral basis at the region and rate cell level. The risk adjustment methodology will vary from the January 1, 2016 through June 30, 2016 rate period due to the usage of CDPS + Rx rather than Medicaid Rx. We believe that moving the diagnosis collection period forward six months will allow for a sufficient number of Extension beneficiaries to meet the requirements for being a 'scored' member (three months of Medicaid eligibility during the collection period). No other changes will be made to the risk adjustment methodology. The July 1, 2016 through December 31, 2016 rate period will be risk adjusted based on a diagnosis and prescription drug collection period based on incurred (dispensed) dates from July 1, 2014 through June 30, 2015. Consistent with the ABD risk adjustment methodology, the risk adjustment diagnosis base will exclude diagnosis codes associated with diagnostic testing and certain medical supply codes.

CFC

Historically, the CFC population has not been risk adjusted using a diagnosis or pharmaceutical-based methodology. The calendar year 2016 capitation rates for CFC will not be risk-adjusted beyond rate cell, Hepatitis C risk pool, and the maternity delivery kick payment.

VII. LIMITATIONS AND DATA RELIANCE

The information contained in this report has been prepared for the Ohio Department of Medicaid (ODM) to provide documentation of the development of the July 1, 2016 amendment to the certified calendar year (CY) 2016 capitation rates for the Medicaid Managed Care Program (MMC). The data and information presented may not be appropriate for any other purpose.

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

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

Milliman has relied upon certain data and information provided by ODM and the participating Medicaid MCPs in the development of the July 1, 2016 amendment to the certified CY 2016 capitation rates. Milliman has relied upon ODM and the MCPs for the accuracy of the data and accept it without audit. To the extent that the data provided is not accurate, the capitation rate development would need to be modified to reflect revised information.

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

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

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses contained herein.

APPENDIX 1

Ohio Department of Medicaid
July 1, 2016 Medicaid Managed Care Capitation Rate Update
Rate Change Summary - Premium

Region: North Central

Rate Cell	CY 2016 Average Monthly Enrollment/Deliveries	July 2016 Average Monthly Enrollment/Deliveries	CY 2016 Capitation Rate	July 2016 - December 2016 Capitation Rate	Total Change
CFC					
HF/HST <1 M+F	4,706	4,706	$ 585.91	$ 584.57	(0.23%)
HF/HST 1 M+F	4,852	4,845	147.00	138.61	(5.71%)
HF/HST 2-13 M+F	47,789	47,600	116.15	113.81	(2.02%)
HF/HST 14-18 M	7,419	7,382	166.95	163.98	(1.78%)
HF/HST 14-18 F	7,558	7,533	217.95	219.79	0.84%
HF 19-44 M	7,434	7,415	292.22	290.65	(0.54%)
HF 19-44 F	22,300	22,245	382.96	384.17	0.32%
HF 45+ M+F	3,519	3,488	721.29	716.19	(0.71%)
HST 19-64 F	2,127	2,125	398.99	401.30	0.58%
Subtotal - CFC	**107,706**	**107,341**	**$ 241.47**	**$ 239.97**	**(0.62%)**
Extension					
EXT 19-34 M	9,411	9,353	$ 317.04	$ 312.46	(1.45%)
EXT 19-34 F	8,476	8,438	363.59	356.64	(1.91%)
EXT 35-44 M	4,382	4,343	526.07	521.69	(0.83%)
EXT 35-44 F	3,539	3,510	613.99	605.74	(1.34%)
EXT 45-54 M	4,472	4,390	740.07	722.84	(2.33%)
EXT 45-54 F	4,752	4,684	825.04	812.64	(1.50%)
EXT 55-64 M	3,317	3,247	921.54	912.70	(0.96%)
EXT 55-64 F	3,802	3,735	813.90	800.65	(1.63%)
Subtotal - Extension	**42,151**	**41,701**	**$ 567.59**	**$ 557.72**	**(1.74%)**
ABD					
ABD <21	2,511	2,784	$ 519.12	$ 556.86	7.27%
ABD 21 +	7,591	8,132	1,587.89	1,582.67	(0.33%)
Subtotal - ABD	**10,101**	**10,916**	**$ 1,322.26**	**$ 1,321.02**	**(0.09%)**
CFC & EXT Delivery	**304**	**304**	**$ 6,406.05**	**$ 6,406.05**	**0.00%**
Total	**159,958**	**159,958**	**$ 407.81**	**$ 408.74**	**0.23%**

Ohio Department of Medicaid
July 1, 2016 Medicaid Managed Care Capitation Rate Update
Rate Change Summary - Premium

Region: Northwest

Rate Cell	CY 2016 Average Monthly Enrollment/Deliveries	July 2016 Average Monthly Enrollment/Deliveries	CY 2016 Capitation Rate	July 2016 - December 2016 Capitation Rate	Total Change
CFC					
HF/HST <1 M+F	3,350	3,350	$ 582.28	$ 580.94	(0.23%)
HF/HST 1 M+F	3,282	3,280	148.11	139.94	(5.51%)
HF/HST 2-13 M+F	33,281	33,186	117.78	115.35	(2.07%)
HF/HST 14-18 M	5,383	5,350	161.31	158.53	(1.73%)
HF/HST 14-18 F	5,362	5,345	188.65	186.73	(1.02%)
HF 19-44 M	4,750	4,738	256.99	256.25	(0.29%)
HF 19-44 F	13,470	13,434	365.37	362.27	(0.85%)
HF 45+ M+F	1,995	1,981	684.10	675.24	(1.29%)
HST 19-64 F	1,713	1,711	334.73	333.30	(0.43%)
Subtotal - CFC	**72,587**	**72,375**	**$ 224.80**	**$ 222.01**	**(1.24%)**
Extension					
EXT 19-34 M	4,529	4,510	$ 290.01	$ 287.05	(1.02%)
EXT 19-34 F	4,756	4,739	347.79	346.14	(0.47%)
EXT 35-44 M	2,208	2,200	543.91	533.59	(1.90%)
EXT 35-44 F	2,227	2,212	676.49	671.65	(0.72%)
EXT 45-54 M	2,302	2,285	837.91	834.52	(0.40%)
EXT 45-54 F	2,801	2,782	799.12	786.77	(1.55%)
EXT 55-64 M	1,895	1,880	862.61	861.73	(0.10%)
EXT 55-64 F	2,188	2,170	878.24	843.66	(3.94%)
Subtotal - Extension	**22,904**	**22,778**	**$ 584.94**	**$ 576.92**	**(1.37%)**
ABD					
ABD <21	526	685	$ 518.96	$ 555.37	7.02%
ABD 21 +	2,927	3,107	1,411.81	1,430.40	1.32%
Subtotal - ABD	**3,453**	**3,792**	**$ 1,275.86**	**$ 1,272.34**	**(0.28%)**
CFC & EXT Delivery	**209**	**209**	**$ 5,666.79**	**$ 5,666.79**	**(0.00%)**
Total	**98,945**	**98,945**	**$ 356.83**	**$ 355.95**	**(0.25%)**

Ohio Department of Medicaid
July 1, 2016 Medicaid Managed Care Capitation Rate Update
Rate Change Summary - Premium

Region: Southwest

Rate Cell	CY 2016 Average Monthly Enrollment/Deliveries	July 2016 Average Monthly Enrollment/Deliveries	CY 2016 Capitation Rate	July 2016 - December 2016 Capitation Rate	Total Change
CFC					
HF/HST <1 M+F	17,085	17,085	$ 851.30	$ 850.66	(0.08%)
HF/HST 1 M+F	17,283	17,262	184.05	173.43	(5.77%)
HF/HST 2-13 M+F	182,585	181,991	142.04	138.86	(2.24%)
HF/HST 14-18 M	28,339	28,192	210.22	206.37	(1.83%)
HF/HST 14-18 F	29,181	29,088	235.85	234.67	(0.50%)
HF 19-44 M	25,968	25,900	267.83	265.20	(0.98%)
HF 19-44 F	80,251	80,071	363.93	362.90	(0.28%)
HF 45+ M+F	13,279	13,197	653.26	646.41	(1.05%)
HST 19-64 F	8,341	8,332	358.09	358.41	0.09%
Subtotal - CFC	**402,313**	**401,118**	**$ 259.31**	**$ 256.50**	**(1.08%)**
Extension					
EXT 19-34 M	33,129	32,993	$ 313.38	$ 308.95	(1.41%)
EXT 19-34 F	28,527	28,429	367.33	362.40	(1.34%)
EXT 35-44 M	16,512	16,428	505.59	500.26	(1.05%)
EXT 35-44 F	13,087	13,001	573.36	565.23	(1.42%)
EXT 45-54 M	17,023	16,862	746.30	738.25	(1.08%)
EXT 45-54 F	17,687	17,515	761.36	753.47	(1.04%)
EXT 55-64 M	12,213	12,008	831.05	819.30	(1.41%)
EXT 55-64 F	14,338	14,154	777.16	769.32	(1.01%)
Subtotal - Extension	**152,516**	**151,390**	**$ 551.91**	**$ 544.52**	**(1.34%)**
ABD					
ABD <21	6,453	7,377	$ 892.80	$ 960.76	7.61%
ABD 21 +	22,721	24,119	1,455.42	1,453.10	(0.16%)
Subtotal - ABD	**29,175**	**31,496**	**$ 1,330.97**	**$ 1,337.78**	**0.51%**
CFC & EXT Delivery	**1,066**	**1,066**	**$ 6,012.13**	**$ 6,012.13**	**(0.00%)**
Total	**584,004**	**584,004**	**$ 400.23**	**$ 400.46**	**0.06%**

Ohio Department of Medicaid
July 1, 2016 Medicaid Managed Care Capitation Rate Update
Rate Change Summary - Premium

Region: South Central

Rate Cell	CY 2016 Average Monthly Enrollment/Deliveries	July 2016 Average Monthly Enrollment/Deliveries	CY 2016 Capitation Rate	July 2016 - December 2016 Capitation Rate	Total Change
CFC					
HF/HST <1 M+F	15,277	15,277	$ 904.99	$ 904.97	(0.00%)
HF/HST 1 M+F	15,582	15,567	181.44	170.55	(6.00%)
HF/HST 2-13 M+F	155,070	154,565	129.57	127.01	(1.98%)
HF/HST 14-18 M	24,158	24,038	159.89	157.15	(1.72%)
HF/HST 14-18 F	24,411	24,332	211.02	212.82	0.85%
HF 19-44 M	25,329	25,237	292.13	289.17	(1.01%)
HF 19-44 F	67,032	66,822	394.54	395.02	0.12%
HF 45+ M+F	12,199	12,064	667.64	658.67	(1.34%)
HST 19-64 F	7,101	7,088	399.97	402.86	0.72%
Subtotal - CFC	**346,159**	**344,989**	**$ 261.70**	**$ 259.61**	**(0.80%)**
Extension					
EXT 19-34 M	26,592	26,458	$ 334.60	$ 329.20	(1.61%)
EXT 19-34 F	23,655	23,562	361.33	354.28	(1.95%)
EXT 35-44 M	12,793	12,678	546.03	538.07	(1.46%)
EXT 35-44 F	10,669	10,579	616.05	605.54	(1.71%)
EXT 45-54 M	12,506	12,328	794.03	775.04	(2.39%)
EXT 45-54 F	13,314	13,110	726.03	712.35	(1.88%)
EXT 55-64 M	8,719	8,528	768.78	757.36	(1.48%)
EXT 55-64 F	10,633	10,434	791.46	776.91	(1.84%)
Subtotal - Extension	**118,881**	**117,676**	**$ 552.81**	**$ 541.68**	**(2.01%)**
ABD					
ABD <21	5,164	5,948	$ 836.02	$ 890.52	6.52%
ABD 21 +	23,148	24,739	1,432.56	1,442.24	0.68%
Subtotal - ABD	**28,313**	**30,688**	**$ 1,323.75**	**$ 1,335.30**	**0.87%**
CFC & EXT Delivery	**887**	**887**	**$ 5,428.51**	**$ 5,428.51**	**0.00%**
Total	**493,353**	**493,353**	**$ 402.56**	**$ 403.56**	**0.25%**

Ohio Department of Medicaid
July 1, 2016 Medicaid Managed Care Capitation Rate Update
Rate Change Summary - Premium

Region: Southeast

Rate Cell	CY 2016 Average Monthly Enrollment/Deliveries	July 2016 Average Monthly Enrollment/Deliveries	CY 2016 Capitation Rate	July 2016 - December 2016 Capitation Rate	Total Change
CFC					
HF/HST <1 M+F	5,154	5,154	$ 868.00	$ 868.04	0.00%
HF/HST 1 M+F	4,886	4,881	167.27	157.35	(5.93%)
HF/HST 2-13 M+F	52,997	52,850	141.70	138.83	(2.02%)
HF/HST 14-18 M	9,413	9,371	185.69	182.35	(1.80%)
HF/HST 14-18 F	9,336	9,312	215.88	213.66	(1.03%)
HF 19-44 M	10,495	10,469	253.45	251.62	(0.72%)
HF 19-44 F	24,143	24,078	372.72	369.63	(0.83%)
HF 45+ M+F	4,234	4,205	610.19	606.80	(0.56%)
HST 19-64 F	2,607	2,605	368.91	368.23	(0.18%)
Subtotal - CFC	**123,265**	**122,924**	**$ 257.72**	**$ 254.81**	**(1.13%)**
Extension					
EXT 19-34 M	10,825	10,788	$ 233.97	$ 232.27	(0.73%)
EXT 19-34 F	9,391	9,369	347.84	346.71	(0.33%)
EXT 35-44 M	4,890	4,869	466.32	462.13	(0.90%)
EXT 35-44 F	4,654	4,621	582.39	576.43	(1.02%)
EXT 45-54 M	5,204	5,149	654.70	648.19	(0.99%)
EXT 45-54 F	6,017	5,960	669.49	662.54	(1.04%)
EXT 55-64 M	3,815	3,771	797.37	788.16	(1.16%)
EXT 55-64 F	4,791	4,745	752.04	748.86	(0.42%)
Subtotal - Extension	**49,586**	**49,272**	**$ 501.55**	**$ 496.83**	**(0.94%)**
ABD					
ABD <21	1,390	1,623	$ 708.15	$ 759.97	7.32%
ABD 21 +	8,632	9,055	1,306.30	1,302.64	(0.28%)
Subtotal - ABD	**10,022**	**10,678**	**$ 1,223.32**	**$ 1,220.17**	**(0.26%)**
CFC & EXT Delivery	**325**	**325**	**$ 4,806.59**	**$ 4,806.59**	**0.00%**
Total	**182,874**	**182,874**	**$ 385.28**	**$ 384.91**	**(0.10%)**

Ohio Department of Medicaid
July 1, 2016 Medicaid Managed Care Capitation Rate Update
Rate Change Summary - Premium

Region: Northeast

Rate Cell	CY 2016 Average Monthly Enrollment/Deliveries	July 2016 Average Monthly Enrollment/Deliveries	CY 2016 Capitation Rate	July 2016 - December 2016 Capitation Rate	Total Change
CFC					
HF/HST <1 M+F	18,046	18,046	$ 946.10	$ 946.28	0.02%
HF/HST 1 M+F	19,496	19,463	192.72	181.39	(5.88%)
HF/HST 2-13 M+F	205,245	204,331	130.69	127.91	(2.12%)
HF/HST 14-18 M	35,916	35,661	171.62	168.73	(1.69%)
HF/HST 14-18 F	36,369	36,222	204.81	204.56	(0.13%)
HF 19-44 M	31,710	31,607	261.77	257.44	(1.65%)
HF 19-44 F	99,378	99,043	357.47	355.80	(0.47%)
HF 45+ M+F	18,593	18,439	619.51	608.57	(1.77%)
HST 19-64 F	7,767	7,751	395.36	395.94	0.15%
Subtotal - CFC	**472,521**	**470,565**	**$ 253.28**	**$ 250.42**	**(1.13%)**
Extension					
EXT 19-34 M	45,330	45,120	$ 287.12	$ 282.23	(1.70%)
EXT 19-34 F	40,117	39,990	320.18	317.88	(0.72%)
EXT 35-44 M	21,546	21,401	435.73	429.72	(1.38%)
EXT 35-44 F	17,327	17,233	518.25	513.01	(1.01%)
EXT 45-54 M	23,563	23,312	644.99	633.01	(1.86%)
EXT 45-54 F	24,511	24,225	683.85	673.53	(1.51%)
EXT 55-64 M	18,876	18,552	784.41	774.72	(1.24%)
EXT 55-64 F	22,266	21,926	668.90	660.44	(1.26%)
Subtotal - Extension	**213,537**	**211,759**	**$ 495.88**	**$ 488.34**	**(1.52%)**
ABD					
ABD <21	10,698	12,142	$ 675.51	$ 726.01	7.48%
ABD 21 +	35,887	38,176	1,489.12	1,488.95	(0.01%)
Subtotal - ABD	**46,584**	**50,318**	**$ 1,302.28**	**$ 1,304.84**	**0.20%**
CFC & EXT Delivery	**1,283**	**1,283**	**$ 5,759.83**	**$ 5,759.83**	**(0.00%)**
Total	**732,642**	**732,642**	**$ 400.78**	**$ 401.69**	**0.23%**

Ohio Department of Medicaid
July 1, 2016 Medicaid Managed Care Capitation Rate Update
Rate Change Summary - Premium

Region: Northeast Central

Rate Cell	CY 2016 Average Monthly Enrollment/Deliveries	July 2016 Average Monthly Enrollment/Deliveries	CY 2016 Capitation Rate	July 2016 - December 2016 Capitation Rate	Total Change
CFC					
HF/HST <1 M+F	5,081	5,081	$ 654.66	$ 654.51	(0.02%)
HF/HST 1 M+F	5,061	5,058	177.88	168.51	(5.27%)
HF/HST 2-13 M+F	51,192	51,052	125.13	122.77	(1.88%)
HF/HST 14-18 M	8,625	8,586	165.40	162.60	(1.69%)
HF/HST 14-18 F	8,624	8,601	202.22	203.83	0.79%
HF 19-44 M	8,311	8,295	226.77	225.56	(0.53%)
HF 19-44 F	22,669	22,627	344.04	344.34	0.09%
HF 45+ M+F	3,892	3,874	546.04	542.75	(0.60%)
HST 19-64 F	2,549	2,547	362.29	363.78	0.41%
Subtotal - CFC	**116,003**	**115,720**	**$ 228.74**	**$ 227.15**	**(0.70%)**
Extension					
EXT 19-34 M	8,355	8,325	$ 249.59	$ 247.29	(0.92%)
EXT 19-34 F	8,107	8,088	371.60	368.30	(0.89%)
EXT 35-44 M	4,152	4,133	420.87	418.07	(0.67%)
EXT 35-44 F	3,934	3,917	580.23	576.54	(0.64%)
EXT 45-54 M	4,333	4,315	709.46	703.88	(0.79%)
EXT 45-54 F	5,069	5,035	625.36	620.16	(0.83%)
EXT 55-64 M	3,373	3,344	757.92	748.47	(1.25%)
EXT 55-64 F	4,383	4,348	723.43	715.12	(1.15%)
Subtotal - Extension	**41,705**	**41,505**	**$ 505.90**	**$ 501.04**	**(0.96%)**
ABD					
ABD <21	1,602	1,819	$ 666.17	$ 713.44	7.10%
ABD 21 +	6,219	6,484	1,288.62	1,294.02	0.42%
Subtotal - ABD	**7,821**	**8,304**	**$ 1,161.13**	**$ 1,166.80**	**0.49%**
CFC & EXT Delivery	**314**	**314**	**$ 4,988.51**	**$ 4,988.51**	**(0.00%)**
Total	**165,529**	**165,529**	**$ 352.08**	**$ 352.42**	**0.10%**

Ohio Department of Medicaid
July 1, 2016 Medicaid Managed Care Capitation Rate Update
Rate Change Summary - Premium

Region: Statewide

Rate Cell	CY 2016 Average Monthly Enrollment/Deliveries	July 2016 Average Monthly Enrollment/Deliveries	CY 2016 Capitation Rate	July 2016 - December 2016 Capitation Rate	Total Change
CFC					
HF/HST <1 M+F	68,700	68,700	$ 843.55	$ 843.27	(0.03%)
HF/HST 1 M+F	70,443	70,357	180.04	169.57	(5.82%)
HF/HST 2-13 M+F	728,159	725,576	132.16	129.40	(2.09%)
HF/HST 14-18 M	119,253	118,579	178.32	175.21	(1.75%)
HF/HST 14-18 F	120,841	120,433	214.34	214.31	(0.01%)
HF 19-44 M	113,997	113,662	268.37	265.51	(1.06%)
HF 19-44 F	329,244	328,320	368.84	367.93	(0.25%)
HF 45+ M+F	57,712	57,247	640.25	632.13	(1.27%)
HST 19-64 F	32,206	32,157	378.98	379.97	0.26%
Subtotal - CFC	**1,640,555**	**1,635,032**	**$ 253.10**	**$ 250.59**	**(0.99%)**
Extension					
EXT 19-34 M	138,170	137,547	$ 298.25	$ 293.86	(1.47%)
EXT 19-34 F	123,029	122,615	348.58	344.48	(1.18%)
EXT 35-44 M	66,483	66,052	485.18	479.23	(1.23%)
EXT 35-44 F	55,436	55,073	572.33	565.23	(1.24%)
EXT 45-54 M	69,402	68,642	713.97	702.42	(1.62%)
EXT 45-54 F	74,151	73,310	718.15	708.20	(1.39%)
EXT 55-64 M	52,208	51,330	803.50	793.46	(1.25%)
EXT 55-64 F	62,401	61,513	741.05	730.91	(1.37%)
Subtotal - Extension	**641,281**	**636,082**	**$ 528.74**	**$ 520.79**	**(1.50%)**
ABD					
ABD <21	28,344	32,380	$ 738.55	$ 792.56	7.31%
ABD 21 +	107,126	113,812	1,448.26	1,450.37	0.15%
Subtotal - ABD	**135,469**	**146,192**	**$ 1,299.77**	**$ 1,304.67**	**0.38%**
CFC & EXT Delivery	**4,388**	**4,388**	**$ 5,668.77**	**$ 5,668.77**	**0.00%**
Total	**2,417,305**	**2,417,305**	**$ 395.17**	**$ 395.73**	**0.14%**

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APPENDIX 1: 2016 RATE CHANGE SUMMARIES

INTRODUCTION

This document is an abridged version of the file titled "CY 2016 Medicaid Managed Care Certification" dated December 8, 2015. Please refer to the certification report for a complete version of the calendar year 2016 Medicaid Managed Care capitation rate development documentation.

BACKGROUND

Milliman, Inc. (Milliman) has been retained by the Ohio Department of Medicaid (ODM) to provide actuarial and consulting services related to the development of capitation rates for its Medicaid Managed Care Program (MMC) effective January 1, 2016.

This letter provides documentation for the development of the actuarially sound capitation rates.

The certified capitation rates for the Medicaid managed care program are effective from January 1, 2016 through December 31, 2016.

SECTION I. MEDICAID MANAGED CARE RATES

1. GENERAL INFORMATION

The capitation rates provided with this certification are "actuarially sound" for purposes of 42 CFR 438.6(c), according to the following criteria:

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

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

- Actuarial standards of practice applicable to Medicaid managed care rate setting which have been enacted as of the capitation rate certification date, including: ASOP 1 (Introductory Actuarial Standard of Practice); ASOP 5 (Incurred Health and Disability Claims); ASOP 23 (Data Quality); ASOP 25 (Credibility Procedures); ASOP 41 (Actuarial Communications); ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies); and ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification).
- Federal regulation 42 CFR §438.6(c).
- *2016 Medicaid Managed Care Rate Development Guide* published by CMS on September 23, 2015.
- Throughout this document, the term "actuarially sound" will be defined in ASOP 49:

"Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income.

For purposes of this definition, costs include, but are not limited to, expected health benefits; health benefit settlement expenses; administrative expenses; the cost of capital, and government-mandated assessments, fees, and taxes."

A. ANNUAL BASIS

The actuarial certification contained in this report is effective for the capitation rates for the one year rate period from January 1, 2016 through December 31, 2016.

B. DOCUMENTATION

This report contains appropriate documentation of all elements described in the rate certification, including data used, assumptions made, and methods for analyzing data and developing assumptions and adjustments.

2. DATA

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

A. DESCRIPTION OF THE DATA

i. Description of the data

(a) Types of data

The primary data sources used in the development of the MMC rates are the following:

- Historical enrollment and eligibility files;
- Encounter data submitted by the MCPs;
- Annual cost report data submitted by the MCPs;
- Re-priced inpatient hospital claims experience provided by ODM;
- Calendar year 2014 Managed Care Survey completed by each MCP; and,
- Statutory financial statement data.

(b) Age of the data

The data serving as the base experience in the capitation rate development process was incurred during calendar year 2014. The encounter data used in our rate development process reflected encounters adjudicated through June 30, 2015. The annual cost report data reflects claims paid through March 31, 2015.

For the purposes of trend development and analyzing emerging population enrollment patterns and claims experience, we also reviewed encounter and cost report experience from calendar year 2013 and the first half of calendar year 2015. Cost report and encounter data was provided by ODM.

For the purpose of analyzing inpatient hospital reimbursement changes, we received inpatient hospital encounter data (re-priced to ODM's fee schedule) for the majority of inpatient hospital admissions incurred during calendar year 2014 from ODM. We also summarized statutory financial statement data from calendar years 2013 and 2014, and the second quarter of calendar year 2015. Financial statement data was collected using SNL Financial.

(c) Data sources

The historical encounter data experience used for this certification is submitted by the five MCPs on an ongoing basis. This data is stored in ODM's Medicaid Information Technology System (MITS). Medicaid enrollment and encounter data stored in MITS was provided to us for the purposes of developing the calendar year 2016 capitation rates.

Calendar year 2014 annual cost report data was also provided to us. The cost report data is contained in Microsoft excel files that the MCPs submit to ODM.

(d) Sub-capitation

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

Encounter Data: MCPs indicated whether an encounter is sub-capitated and "shadow priced" at the detail and header level, depending on how the encounter was paid. In the payment arrangement field ('CDE_PAY_ARR'), code '05' indicates sub-capitated arrangements. This field was used to separate sub-capitated claims from the non-sub-capitated encounter data.

Cost Report: We relied on the separate reporting of non-sub-capitated and sub-capitated experience by the MCPs in the medical cube worksheets of the calendar year 2014 cost reports.

ii. Availability and quality of the data

(a) Steps taken to validate the data

The base experience used in the capitation rates relies on cost report and encounter data submitted to ODM by participating MCPs. Managed care eligibility is maintained in MITS by ODM. The actuary, the MCPs, and ODM all play a role in validating the quality of encounter and cost report data used in the development of the capitation rates. The MCPs play the initial role, collecting and summarizing data sent to the state. ODM's Bureau of Health Research and Quality Improvement, Data Analytics section focuses on encounter data quality and MCP performance measurement, with measures focused on completeness, accuracy, and comparison between data sources. Appendix L of ODM's contract with the MCPs stipulates encounter data specific submission and quality standards. Additionally, the state's actuary performs independent analysis of encounter data and cost report data to evaluate the quality of the data being used in the rate development process. Below is a summary of measures specific to each quality area that are applied by ODM or the actuary.

Completeness

Encounter Data

ODM applies several measures to the MCP-submitted encounter data to evaluate the completeness of the data. A sample of measures focused on the completeness of the data include:

- Encounter data volume measures by population and service category;
- Incomplete rendering provider data;
- NPI provider number usage without Medicaid / reporting provider numbers;
- Percentage of encounters in an MCP's fully adjudicated claims file not present in the ODM encounter data files; and,
- Percentage of encounters in the ODM encounter data files not present in the MCP's fully adjudicated claims file.

The actuary also summarizes the encounter data to assess month to month completeness of the encounter data. These measures include:

- Encounter per member per month (PMPM) by MCP and high level service categories;
- MCP distribution of members by annual encounter-reported expenditures; and,
- MCP distribution of members by monthly encounter-reported expenditures.

These measures are applied to identify any months where encounter data volume is unusually large or small, indicating a potential issue with the submitted encounter data.

The calendar year 2014 encounter data used in the development of the rates was adjudicated through June 30, 2015. The six months of claims run-out after year-end results in incurred but not paid (IBNP) claim liability estimates having a limited effect on the estimated incurred expenditures for calendar year 2014. However, as noted in this report, claims completion is applied to the encounter data for estimated calendar year 2014 claims adjudicated after June 30, 2015.

Cost Report Data

MCP's submit quarterly cost-report data to ODM and a year-end annual cost report. We reviewed each MCP quarterly cost report and the annual cost report to identify large data variances, incomplete data, and other reporting issues. These issues are provided to each MCP by ODM and the cost reports are re-submitted to ODM as necessary.

The year-end cost report data must be certified by two officers of each MCP and externally audited. The year-end annual cost report is completed by the MCPs using claims incurred and paid through March 31st of the following calendar year. The three months of claims run-out limits the impact of the IBNP estimate on the incurred expenditure estimates used in the development of the rates.

Accuracy

Encounter Data

ODM also reviews the accuracy of the encounter data by reviewing the percentage of matched encounters between the ODM encounter data files and an MCP's fully adjudicated claims files where a payment amount discrepancy is identified. The MCP contract stipulates the payment error rate cannot exceed 4%.

The state actuary also reviews the encounter data to ensure each claim is related to a covered individual and a covered service. The actuary also summarizes the encounter data into an actuarial cost model format. Annual base period data summaries are created to ensure that the data for each service is consistent across the health plans and with prior historical periods. Stratification by rate cell facilitates this review, as it minimizes the impact of changes in population mix. This process identifies service MCP and service category combinations that may have unreasonable reported data.

Cost Report Data

As stated in the *Completeness* section, MCP's submit quarterly cost-report data to ODM and a year-end annual cost report. In terms of accuracy measures, this process identifies unreasonable or inconsistent values in the cost report data. In addition to utilization and cost metrics, financial measures such as medical loss ratio, underwriting margin, and administrative loss ratio are tracked across plans and rate cells. These metrics enable identification of potential cost allocation issues to be quickly identified. We also evaluated the cost report expenditures in relation to statutory financial statements for each MCP to ensure expenditure differences were reasonable.

Consistency of data across data sources

As both encounter data and cost report data are used in the development of capitation rates effective January 1, 2016, assessing the consistency of the cost report and encounter data was a vital part of the rate development process. We reviewed utilization and cost metrics by rate cell and region for calendar year 2014 encounter data and cost reports. Experience was reviewed for non-sub-capitated services, sub-capitated services, and in aggregate. Aggregate expenditures in the encounter data (prior to adjustment) were approximately 10% less than aggregate expenditures in the cost report data prior to any data adjustments. Differences between the encounter data and cost report expenditures were generally greater in rate cells where a large portion of the expenditures were sub-capitated.

We also reviewed the consistency of other data sources that have been used to inform assumptions in the rate setting process:

- Eligibility – Monthly enrollment in eligibility files received by ODM was reconciled with publicly available values on ODM's website.
- Re-priced inpatient claims experience – To support our analysis of the impact of the APR-DRG changes during the historical experience period and rate period, we received re-priced inpatient encounter records from ODM. The claims experience included the actual MCP paid amount, along with claims re-priced to ODM's July 1, 2015 fee schedule. We confirmed the MCP paid amount was consistent with the encounter experience we had previously received, and confirmed the re-priced July 1, 2015 fee amounts were consistent with ODM's published inpatient hospital fee schedule.

(b) Actuary's assessment

As required by Actuarial Standard of Practice (ASOP) No. 23, Data Quality, we disclose that Milliman has relied upon certain data and information provided by the Ohio Department of Medicaid and their vendors, primarily the health plans. The values presented in this letter are dependent upon this reliance.

While there are areas for data improvement, as detailed in the *Data concerns* section below, we found the encounter data to be of appropriate quality for the purposes of developing specific adjustments for reimbursement and program changes that will impact MCP expenditures during the rate period beginning January 1, 2016. However, due to the potential under-reporting of encounter data expenditures in relation to the cost report data, we have weighted the base expenditures more heavily on the cost report data (90% weighting) relative to the encounter data (10% weighting).

We find the cost report data used to develop the 2016 capitation rates to be of appropriate quality and suitable for the purpose of developing actuarially sound rates. Underlying MCP financial experience based on the cost report data is reasonable in relation to Medicaid managed care industry experience. The data has been reviewed by multiple parties for completeness and accuracy.

(c) Data concerns

Through discussions with ODM, we were made aware and confirmed several encounter data quality concerns. We have not made any adjustments to the cost report data, and have not identified any material concerns with the data.

i. Use of encounter and fee-for-service data

As all the populations that will be enrolled in managed care during the rate period were included in the risk-based managed care delivery system in the calendar year 2014 base experience period, fee-for-service (FFS) data was not included in the base experience used to develop the capitation rates. FFS experience was used to estimate the potential impact of ODM's policy decision to move certain periods of retro-active FFS eligibility into the managed care delivery system. Managed care encounter data was weighted with MCP cost report data in the development of the capitation rates. The base data used reflects the historical experience and covered services used by the covered populations.

ii. Use of managed care encounter data

Managed care encounter data was blended with MCP submitted cost reports in the development of the capitation rates. Encounter data was the primary source in the development of adjustments for program and reimbursement changes.

iii. Reliance on a data book

Development of the capitation rates did not rely on a data book or other summarized data source. We were provided with detailed claims data for all covered services and populations. We created separate data books summarizing calendar year 2014 submitted data for both the encounter and cost report data, which were shared with ODM and participating MCPs.

B. DATA ADJUSTMENTS

Capitation rates were developed from a blending of historical calendar year 2014 encounter and cost report data. Adjustments were made to the base experience for data credibility, completion, reimbursement changes, and other program adjustments.

i. Credibility adjustment

The base experience data was developed based on blending calendar year 2014 cost report and encounter data at the rate cell level using a 90% (cost report) / 10% (encounter) weighting. As discussed later in this section, known encounter data issues were addressed prior to blending the two data sources. Aggregate expenditures in the encounter data were approximately 10% less than those reported in the cost report data prior to addressing known encounter data issues. While the encounter data is underreported relative to cost reports, it is the only source of member and claim level experience.

We believe it is an appropriate source of utilization and expenditures for the MMC program, which is why it is assigned a credibility of 10% after addressing known encounter data quality issues. It is our goal to increase the weighting of the encounter data in the development of capitation rates in rates periods after calendar year 2016 by addressing any data quality issues in conjunction with ODM.

ii. Completion adjustment

The capitation rates are based on calendar year 2014 experience. Encounter data is paid through June 30, 2015, while cost report data is paid through March 31, 2015. Separate sets of completion factors for the two data sources were developed by summarizing encounter data and applying traditional actuarial techniques to develop estimates of incurred but not paid (IBNP) liability.

First, we stratified the data by category of service and population groupings. Claims for each of these population-service category stratifications were analyzed and formed into lag triangles by paid and incurred month. Claim completion factors were developed for each month of the base experience period, based on historical completion patterns. The monthly completion factors were applied to calendar year 2014 experience to estimate the remaining claims liability for the calendar year. Results were aggregated into annual completion factors for each calendar year.

iii. Errors found in the data

Through discussions with ODM and our independent review of the data, we were made aware and confirmed several encounter data quality concerns. After applying the adjustments, the aggregate encounter data expenditures were 93% of the aggregate expenditures reported in the cost report data.

iv. Program change adjustments

Inpatient Hospital Facility Reimbursement Changes

Beginning on July 1, 2013, ODM rebased its hospital base rates using All Patients Refined Diagnosis Related Groups (APR-DRG). If a hospital is in a Metropolitan Statistical Area (MSA) peer group and is not a Medicare designated critical access hospital, then the hospital's APR-DRG payments are subject to a two-sided risk corridor relative to the prior DRG prospective payment system in effect prior to July 1, 2013. This risk corridor percentage has been increased according to the following schedule: 3% for the 12 month period beginning July 1, 2013; 5% for the 12 month period beginning July 1, 2014; and 8% for the 12 month period beginning July 1, 2015.

To estimate the impact of this reimbursement change, we received re-priced calendar year 2014 inpatient hospital encounter experience to reflect reimbursement rates effective July 1, 2015 from ODM. Reimbursement as of the inpatient admission date was compared relative to reimbursement levels as of July 1, 2015. The aggregate percentage change in ODM reimbursement was calculated by rate cell. This percentage change was applied to the inpatient paid claims experience, weighted by the proportion of total inpatient encounter data expenditures included in the re-priced data. The adjustment does not reflect hospital charge inflation impacting outlier payments. The impact of outlier payments is addressed in the development of prospective unit cost trends. Separate adjustments were developed for maternity delivery and non-maternity delivery inpatient services. We did not apply adjustments to nursing home services.

DRG-Exempt Reimbursement Adjustments.

Effective October 1, 2014, DRG-exempt hospitals are reimbursed for hospital services at 90% of the calculated cost-to-charge ratio for freestanding rehabilitation hospitals and freestanding long-term care hospitals. For James Cancer Center, reimbursement for hospital services will be set at 97% of the calculated cost-to-charge ratio for services incurred from October 1, 2014 through June 30, 2015, 94% of the calculated cost-to-charge ratio for services incurred from July 1, 2015 through June 30, 2016, and 91.7% of the calculated cost-to-charge ratio for services incurred after July 1, 2016[1].

[1] http://codes.ohio.gov/oac/5160-2-22

Calendar year 2014 hospital experience from DRG-exempt hospitals was adjusted to reflect reimbursement rates effective January 1, 2016.

The aggregate percentage change in ODM reimbursement was applied to DRG-exempt facility expenditures incurred during the calendar year 2014 base experience period and weighted with other facility expenditures to estimate the impact of this reimbursement change for inpatient and outpatient services.

Metabolic Nutrition Coverage Clarification.

A small number of MCP enrollees had been receiving metabolic nutrition services from the Ohio Department of Health prior to June 30, 2014. MCPs were instructed to provide these services beginning on July 1, 2014. We reviewed utilization changes for services reflecting this benefit to assess experience changes from first half to second half of calendar year 2014. Adjustments have been made to the 'Other – Supplies and DME' category service for CFC Child and ABD <21 rate cells to estimate the impact of this program change being applied to 12 months of experience. The program change did not have a material impact on costs for adult populations, and therefore no adjustments have been made for this program change in adult rate cells.

Children with Medical Handicaps Program (BCMH).

Prior to July 1, 2014, BCMH children with cancer, hemophilia, or cystic fibrosis were excluded from managed care. Beginning on July 1, 2014, families of these children may choose managed care enrollment on a voluntary basis[2]. As we are unable to identify these children in the eligibility or encounter data, we reviewed the changes in the prevalence of these conditions among the managed care children's populations in the second half of calendar year 2014. We have estimated a 0.25% impact to expenditures in the ABD <21 rate cell.

Nurse & Aide Service Modernization

Effective July 1, 2015, ODM instituted new services and reimbursement changes for nurse and aide services[3]. The changes include:

- Restructuring of home care attendant and nurse rates for LPNs and RNs;
- Creation of rates for assessment and consultation by an RN when an LPN is providing services;
- Policy changes related to billing guidance for base rates; and,
- Rebalancing of base rates and 15-minute rates.

We estimated the impact to applicable services in the 2014 encounter data under the prior and new reimbursement methodologies. Services were contained in the Other – Home Health category of service. The percentage reimbursement change was calculated at the rate cell and category service level and weighted by unaffected expenditures. The developed program adjustments reflect a different adjustment factor based on the mix of the individual nurse/aide services contained within the statewide rate cell. Regional adjustment factors were not developed by rate cell due to limited historical experience available in certain regions.

Former Inmate Outreach

ODM, in partnership with Ohio Department of Rehabilitation and Corrections (ODRC) and other state entities, has created a program to provide initial discharge planning/transition of care coordination for offenders who are determined to be at high risk of poor health as determined by their health care status while incarcerated[4]. We worked with ODM to gather information on the estimated number of beneficiaries that are likely to be in this program during calendar year 2016, as well as the potential health conditions of this population. Based on this information, we estimated an additional 9,500 member months for calendar year 2016. The estimated distribution of prisoners with qualifying health conditions by rate cell was used to develop estimates of the program's impact at the rate cell level.

[2] http://medicaid.ohio.gov/Portals/0/For%20Ohioans/Programs/exceptions.pdf

[3] http://medicaid.ohio.gov/Portals/0/Providers/rate-changes-2015.pdf

[4] http://www.ehcca.com/presentations/phhosp1/davidson_1_3.pdf

Dental Fee Schedule Increase

Effective January 1, 2016, ODM will institute a 5% rate increase for dental providers in rural counties. We estimated the impact to applicable services in the 2014 encounter data under the prior and new reimbursement methodologies. The percentage reimbursement change was calculated at the region, rate cell, and category service level and weighted by unaffected expenditures.

Periodontal / Scaling / Root Services

Periodontal / scaling / root services became a covered dental benefit effective January 1, 2015. The services are only covered if provided in a dental office. Using information contained in Milliman's Dental Health Cost Guidelines™ and ODM's fee schedule effective January 1, 2016, we estimated the impact of covering these services for adult rate cells. We estimated the inclusion of this benefit would increase the cost of covered adult dental services by approximately 8%.

Other Non-Facility Reimbursement Changes

Beginning on January 1, 2016, ODM will provide an enhanced payment amount to providers that bill for office or outpatient service codes, and preventive services codes. We evaluated the impact of this program adjustment by estimating paid claim amounts under 2014 ODM reimbursement and 2016 ODM reimbursement levels to determine the percentage impact to applicable services. Additionally, we estimated the impact of other non-facility reimbursement changes including the following:

- A 5% reimbursement increase to the wheelchair van procedure code A0130;
- Increase in reimbursement to vaccine administration codes;
- Reimbursement increases to specific dental codes related to denture repair codes (D5510, D5520, D5610, D5620, D5630, and D5640), along with tooth extraction code D7140; and,
- Other fee schedule changes provided by ODM.

The percentage reimbursement changes were calculated at the rate cell and category service level and weighted by unaffected expenditures.

Hospital-Administered Drugs

Beginning on January 1, 2016, when a hospital independently bills for prescription drugs on ODM's provider-administered pharmaceuticals fee schedule, reimbursement will be based on the fee schedule amount. To the extent the drug is not on the fee schedule, the drug will continue to be reimbursed at 60% of cost. We estimated the impact to applicable services in the 2014 encounter data under the prior and new reimbursement methodologies. The percentage reimbursement change was calculated at the rate cell and category service level and weighted by unaffected expenditures in the Outpatient – Other and Emergency Room – Other categories of service.

Outpatient Hospital Reimbursement

Effective January 1, 2016, outpatient hospital facility reimbursement for all providers, with the exception of children's hospitals, will be reduced by 5%. Ambulatory surgical centers are not impacted by this reimbursement change. We applied a 5% reduction to paid claims in the base experience period for services that are impacted by this reimbursement change. The impact of the reimbursement change was estimated at the rate cell and category of service level by calculating the aggregate percentage impact to expenditures for applicable categories of services.

Home Health Aide Reimbursement

Effective January 1, 2016, the reimbursement for home health aide services, other than those provided by an independent provider, will be increased by 5% over the rate in effect on October 1, 2015. This policy change impacts procedure code G0156, home health aide services. We increased the expenditures for this service in the base encounter data experience by 5%, and then calculated the percentage impact to aggregate expenditures in the Other – Home Health category of service by rate cell.

Reimbursement of Outpatient Expenditures 3 Calendar Days Prior to Inpatient Admission

Effective January 1, 2016, ODM will no longer separately reimburse outpatient services delivered three calendar days prior to an inpatient admission for the same billing provider. These services will be rolled into the inpatient admission claim. We analyzed outpatient experience (including emergency room) meeting this criteria during the base experience period. We assumed that a portion of the outpatient expense rolled into inpatient claims would result in a higher payment as a result of ODM's inpatient outlier claim reimbursement methodology. Adjustments were developed for each affected category of service by rate cell.

Targeted Reimbursement

We reviewed MCP provider reimbursement levels in 2014 in relation to ODM's FFS reimbursement methodologies. The 2014 Managed Care Plan Survey required each participating MCP to report its provider reimbursement methodologies by population (CFC, ABD, and Extension), region, and service category. Additionally, reimbursement levels in relation to Ohio Medicaid's fee-for-service reimbursement schedule were required to be reported at the same level of granularity. This information was provided for the following service categories:

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

Additionally, we received inpatient encounter data from ODM that was re-priced to the FFS fee schedule. We reviewed the ratio of MCP paid to FFS reimbursement for inpatient admissions where the ratio between MCP paid and FFS re-priced amounts was within a 0.9 to 1.1 corridor.

In discussion with ODM, we adjusted the base experience to reflect a targeted reimbursement ratio between the composite base experience MCP reimbursement and fee-for-service reimbursement. The targeted reimbursement ratios reflect 2016 fee-for-service reimbursement changes.

Program changes deemed immaterial to benefit expenses in the rate period

Adjustment factors were developed for policy and program changes estimated to ***materially*** affect the managed care program during calendar year 2016 that are not fully reflected in the 2014 base experience. Program adjustments were made in the rate development process to the extent a policy or reimbursement change is deemed to have a material cost impact to the MCPs. *We defined a program adjustment to be 'material' if the total benefit expense for any individual rate cell is impacted by more than 0.1%.* The following is a list of program adjustments deemed immaterial based on our review of the experience data and policy change.

- **SSI Children Respite Services.** Effective January 1, 2014, children under age 21 who are receiving Supplemental Security Income (SSI) payments became eligible for respite services. Only children who meet an institutional level of care, require skilled nursing or skilled rehab services at least once per week, and meet additional requirements are eligible for respite services. The respite benefit cannot exceed more than 24 hours of service during a month or 250 hours per calendar year. Because the respite benefit was implemented on January 1, 2014, we examined emerging utilization and cost of the benefit to determine if usage of the benefit had not yet met long-term levels in calendar year 2014 and the first half of calendar year 2015[5]. We did not observe any change in utilization during the course of the 18 month period.

[5] Please see for more information: http://www.helpmegrow.ohio.gov/~/media/HelpMeGrow/ASSETS/Files/Professionals%20Gallery/HMG%20Early%20Intervention/EI%20Resources/Ohio%20Respite%20Services%20for%20Children%20with%20Disabilities.pdf.

- **Reimbursement Refinements for Radiology Services.** Effective January 1, 2014, ODM modified its reimbursement policy for radiology services that occur when more than one radiology procedure is performed by the same provider or provider group for an individual patient on the same date. Payment for the primary procedure is made at 100% of the Medicaid fee schedule amount, with the additional global, professional, or technical component reduced to 50% of the Medicaid fee schedule amount. Effective July 1, 2014, each additional professional component of the procedure was reduced to 75% of the Medicaid fee schedule amount[6]. We repriced 2014 experience and did not find justification to reflect a program adjustment.

- **Telemedicine Services**. Telemedicine services became a covered benefit in calendar year 2015[7]. We reviewed the usage of these services in the first half of calendar year 2015 and did not find utilization to be material.

- **Special unlisted dental surgery pricing for claims with an intellectual disability diagnosis code.** Based on Ohio Administrative Code Section 5160-2-21[8], F.2.b.iii., Grandview Hospital's Medicaid reimbursement for procedure code 41899 with ICD-9 diagnosis code of 317, 318.0, 318.1, 318.2, or 319 (special unlisted dental surgery for claims with an intellectual disability diagnosis code) will be reimbursed at $5,500 per claim for dates of service on or between January 1, 2014 and December 31, 2015. In 2016, the hospital will be paid at the state Medicaid fee schedule for the service, $1,255. We evaluated utilization of this service by Grandview Hospital in the calendar year 2014 base experience and did not find a material number of expenditures impacted.

v. Exclusion of payments or services from the data

Uncollected Co-pays

Adjustments were made to reflect fee-for-service co-pay amounts that were not collected by the MCPs in 2014. Co-pay amounts were estimated by applying ODM's co-pay policies to the MCP encounter data[9]. Separate adjustments were made for emergency room, dental, vision, and pharmacy categories of service based on the uncollected co-pay amounts as a percentage of 2014 expenditures. Co-pay adjustments were not applied to children or pregnant women rate cells, with the exception of co-pays for vision services for pregnant women.

Other Non-State Plan Services

We adjusted the base experience data for services included in the encounter or cost report data that do not reflect approved state plan services (nor are an approved in-lieu of service). These adjustments were developed based on our review of the 2014 encounter data and amounts submitted by the MCPs in the 2014 Managed Care Plan Survey and 2014 annual cost report.

Pharmacy Rebates

Based on an analysis of calendar year 2014 Annual Cost Report data, retail pharmacy expenditures were reduced by the reported supplemental rebate percentage during the 2014 historical experience period.

Third Party Liability/Fraud and Abuse

In addition to actual cost avoidance reflected in the encounter data, we estimated additional third party liability (TPL) and fraud recoveries based on data available in calendar year 2014 cost report and MCP surveys. These data sources indicated that approximately 0.55% total claims were recovered and not reflected in the baseline experience data. We separately adjusted cost report and encounter baseline data by region to reflect an estimated amount of TPL and fraud recoveries using data reported by the MCPs.

[6] http://www.odjfs.state.oh.us/lpc/calendar/fileLINKNAME.asp?ID=MHTL3334-14-04

[7] http://www.odjfs.state.oh.us/lpc/calendar/fileLINKNAME.asp?ID=MHTL3334-15-01

[8] http://codes.ohio.gov/oac/5160-2-21

[9] http://medicaid.ohio.gov/FOROHIOANS/AlreadyCovered/MedicaidCopays.aspx

Net Reinsurance

Ohio Administrative Code requires MCPs contracted with ODM for the MMC program to carry reinsurance for high cost inpatient claims. We have adjusted inpatient expenses in the historical period by the net cost of reinsurance (reinsurance premiums less reinsurance recoveries) as reported in the 2014 annual cost report data. The aggregate statewide reinsurance loss ratio for MCPs in 2014 was approximately 79% (reinsurance recoveries / reinsurance premiums). A statewide estimated reinsurance premium by rate cell was developed by taking statewide reinsurance recoveries for each rate cell and dividing by the 79% loss ratio. The statewide rate cell reinsurance premium estimates were further adjusted based on estimated regional reinsurance loss ratios. Reinsurance recoveries were based on amounts reported in MCP cost report data. While we have not changed the aggregate amount of MMC reinsurance premiums reported, we believe these adjustments allocate the reinsurance premium on a more actuarial sound basis at the rate cell level.

3. PROJECTED BENEFIT COST AND TRENDS

This section provides information on the development of projected benefit costs in the capitation rates.

A. DEVELOPMENT OF PROJECTED BENEFIT COSTS

i. Description of the data, assumptions, and methodologies

This section of the report outlines the data, assumptions, and methodology used to project the benefit costs to the rating period. The baseline benefit costs were developed using the following steps:

Step 1: Create per member per month (PMPM) cost summaries

The capitation rates were developed from historical claims and enrollment data from the managed care enrolled populations. This data consisted of calendar year 2014 incurred encounter data that has been submitted by the MCPs, as well as calendar year 2014 annual cost reports developed by each MCP.

Step 2: Apply historical and other adjustments to cost summaries

As documented in the previous section, utilization and cost per service rates from the base experience period were adjusted for a number of items, including but not limited to, incomplete data adjustments, uncollected co-pays, and policy and program changes that occurred in calendar year 2014.

Step 3: Blend 2014 base experience

Cost report and encounter data was blended to create a single experience base for the development of the capitation rates. A 90% weighting was applied to the cost report data, with 10% weighting given to the encounter data. The encounter data was adjusted for known data issues described previously in this report prior to the application of this weighting.

Step 4: Adjust for prospective program and policy changes and trend to calendar year 2016

We adjusted the 2014 base experience for known policy and program changes that have occurred or are expected to be implemented in calendar years 2015 and 2016. In the previous section, we documented these items and the adjustment factors for each covered population. The adjusted per member per month (PMPM) values from the base experience period were trended forward from the midpoint of the base experience period to the midpoint of the rate period (July 1, 2016). For the CFC and ABD population, we applied 24 months of trend based on an experience period midpoint of 7/1/2014.

For the Extension population, we applied 22 months of trend based on an experience period midpoint of 9/1/2014. The midpoint of the Extension population experience data differs from the CFC and ABD populations due to low enrollment in the first half of calendar year 2014.

Adjustments were applied to the PMPM values to reflect changes in benefits between the base period and effective rate period. Additionally, we targeted improvements in managed care efficiency for specific rate cells and service categories that are estimated to impact projected 2016 benefit expense. The resulting PMPMs established the adjusted benefit expense by population rate cell for the rating period.

We reviewed the need for data smoothing adjustments, other than adjustments for net reinsurance recoveries, in particular for the Extension rate cells. Based on our review of regional rate relativities at the rate cell level, we did not identify regional rate variation that may have been driven by a high degree of claims volatility.

The following items provide more information regarding significant and material items in developing the projected benefit costs other than benefit adjustments previously discussed.

(a) Covered population changes

Children with Medical Handicaps Program (BCMH)

Prior to July 1, 2014, BCMH children with cancer, hemophilia, or cystic fibrosis were excluded from managed care. Beginning on July 1, 2014, families of these children may choose managed care enrollment on a voluntary basis[10]. As we are unable to identify these children in the eligibility or encounter data, we reviewed the changes in the prevalence of these conditions among the managed care children's populations in the second half of calendar year 2014. We have estimated a 0.25% impact to expenditures in the ABD <21 rate cells.

Former Inmate Outreach

ODM, in partnership with Ohio Department of Rehabilitation and Corrections (ODRC) and other state entities, has created a program to provide initial discharge planning/transition of care coordination for offenders who are determined to be at high risk of poor health as determined by their health care status while incarcerated[11].

We worked with ODM to gather information on the estimated number of beneficiaries that are likely to be in this program during calendar year 2016, as well as the potential health conditions of this population. Based on this information, we estimated an additional 9,500 member months for calendar year 2016. The estimated distribution of prisoners with qualifying health conditions by rate cell was used to develop estimates of the program's impact at the rate cell level.

(b) Managed care efficiency adjustments

We calculated percentage adjustments to the experience data to reflect the utilization and cost per unit differential between the base experience and the levels targeted for the projection period managed care environment. We developed the targeted managed care efficiency adjustments through a review and analysis of 2014 utilization levels achieved by each MCP, the NYU Center for Health and Public Service Research (CHPSR) Emergency Department Algorithm, and the AHRQ prevention quality indicators (PQI).

Emergency Room Services - For the outpatient hospital emergency room service category and the corresponding physician emergency room visits category, we reviewed the following: (1) 2014 managed care utilization levels for each MCP and (2) the resulting classification of claims using the NYU CHPSR Emergency Department Algorithm. Both sources of information suggested similar levels of potential for reduced utilization in outpatient hospital emergency room services.

The NYU CHPSR tool classifies emergency room utilization into four (4) primary categories as well as categories that are excluded from the grouping.

[10] http://medicaid.ohio.gov/Portals/0/For%20Ohioans/Programs/exceptions.pdf

[11] http://www.ehcca.com/presentations/phhosp1/davidson_1_3.pdf

The four categories include: Non-emergency, Emergency/Primary Care Treatable, Emergency–Preventable/Avoidable, and Emergency–Not Preventable/Avoidable. Subsequent to the review of the experience into these defined categories, we developed specific adjustments for the first three categories to reflect the target utilization levels for the managed care plans.

Reductions were taken from level 1 emergency room claims first, followed by level 2 and level 3 claims if applicable. No adjustments were made to level 4 or level 5 emergency room claims. In coordination with determination of the managed care adjustments for hospital outpatient emergency room services, we assumed that most emergency room visits reduced would be replaced with an office visit. The utilization of professional office visits and consults was increased proportionately.

Inpatient Hospital Services – We applied managed care adjustments to base year utilization to reflect higher levels of care management relative to the calendar year 2014 experience period. We identified potentially avoidable admissions using the AHRQ PQIs. Inpatient hospital managed care adjustments were developed by applying a 10% reduction to potentially avoidable inpatient admissions. This was completed at the regional level by first reducing readmissions within 30 days, and then reducing non-readmissions for select PQIs. No adjustments were made to corresponding inpatient physician charges to account for the potential shift of these services to an ambulatory setting. Additionally, nursing facility claims were excluded from this analysis.

Pharmacy Services – We reviewed historical pharmacy experience by therapeutic class for each MCP to estimate achievable generic drug dispensing rates (GDR), generic drug cost per script, and brand drug cost per script. For each therapeutic class, we estimated the impact of improvements in GDR and cost per script amounts by repricing MCP historical experience to levels achieved by other MCPs during the same time period. Antipsychotics, Antidepressants, and Anticonvulsant were excluded from this analysis. We developed pharmacy managed care efficiency adjustments by rate cell to reflect mix differences by therapeutic class due to the age, gender, and morbidity of the applicable rate cell.

Delivery Services – Delivery managed care efficiency adjustments were developed by analyzing the percent of cesarean and vaginal deliveries by MCP and region. Vaginal delivery percentages were adjusted to levels achieved by MCP's with at least 1,000 deliveries in a region, with a minimum assumed percentage of 70%. This analysis resulted in shifting approximately 1% of calendar year 2014 deliveries from cesarean to vaginal. Managed care savings were estimated by evaluating the cost per delivery difference between cesarean and vaginal deliveries. No adjustments were made to the total number of deliveries.

ii. Material changes to the data, assumptions, and methodologies

ODM's prior actuarial vendor developed the calendar year 2015 capitation rates for the MMC program. Material changes to the rate development methodology, other than changes for the Extension population (detailed in Section III), include:

- Encounter data weighting – The 2015 rate setting process placed 100% credibility on cost report data expenditures, with zero credibility on encounter data expenditures. The 2016 rate development process places 90% credibility on cost report data expenditures and 10% credibility on encounter data.

- Rate cell expenditure allocation – The 2015 rate setting process used encounter data utilization to allocate cost report expenditures by rate cell and region. The 2016 methodology uses the 90% / 10% blend of cost report and encounter data, respectively, at the region and rate cell level.

- ABD <21 Rates – The 2015 ABD <21 rates relied on FFS claims experience from 2012, as the managed care program was not established until July 1, 2013. The 2016 rate setting process uses actual ABD <21 managed care utilization and cost experience from calendar year 2014.

The above are material changes that we have identified through information that has been provided to us by ODM.

B. PROJECTED BENEFIT COST TRENDS

i. Description of the data, assumptions, and methodologies

This section discusses the data, assumptions, and methodologies used to develop the benefit cost trends, i.e., the annualized projected change in benefit costs from the historical base period (CY 2014) to the CY 2016 rating period of this certification. We evaluated prospective trend rates using ODM, as well as external data sources.

(a) Data

2012 through 2014 MCP encounter was used to develop estimated prospective trend rates. For the ABD <21 rate cell, this data was limited to monthly encounter data beginning July 2013. Similarly, Extension population data was not available until January 2014, with very limited data credibility during the first half of the calendar year.

External data sources that were referenced include:

- *National Health Expenditure (NHE) projections* developed by the CMS office of the actuary, specifically those related to Medicaid. Please note that as these are expenditure projections, projected growth reflects not only unit cost and utilization, but also aggregate enrollment growth and enrollment mix changes such as aging. For trends used in this certification, we are interested only in unit cost and utilization trends, so in general, our combinations of unit cost and utilization trends should be lower than NHE trends. NHE tables and documentation may be found in the location listed below: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsprojected.html
- *Other sources:* We also reviewed internal sources that are not publicly available, such as historical experience from other programs and trends used by other Milliman actuaries.

(b) Methodology

For internal ODM data, historical utilization and per member per month cost data was stratified by month, rate cell, and category of service. The data was adjusted for completion and normalized for historical program and reimbursement changes. We used linear regression to project experience during the contract period. Contract period projections were compared to base period experience to determine an appropriate annualized trend.

As previously mentioned, an explicit adjustment has been made for changes in ODM's inpatient APR-DRG fee schedule from the 2014 base experience period to the July 1, 2015 fee schedule. This adjustment did not include the impact of outlier payment inflation.

For inpatient unit cost trends, we used 2014 inpatient encounter data experience re-priced to the July 1, 2015 fee schedule to evaluate the impact of cost inflation due to outlier payments. We trended reported costs from the admission date to the midpoint of the rate period (July 1, 2016) at an annualized trend rate of six percent. The estimated change in inpatient cost as a result of outlier inflation was used in the development of inpatient unit cost trend assumptions.

(c) Comparisons

Historical trends should not be used in a simple formulaic manner to determine future trends; a great deal of actuarial judgment is also needed. We did not explicitly rely on the historical MCP encounter data trend projections due to anomalies observed in the historical trend data. Because of changes in contracted MCPs effective July 1, 2013, we believe encounter data between contract periods may be influenced by patterns in individual MCP encounter data reporting practices. We referred to the sources listed in the prior section, considered changing practice patterns, the impact of reimbursement changes on utilization in the MMC population, and shifting population mix.

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

ii. Benefit cost trend components

Trend was developed separately for unit cost and utilization which varied by rate cell and category of service. The utilization component includes both the trend in number of units as well as the mix or intensity of services provided.

iii. Variation

We developed trends by rate cell and major category of service. Minor trend variations between populations and service categories reflect observed variation in the underlying historical experience and actuarial judgement based on the sources listed in the section above. All trend values have been rounded to the nearest 0.25%.

iv. Material adjustments

Historical trends should not be used in a simple formulaic manner to determine future trends; a great deal of actuarial judgment is also needed. We did not explicitly rely on the historical MCP encounter data trend projections due to anomalies observed in the historical trend data. We referred to the sources listed in the prior section, considered changing practice patterns, the impact of reimbursement changes on utilization in the MMC population, and shifting population mix.

We made adjustments to the trends derived from historical experience in cases where the resulting trends did not appear reasonably sustainable, or were not within consensus parameters derived from other sources.

For many rate cells and categories of services, raw model output was outside of a range of reasonable results. In these situations, we relied on the sources identified to develop prospective trend.

For pharmacy trends, raw model output reflected a continuation of the observed calendar year 2014 increases, largely due to hepatitis C therapy. Future trends from our model were dampened to be more consistent with projected trend from other sources. For example, while Hepatitis C treatment costs increased significantly in the first half of calendar year 2014, treatment costs have been declining since mid-2014. The baseline pharmacy trend was adjusted to reflect the impact of cystic fibrosis drugs that were not reflected in our experience period. We analyzed the prevalence of cystic fibrosis by rate cell to develop an estimated annualized impact of the introduction of new cystic fibrosis treatments. Assumptions related to the cost of cystic fibrosis medications, the population eligible to receive treatment, and the take-up rate of new treatments were utilized to develop the impact of cystic fibrosis medications on pharmacy expenditures.

C. IN LIEU OF SERVICES

The projected benefit costs do not include costs for in lieu of services.

D. RETROSPECTIVE ELIGIBILITY PERIODS

i. Health plan responsibility

During the 2014 experience period, MCPs were not responsible for periods of retrospective eligibility. Under the ODM contract, beginning April 1, 2016, the MCPs will be responsible for retrospective eligibility periods when the beneficiary was previously enrolled with a MCP in the MMC program less than 90 days prior to re-enrolling with a MCP. ODM will provide capitation payments to the MCPs for beneficiaries meeting this criteria. We reviewed historical eligibility meeting the MCP retro-active eligibility criteria, as well as associated FFS expenses, and did not observe material or consistent cost differences between retro-active eligibility member months (meeting the specific 90 day criteria) and managed care member months. We have not adjusted the estimated benefit expense included in the rates for the retrospective eligibility policy change. Projected member months for calendar year 2016, with the exception of the HF/HST <1 M+F rate cell, were increased by 1.5% as a result of this policy change.

FFS claims incurred during retrospective eligibility periods have been excluded from the base data.

ii. Enrollment treatment

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

iii. Adjustments

As mentioned previously, we have increase the estimated calendar year 2016 member months as a result of the April 1, 2016 policy change.

E. FINAL PROJECTED BENEFIT COSTS

Final projected benefit costs are documented by program and rate cell in the certification titled "CY 2016 Medicaid Managed Care Certification" dated December 8, 2015.

4. PROJECTED NON-BENEFIT COSTS

This section provides information on the development of projected non-benefit costs.

A. DATA, ASSUMPTIONS AND METHODOLOGIES

i. Description of the data, assumptions, and methodologies

(a) Data

The primary data sources used in the development of the calendar year 2016 non-benefit costs are listed below:

- Annual cost report data submitted by the MCPs.
- Calendar year 2014 Managed Care Survey completed by each MCP.
- Statutory financial statement data for each of the MCPs.
- Average costs from the financial statements of Medicaid health plans nationally, as summarized by Palmer and Pettit. These reports date from 2012 through 2015, analyzing financial results from 2011 through 2014. A link to the 2015 report is here: http://us.milliman.com/uploadedFiles/insight/2015/medicaid-risk-based-managed-care.pdf.

(b) Assumptions and methodology

In developing the administrative costs, we reviewed historical administrative expenses for the MMC program along with national Medicaid health plan administrative expenses. We considered the size of participating health plans and the resulting economies of scale that could be achieved, along with the benefits covered and the demographics of the MMC population.

Historical reported administrative expenses were reconciled between the available data sources for the purpose of evaluating the quality of the data provided. Calendar year 2014 cost report administrative expenses were analyzed by MCP for reasonableness and completeness of the data provided. This data formed the baseline for projected 2016 administrative expense amounts. In developed administrative expenses, we assumed an annual administrative expense trend of 1%. Calendar year 2014 administrative expenses were adjusted for the assumed economies of scale that could be achieved due to membership increases from 2014 to the projected 2016 membership levels. Separate administrative expense amounts were developed for CFC Children, ABD < 21, ABD 21 +, Delivery, and the adult CFC/EXT populations.

ii. Material changes

There are no material changes to the data, assumptions, or methodology used to develop the projected non-benefit cost.

B. NON-BENEFIT COSTS, BY COST CATEGORY

Administrative expenses have not been developed from the ground up (based on individual components). However, individual components were reviewed within MCP cost reports and financial statement data. The components may appropriately interact, and the state does not wish to dictate to the plans how these may be allocated.

The calendar year 2016 non-benefit cost allowance is determined as a percentage of the capitation rates before fees and taxes.

It is our understanding that ODM has modified the administrative requirements for MCPs. The existing care management program has a required staffing ratio of one care manager for every 25 members in the top 1% of the members being managed. Revised requirements provide a range of 25-50 members for each care manager in the "Intensive" level (1%) and a range of 50-100 members for each care manager in the "High" level of care management (next 2%). We assumed that inactive members will require about half the effort to manage compared to active members.

ODM's implementation of the new care management ratios does not align with the required ramp-up of the new membership requirement for those to be care managed. Rather than reducing administrative costs for part of 2016 and then increasing administrative costs to account for implementation expenses, ODM will pursue an implementation strategy that is budget-neutral over the 2016 transition period. We assumed that changes in care managed requirements effective during calendar year 2016 are budget neutral to the capitation rates.

Calendar year 2016 capitation rates include amounts for the following non-benefit expense:

- Enhanced Maternal Program: ODM has implemented an enhanced maternal health program to target geographic areas with high infant mortality rates. ODM will provide guidelines to the MCPs for the purposes of developing strategies and systems that will provide enhanced maternal case management and reduce infant mortality rates. Funding to support MCP initiatives for the program is included in the applicable regions and female rate cells. A total of $13.4 million was added to four female CFC rate cells, before fees and taxes, for the enhanced maternal program. The rate cells assumed to be included in the program are HF/HST 14-18 F, HF 19-44 F, HF 45+ M+F, and HST 19-64 F. The total amount of available funding for the enhanced maternal program was allocated based on the assumed percent of targeted membership in each region and rate cell.

- MCP Hospital Incentive: A total of $162 million was added to CFC and ABD non-delivery rates cells, before fees and taxes, for the MCP Hospital Incentive payment. This amount was allocated based on total projected inpatient claims by region and rate cell. The MCP Hospital Incentive program is a pass-through payment and is described fully in Section 4 of this report.

These additional above items were allocated on a PMPM basis. This includes Sales and Use tax along with the Health Insuring Corporation (HIC) tax. The State of Ohio is subject to a Sales and Use tax that varies by county. We sourced the tax rates by county from the State of Ohio website[12] and weighted the county-level tax amounts by calendar year 2014 enrollment by county. A composite Sales and Use tax was then aggregated from the county estimates and applied as a percentage of the total capitation rate for each region.

C. PMPM VERSUS PERCENTAGE

The non-benefit cost was developed as a percentage of the capitation rate before fees and taxes. The enhanced maternal program and MCP Hospital Incentive payments were allocated by region and rate cell on a PMPM basis. Fees and Taxes were develop as a percent of the total capitation rate. Each of these items are illustrated on a PMPM and percentage basis, by region and rate cell in the certification titled "CY 2016 Medicaid Managed Care Certification" dated December 8, 2015.

[12] Please see http://www.tax.ohio.gov/sales_and_use.aspx for additional information.

D. HEALTH INSURER FEE

i. Whether the fee is incorporated in the rates

Consistent with ODM's payment of the Health Insurer Fee (HIF) for the calendar year 2014 and calendar year 2015 rates, calendar year 2016 rates will be amended based on the calculated HIF attributable to ODM premium revenue. To the extent the actual paid HIF is less than the calculated HIF, the rates for the MCP will amended based on actual paid HIF.

ii. Fee year or data year

The HIF for each insurer is calculated based on the data year. Amended calendar year 2016 rates will be based on the 2017 HIF attributable to the 2016 data year.

iii. Determination of fee impact to rates

The calculation of the fee for each MCP subject to the HIF will be based on the final Form 8963 premium amounts reported by the insurer, aggregate HIF premium base, final IRS invoices provided to the MCPs subject to the HIF, Form 8963 premium amounts attributable to ODM, data year HIF tax percentage, and adjustments for premium revenue based on benefits described in 26 CFR 57.2(h)(2)(ix) such as nursing home and home health care. Final fee amounts are adjusted for applicable fees and taxes that are applied to ODM capitation rate revenue (documented in the non-benefit expense section of this report). The 2016 capitation rates will be amended based on the 2017 HIF attributable to the 2016 data year. We anticipate amending the rates in the last quarter of calendar year 2017.

iv. Identification of long-term care benefits

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

5. RISK MITIGATION AND RELATED CONTRACTUAL PROVISIONS

This section provides information on the risk mitigation included in the contract.

A. DESCRIPTION OF RISK MITIGATION

The MMC rates have been developed as full risk rates. The MCP entity assumes risk for the cost of services covered under the contract and incurs loss if the cost of furnishing the services exceeds the payments under the contract.

The composite rates for the ABD and Extension populations will be prospectively risk adjusted by health plan on a regional basis to reflect estimated prospective morbidity differences in the underlying population enrolling with each health plan.

Additionally, ODM will maintain a cost-neutral risk sharing pool for high cost Hepatitis C drugs. To the extent a MCP receives a higher proportion of Hepatitis C drug expenditures in relation to other MCPs, the MCP will receive additional reimbursement. Conversely a MCP receiving a lower portion of Hepatitis drug expenditures will be required to pay into the risk sharing pool.

For state fiscal year 2017, the MCP will be eligible for pay-for-performance payments up to 1.5% of capitation revenue. As stated in Appendix O of the provider agreement, payment is divided equally between seven different measures:

- Follow-up for hospitalization after mental illness (7 days)
- Timeliness of pre-natal care
- Post-partum care
- Controlling high blood pressure
- Adolescent well-care visits

- Appropriate treatment for children with upper respiratory infection
- Comprehensive diabetes control

B. RISK ADJUSTMENT MODEL AND METHODOLOGY

i. Risk adjustment model

Aged, Blind, and Disabled

The ABD population will be risk adjusted using CDPS + Rx. Risk adjustment is performed on a budget neutral basis at the region level, separately between disabled children (under age 21) and adults (age 21+).

Extension

The Extension population will be risk adjusted using Medicaid Rx. Due to the infancy of the Extension population, diagnosis information available in the MCP encounter data may not produce credible risk scores. Additionally, the number of Extension eligibles has increased by approximately 150,000 from December 2014 to August 2015. Using Medicaid Rx allows us to use experience data that is more recent, due to a reduced number of necessary run-out months for pharmacy data.

CFC

Historically, the CFC population has not been risk adjusted using a diagnosis or pharmaceutical-based methodology. The calendar year 2016 capitation rates for CFC will not be risk-adjusted beyond rate cell, Hepatitis C risk pool, and the maternity delivery kick payment.

ii. Data and adjustments

Aged, Blind, and Disabled

For the January 1, 2016 through June 30, 2016 rate period, the diagnosis and prescription drug collection period will be based on incurred (dispensed) dates from January 1, 2014 through December 31, 2014. The July 1, 2016 through December 31, 2016 rate period will use a diagnosis and prescription drug collection period based on incurred (dispensed) dates from July 1, 2014 through June 30, 2015. The diagnosis base, for the purposes of risk adjustment, will exclude diagnosis codes associated with diagnostic testing and certain medical supply codes.

Extension

Below is a summary of the data sources and time periods that the Extension risk adjustment will be based on for the first and second half of 2016:

- Extension Rate Period: 1/1/2016 – 6/30/2016
  Pharmacy Collection Period (Incurred Dates): 7/1/2014 – 6/30/2015
- Extension Rate Period: 7/1/2016 – 12/31/2016
  Pharmacy Collection Period (Incurred Dates): 1/1/2015 – 12/31/2015

As with the ABD population, the risk adjustment diagnosis base will exclude diagnosis codes associated with diagnostic testing and certain medical supply codes.

iii. Changes from the prior year

There are no material changes from the methodology utilized in the prior year.

iv. Frequency

Risk score updates for both the ABD and Extension populations will be performed on a semi-annual basis.

v. How the risk scores will be used to adjust the capitation rates

Risk scores developed by region and MCP will be used to adjust MCP capitation payments on a regional basis.

vi. An attestation that the risk adjustment is cost neutral

The ODM risk adjustment is designed to be cost neutral. Relative risk scores will be normalized to result in a regional risk score of 1.000 for each rate group, across all plans.

C. OTHER RISK SHARING ARRANGEMENTS

i. Introduction

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

ii. Methodology

The CY 2016 hepatitis C drug risk pool aggregate amounts will be developed using the estimated CY 2016 hepatitis C drug benefit expense PMPM included in the CY 2016 capitation rates, multiplied by the actual CY 2016 membership on a region and rate cell basis. The estimated CY 2016 hepatitis C drug PMPM is developed on a prospective basis and is based on a review of historical hepatitis C drug expenditures through June 2015. Program and policy changes developed for the CY 2016 Medicaid Managed Care (MMC) rates impacting hepatitis C expenditures were applied to the base experience.

Please note that consistent with the CY 2015 capitation rates, the estimated CY 2016 hepatitis C drug PMPM is based on the historical hepatitis C drug expenditures, with no smoothing adjustment across region or rate cell. Therefore, certain region and rate cell combinations may have estimated CY 2016 hepatitis C drug expenditures while other similar region and rate cell combinations may not have any or significantly lower estimated CY 2016 hepatitis C drug expenditures.

Estimated CY 2016 hepatitis C drug PMPM will not be updated with actual CY 2016 hepatitis C drug experience, but the actual CY 2016 membership will be used to developed the aggregate expenditures in the hepatitis C drug risk pool development.

iii. Schedule of Risk Pool Submissions

The following table illustrates the expected timeline for implementation of the CY 2016 hepatitis C drug risk pools:

Table 1 Ohio Department of Medicaid Medicaid Managed Care Rates Rates Effective January 1, 2016 Timeline for Hepatitis C Drug Risk Pools		
Function	**Interim**	**Final**
Prescription Dates of Service	January – June 2016	January – December 2016
Prescription Paid Date	September 30, 2016	March 31, 2017
Prescription Submission Date	October 2016 cut-off	April 2017 cut-off
MCP Distribution Calculation	December 16, 2016	June 15, 2017
MCP Payment and Recoupment	December 30, 2016	June 30, 2017

D. MEDICAL LOSS RATIO

i. Description

ODM's provider agreement establishes minimum medical loss ratio of 85% for the Extension population. The specific language from the provider agreement effective July 1, 2015 has been provided below.

B.2.5.1.Establishment of MLR

For Adult Extension members, ODM shall perform an MLR calculation as defined in the ODM Methods for Financial Performance Measures for the periods stated below.

a. ODM shall perform MLR calculations for the incurred periods of January 1, 2014 through December 31, 2014, ("first period"), and January 1, 2015 through December 31, 2015, ("second period").

b. For each period, ODM or its designee will initiate the MLR calculation 12 months after the end of each period.

c. ODM will give consideration to paid claims data through December 31, 2015, for services incurred during the first period, and through December 31, 2016, for the second period. In the determination of Incurred Medical Claims, no estimate of claims to be paid more than 12 months beyond the end of the period will be considered. Incurred Medical Claims includes an adjustment for pharmaceutical rebates collected by the MCP.

d. The MCP shall provide and certify any data used in the calculation of the MLR in accordance with 42 CFR 438.600 et al. Data submitted to ODM is subject to review or audit by ODM or its designee.

e. Net Capitation Payments equals Earned Premiums minus Federal, State, and Local Taxes and Licensing or Regulatory Fees.

f. Allowed Medical Expense equals Incurred Medical Claims plus Expenses for Activities That Improve Health Care Quality (as defined in 45 CFR 158.150)

B.2.5.2. MLR Rebate

The MCP shall be required to expend at minimum 85 percent of Net Capitation Payments for the Extension population on Allowed Medical Expenses.

If the MCP does not meet the minimum 85 percent MLR threshold, then the MCP shall return to the State the difference between 85 percent of total Net Capitation Payments to the MCP and actual Allowed Medical Expenses incurred. After completion of the MLR calculation, if it is determined that the MLR of the MCP is less than 85 percent, then ODM will notify the MCP of the capitation payments to be returned to the State.

a. The MCP shall remit to the State the full amount due no later than ninety (90) calendar days after the date ODM delivers notice to the MCP of that amount.

b. It is explicitly noted that this MLR contract provision may result in payment by the MCP to ODM.

c. In the event of a change in capitation rate for the Extension population, for each period provided in this Provision, a MLR calculation in accordance with the requirements of this Provision shall be re-determined by ODM. Subsequent to this re-determination, adjustments to payments in accordance with this Provision may result in changes in payment by the MCP to ODM.

ii. Financial consequences

As stated in the provider agreement, "*If the MCP does not meet the minimum 85 percent MLR threshold, then the MCP shall return to the State the difference between 85 percent of total Net Capitation Payments to the MCP and actual Allowed Medical Expenses incurred. After completion of the MLR calculation, if it is determined that the MLR of the MCP is less than 85 percent, then ODM will notify the MCP of the capitation payments to be returned to the State.*"

E. REINSURANCE REQUIREMENTS AND EFFECT ON CAPITATION RATES

Ohio Administrative Code requires MCPs contracted with ODM for the MMC program to carry reinsurance for high cost inpatient claims[13]. We have adjusted inpatient expenses in the historical period by the net cost of reinsurance (reinsurance premiums less reinsurance recoveries) as reported in the 2014 annual cost report data. The aggregate statewide reinsurance loss ratio for MCPs in 2014 was approximately 79% (reinsurance recoveries / reinsurance premiums). A statewide estimated reinsurance premium by rate cell was developed by taking statewide reinsurance recoveries for each rate cell and dividing by the 79% loss ratio. The statewide rate cell reinsurance premium estimates were further adjusted based on estimated regional reinsurance loss ratios. Reinsurance recoveries were based on amounts reported in MCP cost report data. While we have not changed the aggregate amount of MMC reinsurance premiums reported, we believe these adjustments allocate the reinsurance premium on a more actuarial sound basis at the rate cell level.

F. INCENTIVES AND WITHHOLDS

i. Incentives

Incentive payments under this plan are below 105% of the certified rates paid under the contract, as pay-for-performance payments are 1.5% in aggregate. Note, the MCP/Hospital Incentive program is a provider pass-through payment, not an incentive program that potentially provides additional funding to contracted MCPs.

ii. Withholds

There are no provisions for withholds in the calendar year 2016 capitation payments.

iii. Estimate of percent to be returned

In SFY 2014 and SFY 2015, the MCPs in aggregate received 22% and 26%, respectively, of available pay-for-performance payments from ODM.

[13] http://codes.ohio.gov/oac/5160-26-09

iv. Effect on the capitation rates

The rate is certified as actuarially sound with or without the pay for performance incentive measures.

SECTION II. NEW ADULT GROUP CAPITATION RATES

ODM implemented the Affordable Care Act's Medicaid expansion on January 1, 2014. As of October 2015, approximately 590,000 individuals receive Medicaid benefits through MCPs under ODM's expansion population, known as the 'Extension' population.

A. PROJECTED BENEFIT COSTS

i. 2014 and 2015 Experience Used in Rate Development

2014 Extension population experience, in the form of both encounter data and cost report data, is used as the underlying data source for the development of the calendar year 2016 capitation rates. Emerging data from these two data sources in the first half of calendar year 2015 was used to assess emerging enrollment and cost patterns, particularly from beneficiaries entering the program in the first half of 2015.

ii. Changes in Data Sources, Assumptions, or Methodologies Since Last Certification

As mentioned previously, the 2015 Extension rate certification developed by ODM's previous actuarial vendor was based on a blend of CFC and ABD experience due to the lack of credible data for the Extension population, while the 2016 rate development process uses actual 2014 Extension experience. Discussion of other assumption changes is provided in the next section.

iii. Assumption Changes Since 2014 and 2015 Certification

Acuity or health status adjustments – The 2014 and 2015 rates were based on a blend of CFC and ABD experience. Acuity or health status was estimated based on blending the following populations: 'Parents Disabled-like', 'Parents CFC-like', 'Childless Adults Disabled-like', 'Childless Adults CFC-like'. The 2016 rates use actual Extension experience and have not been adjusted by acuity or health status adjustments (adjustments for pent-up demand and adverse selection have been made).

Adjustments for pent-up demand – The Calendar Year 2014 and 2015 Extension capitation rates included a 5% and 2.07% upward adjustment for assumed pent-up demand. Because we used actual Extension experience data to develop the Calendar Year 2016 rates, it was necessary to estimate the pent-up demand embedded in the experience data and make a downward adjustment to the rates. We isolated pent-up demand by performing a durational analysis that reviewed monthly costs for the Extension population by month of entry into the program. For example, we reviewed monthly costs for the population that enrolled in March 2014 separate from enrollees entering the program in April 2014. We defined pent-up demand as an entry month cohort having higher average PMPM expenses in initial months relative to enrollment months of longer duration relative to program entry.

Pent-up demand was observed for Extension enrollees entering the MMC delivery system from January 2014 through May 2014, with pent-up demand being the highest amongst enrollees in the January through March time frame. A calendar year 2014 pent-up demand factor for each Extension rate cell was developed based on calculating an estimated calendar year 2014 PMPM expense with and without pent-up demand for the January through May time frame. After rounding, we estimated the pent-up demand included in each Extension rate cell during calendar year 2014 was 1.5%. While total Extension enrollment was approximately 210,000 member months during the January through May 2014 time period, enrollment during the June through December 2014 time period was 2.2 million member months. To the extent enrollment had not increased significantly during the last seven months of the year, the pent-up demand adjustment may have been greater.

Adjustment for adverse selection – We developed an adverse selection adjustment, net of pent-up demand, to reflect that initial enrollment in the Extension population represented a higher acuity mix relative to enrollment during the second half of the year.

We summarized calendar year 2014 Extension enrollee experience by month of entry into the population, and calculated a 2014 PMPM by month of entry into the population.

We assumed enrollees entering the Extension population after December 31, 2014 would have a acuity profile similar to the population that enrolled in the program during the June 2014 through December 2014 time frame. We estimated the relative acuity mix of 2016 enrollees by using the December 2014 enrollment mix (by month of entry) and estimated growth in enrollment through Calendar Year 2016. This acuity mix was compared relative to the calendar year 2014 experience period.

Adjustment for demographics of the new adult group – We believe the current rate cell structure of the Extension population appropriately adjusts capitation payments to the MCPs to the extent the demographic mix of the Extension population were to change significantly during the Calendar Year 2016 rate period.

Differences in provider reimbursement rates or provider networks – MCPs were required to report provider reimbursement relative to ODM's reimbursement schedule by population group (CFC, ABD <21, ABD 21+, and Extension) and major service category in the 2014 MCP Survey. Additionally, we received re-priced inpatient claims experience from ODM that allowed us to evaluate MCP inpatient hospital reimbursement relative to ODM's reimburse schedule. In both data sources, we did not observe material differences between provider reimbursement levels for the Extension population and existing Medicaid populations. We are not aware of any provider network differences between the Extension population and other Medicaid populations.

Other material adjustments – We did not make any other adjustments in the Extension rate development process other than those previously outlined in the report.

B. PROJECTED NON-BENEFIT COSTS

i. Changes in Data Sources, Assumptions, or Methodologies Since Last Certification

Cost report data, including non-benefit costs, was available for calendar year 2014. We used this information to evaluate the reasonableness of our non-benefit expense assumptions for the Extension population. As reported non-benefit expenses in the calendar year 2014 cost reports did not differ significantly between the CFC Adult and Extension populations, the non-benefit expense percentage loads have been set equal for the two populations in the development of the calendar year 2016 rates. We have decreased the risk margin for calendar year 2016 based on the Extension population entering year three of its existence and high enrollment growth during the course of 2015.

ii. Assumption Differences Relative to Other Medicaid Populations

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

LIMITATIONS

The information contained in this report has been prepared for the Ohio Department of Medicaid (ODM) to provide documentation of the development of the calendar year 2016 actuarially sound capitation rates for the Medicaid Managed Care Program (MMC). The data and information presented may not be appropriate for any other purpose.

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

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

Milliman has relied upon certain data and information provided by ODM and the participating Medicaid MCPs in the development of the calendar year 2016 capitation rates. Milliman has relied upon ODM and the MCPs for the accuracy of the data and accept it without audit. To the extent that the data provided is not accurate, the capitation rate development would need to be modified to reflect revised information.

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

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

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses contained herein.

APPENDIX 1: 2016 RATE CHANGE SUMMARIES

Ohio Department of Medicaid
CY 2016 Medicaid Managed Care Capitation Rate Development
Rate Change Summary

Region: North Central

Rate Cell	Projected Member Months/Deliveries	January 2015 - December 2015 Capitation Rate	January 2016 - December 2016 Capitation Rate	Total Change
CFC				
HF/HST <1 M+F	56,477	$ 632.26	$ 585.91	(7.33%)
HF/HST 1 M+F	58,227	177.84	147.00	(17.34%)
HF/HST 2-13 M+F	573,465	131.62	116.15	(11.75%)
HF/HST 14-18 M	89,031	162.09	166.95	3.00%
HF/HST 14-18 F	90,702	222.91	217.95	(2.22%)
HF 19-44 M	89,213	293.73	292.22	(0.51%)
HF 19-44 F	267,604	453.36	382.96	(15.53%)
HF 45+ M+F	42,234	725.90	721.29	(0.63%)
HST 19-64 F	25,521	546.44	398.99	(26.98%)
Subtotal - CFC	**1,292,474**	**$ 269.50**	**$ 241.47**	**(10.40%)**
Extension				
EXT 19-34 M	112,937	$ 274.79	$ 317.04	15.38%
EXT 19-34 F	101,715	433.80	363.59	(16.19%)
EXT 35-44 M	52,585	495.90	526.07	6.08%
EXT 35-44 F	42,465	588.70	613.99	4.30%
EXT 45-54 M	53,659	753.62	740.07	(1.80%)
EXT 45-54 F	57,019	907.06	825.04	(9.04%)
EXT 55-64 M	39,807	882.28	921.54	4.45%
EXT 55-64 F	45,618	987.90	813.90	(17.61%)
Subtotal - Extension	**505,806**	**$ 590.31**	**$ 567.59**	**(3.85%)**
ABD				
ABD <21	30,127	$ 456.24	$ 519.12	13.78%
ABD 21 +	91,090	1,368.44	1,587.89	16.04%
Subtotal - ABD	**121,216**	**$ 1,141.72**	**$ 1,322.26**	**15.81%**
CFC & EXT Delivery	**3,643**	**$ 6,564.97**	**$ 6,406.05**	**(2.42%)**
Total	**1,919,496**	**$ 421.57**	**$ 407.81**	**(3.26%)**

Ohio Department of Medicaid
CY 2016 Medicaid Managed Care Capitation Rate Development
Rate Change Summary

Region: Northwest

Rate Cell	Projected Member Months/Deliveries	January 2015 - December 2015 Capitation Rate	January 2016 - December 2016 Capitation Rate	Total Change
CFC				
HF/HST <1 M+F	40,205	$ 557.60	$ 582.28	4.43%
HF/HST 1 M+F	39,387	140.15	148.11	5.68%
HF/HST 2-13 M+F	399,375	122.19	117.78	(3.60%)
HF/HST 14-18 M	64,594	157.76	161.31	2.25%
HF/HST 14-18 F	64,341	195.82	188.65	(3.66%)
HF 19-44 M	56,998	261.11	256.99	(1.58%)
HF 19-44 F	161,642	406.63	365.37	(10.15%)
HF 45+ M+F	23,943	644.62	684.10	6.12%
HST 19-64 F	20,560	392.50	334.73	(14.72%)
Subtotal - CFC	**871,046**	**$ 233.79**	**$ 224.80**	**(3.85%)**
Extension				
EXT 19-34 M	54,344	$ 242.91	$ 290.01	19.39%
EXT 19-34 F	57,067	383.20	347.79	(9.24%)
EXT 35-44 M	26,491	444.08	543.91	22.48%
EXT 35-44 F	26,723	520.39	676.49	30.00%
EXT 45-54 M	27,621	678.26	837.91	23.54%
EXT 45-54 F	33,611	821.25	799.12	(2.69%)
EXT 55-64 M	22,734	794.22	862.61	8.61%
EXT 55-64 F	26,260	889.53	878.24	(1.27%)
Subtotal - Extension	**274,852**	**$ 540.26**	**$ 584.94**	**8.27%**
ABD				
ABD <21	6,309	$ 574.05	$ 518.96	(9.60%)
ABD 21 +	35,129	1,296.06	1,411.81	8.93%
Subtotal - ABD	**41,438**	**$ 1,186.13**	**$ 1,275.86**	**7.57%**
CFC & EXT Delivery	**2,511**	**$ 6,416.62**	**$ 5,666.79**	**(11.69%)**
Total	**1,187,337**	**$ 351.54**	**$ 356.83**	**1.51%**

Ohio Department of Medicaid
CY 2016 Medicaid Managed Care Capitation Rate Development
Rate Change Summary

Region: Southwest

Rate Cell	Projected Member Months/Deliveries	January 2015 - December 2015 Capitation Rate	January 2016 - December 2016 Capitation Rate	Total Change
CFC				
HF/HST <1 M+F	205,016	$ 821.18	$ 851.30	3.67%
HF/HST 1 M+F	207,400	174.22	184.05	5.64%
HF/HST 2-13 M+F	2,191,016	139.98	142.04	1.47%
HF/HST 14-18 M	340,072	180.83	210.22	16.26%
HF/HST 14-18 F	350,175	224.67	235.85	4.98%
HF 19-44 M	311,622	277.26	267.83	(3.40%)
HF 19-44 F	963,012	380.96	363.93	(4.47%)
HF 45+ M+F	159,350	675.48	653.26	(3.29%)
HST 19-64 F	100,093	436.69	358.09	(18.00%)
Subtotal - CFC	**4,827,756**	**$ 260.16**	**$ 259.31**	**(0.33%)**
Extension				
EXT 19-34 M	397,553	$ 243.36	$ 313.38	28.77%
EXT 19-34 F	342,326	383.57	367.33	(4.23%)
EXT 35-44 M	198,146	450.89	505.59	12.13%
EXT 35-44 F	157,048	521.47	573.36	9.95%
EXT 45-54 M	204,272	692.09	746.30	7.83%
EXT 45-54 F	212,248	843.35	761.36	(9.72%)
EXT 55-64 M	146,551	810.77	831.05	2.50%
EXT 55-64 F	172,054	908.25	777.16	(14.43%)
Subtotal - Extension	**1,830,197**	**$ 543.52**	**$ 551.91**	**1.54%**
ABD				
ABD <21	77,439	$ 813.73	$ 892.80	9.72%
ABD 21 +	272,656	1,429.03	1,455.42	1.85%
Subtotal - ABD	**350,095**	**$ 1,292.93**	**$ 1,330.97**	**2.94%**
CFC & EXT Delivery	**12,795**	**$ 6,847.04**	**$ 6,012.13**	**(12.19%)**
Total	**7,008,049**	**$ 398.25**	**$ 400.23**	**0.50%**

Ohio Department of Medicaid
CY 2016 Medicaid Managed Care Capitation Rate Development
Rate Change Summary

Region: South Central

Rate Cell	Projected Member Months/Deliveries	January 2015 - December 2015 Capitation Rate	January 2016 - December 2016 Capitation Rate	Total Change
CFC				
HF/HST <1 M+F	183,324	$ 894.52	$ 904.99	1.17%
HF/HST 1 M+F	186,980	186.61	181.44	(2.77%)
HF/HST 2-13 M+F	1,860,839	140.03	129.57	(7.47%)
HF/HST 14-18 M	289,893	169.48	159.89	(5.66%)
HF/HST 14-18 F	292,935	227.57	211.02	(7.27%)
HF 19-44 M	303,946	286.64	292.13	1.92%
HF 19-44 F	804,386	406.22	394.54	(2.87%)
HF 45+ M+F	146,389	667.14	667.64	0.08%
HST 19-64 F	85,214	421.37	399.97	(5.08%)
Subtotal - CFC	**4,153,907**	**$ 270.28**	**$ 261.70**	**(3.17%)**
Extension				
EXT 19-34 M	319,101	$ 242.05	$ 334.60	38.23%
EXT 19-34 F	283,855	400.87	361.33	(9.86%)
EXT 35-44 M	153,521	457.52	546.03	19.35%
EXT 35-44 F	128,023	709.12	616.05	(13.13%)
EXT 45-54 M	150,076	891.18	794.03	(10.90%)
EXT 45-54 F	159,769	947.18	726.03	(23.35%)
EXT 55-64 M	104,631	842.94	768.78	(8.80%)
EXT 55-64 F	127,599	1,008.62	791.46	(21.53%)
Subtotal - Extension	**1,426,576**	**$ 598.65**	**$ 552.81**	**(7.66%)**
ABD				
ABD <21	61,972	$ 988.17	$ 836.02	(15.40%)
ABD 21 +	277,781	1,391.33	1,432.56	2.96%
Subtotal - ABD	**339,753**	**$ 1,317.79**	**$ 1,323.75**	**0.45%**
CFC & EXT Delivery	**10,646**	**$ 7,549.74**	**$ 5,428.51**	**(28.10%)**
Total	**5,920,235**	**$ 423.09**	**$ 402.56**	**(4.85%)**

Ohio Department of Medicaid
CY 2016 Medicaid Managed Care Capitation Rate Development
Rate Change Summary

Region: Southeast

Rate Cell	Projected Member Months/Deliveries	January 2015 - December 2015 Capitation Rate	January 2016 - December 2016 Capitation Rate	Total Change
CFC				
HF/HST <1 M+F	61,853	$ 720.12	$ 868.00	20.54%
HF/HST 1 M+F	58,631	177.23	167.27	(5.62%)
HF/HST 2-13 M+F	635,969	142.84	141.70	(0.80%)
HF/HST 14-18 M	112,956	191.70	185.69	(3.14%)
HF/HST 14-18 F	112,034	222.50	215.88	(2.98%)
HF 19-44 M	125,937	278.51	253.45	(9.00%)
HF 19-44 F	289,712	419.69	372.72	(11.19%)
HF 45+ M+F	50,807	655.08	610.19	(6.85%)
HST 19-64 F	31,287	447.38	368.91	(17.54%)
Subtotal - CFC	**1,479,186**	**$ 267.92**	**$ 257.72**	**(3.81%)**
Extension				
EXT 19-34 M	129,897	$ 239.93	$ 233.97	(2.48%)
EXT 19-34 F	112,696	396.96	347.84	(12.37%)
EXT 35-44 M	58,681	445.21	466.32	4.74%
EXT 35-44 F	55,844	675.82	582.39	(13.83%)
EXT 45-54 M	62,445	836.74	654.70	(21.76%)
EXT 45-54 F	72,198	904.18	669.49	(25.96%)
EXT 55-64 M	45,777	810.28	797.37	(1.59%)
EXT 55-64 F	57,494	956.62	752.04	(21.39%)
Subtotal - Extension	**595,032**	**$ 587.18**	**$ 501.55**	**(14.58%)**
ABD				
ABD <21	16,683	$ 733.91	$ 708.15	(3.51%)
ABD 21 +	103,587	1,260.87	1,306.30	3.60%
Subtotal - ABD	**120,270**	**$ 1,187.78**	**$ 1,223.32**	**2.99%**
CFC & EXT Delivery	**3,894**	**$ 6,313.13**	**$ 4,806.59**	**(23.86%)**
Total	**2,194,488**	**$ 416.10**	**$ 385.28**	**(7.41%)**

Ohio Department of Medicaid
CY 2016 Medicaid Managed Care Capitation Rate Development
Rate Change Summary

Region: Northeast

Rate Cell	Projected Member Months/Deliveries	January 2015 - December 2015 Capitation Rate	January 2016 - December 2016 Capitation Rate	Total Change
CFC				
HF/HST <1 M+F	216,555	$ 907.31	$ 946.10	4.28%
HF/HST 1 M+F	233,956	168.37	192.72	14.46%
HF/HST 2-13 M+F	2,462,944	126.11	130.69	3.63%
HF/HST 14-18 M	430,989	159.97	171.62	7.28%
HF/HST 14-18 F	436,427	198.89	204.81	2.98%
HF 19-44 M	380,520	245.75	261.77	6.52%
HF 19-44 F	1,192,540	371.68	357.47	(3.82%)
HF 45+ M+F	223,117	588.35	619.51	5.30%
HST 19-64 F	93,206	470.90	395.36	(16.04%)
Subtotal - CFC	**5,670,257**	**$ 249.40**	**$ 253.28**	**1.56%**
Extension				
EXT 19-34 M	543,955	$ 213.37	$ 287.12	34.57%
EXT 19-34 F	481,408	380.76	320.18	(15.91%)
EXT 35-44 M	258,551	440.60	435.73	(1.11%)
EXT 35-44 F	207,929	504.34	518.25	2.76%
EXT 45-54 M	282,759	670.11	644.99	(3.75%)
EXT 45-54 F	294,136	781.56	683.85	(12.50%)
EXT 55-64 M	226,517	846.13	784.41	(7.29%)
EXT 55-64 F	267,187	880.06	668.90	(23.99%)
Subtotal - Extension	**2,562,442**	**$ 532.43**	**$ 495.88**	**(6.86%)**
ABD				
ABD <21	128,370	$ 646.60	$ 675.51	4.47%
ABD 21 +	430,640	1,342.62	1,489.12	10.91%
Subtotal - ABD	**559,010**	**$ 1,182.78**	**$ 1,302.28**	**10.10%**
CFC & EXT Delivery	**15,400**	**$ 5,495.26**	**$ 5,759.83**	**4.81%**
Total	**8,791,709**	**$ 400.86**	**$ 400.78**	**(0.02%)**

Ohio Department of Medicaid
CY 2016 Medicaid Managed Care Capitation Rate Development
Rate Change Summary

Region: Northeast Central

Rate Cell	Projected Member Months/Deliveries	January 2015 - December 2015 Capitation Rate	January 2016 - December 2016 Capitation Rate	Total Change
CFC				
HF/HST <1 M+F	60,968	$ 667.09	$ 654.66	(1.86%)
HF/HST 1 M+F	60,737	154.32	177.88	15.27%
HF/HST 2-13 M+F	614,306	128.92	125.13	(2.94%)
HF/HST 14-18 M	103,495	163.17	165.40	1.36%
HF/HST 14-18 F	103,483	193.29	202.22	4.62%
HF 19-44 M	99,731	232.87	226.77	(2.62%)
HF 19-44 F	272,027	355.87	344.04	(3.33%)
HF 45+ M+F	46,704	525.02	546.04	4.00%
HST 19-64 F	30,588	427.69	362.29	(15.29%)
Subtotal - CFC	**1,392,039**	**$ 232.58**	**$ 228.74**	**(1.65%)**
Extension				
EXT 19-34 M	100,258	$ 196.90	$ 249.59	26.76%
EXT 19-34 F	97,286	351.23	371.60	5.80%
EXT 35-44 M	49,819	405.21	420.87	3.87%
EXT 35-44 F	47,205	464.64	580.23	24.88%
EXT 45-54 M	51,993	615.54	709.46	15.26%
EXT 45-54 F	60,826	717.89	625.36	(12.89%)
EXT 55-64 M	40,477	776.67	757.92	(2.41%)
EXT 55-64 F	52,598	808.92	723.43	(10.57%)
Subtotal - Extension	**500,462**	**$ 490.92**	**$ 505.90**	**3.05%**
ABD				
ABD <21	19,223	$ 767.15	$ 666.17	(13.16%)
ABD 21 +	74,627	1,225.89	1,288.62	5.12%
Subtotal - ABD	**93,850**	**$ 1,131.93**	**$ 1,161.13**	**2.58%**
CFC & EXT Delivery	**3,765**	**$ 4,599.83**	**$ 4,988.51**	**8.45%**
Total	**1,986,351**	**$ 348.88**	**$ 352.08**	**0.92%**

Ohio Department of Medicaid
CY 2016 Medicaid Managed Care Capitation Rate Development
Rate Change Summary

Region: Statewide

Rate Cell	Projected Member Months/Deliveries	January 2015 - December 2015 Capitation Rate	January 2016 - December 2016 Capitation Rate	Total Change
CFC				
HF/HST <1 M+F	824,399	$ 815.34	$ 843.55	3.46%
HF/HST 1 M+F	845,319	172.78	180.04	4.20%
HF/HST 2-13 M+F	8,737,913	134.15	132.16	(1.48%)
HF/HST 14-18 M	1,431,030	169.62	178.32	5.13%
HF/HST 14-18 F	1,450,098	213.70	214.34	0.30%
HF 19-44 M	1,367,968	267.86	268.37	0.19%
HF 19-44 F	3,950,923	390.37	368.84	(5.52%)
HF 45+ M+F	692,545	636.01	640.25	0.67%
HST 19-64 F	386,470	446.61	378.98	(15.14%)
Subtotal - CFC	**19,686,665**	**$ 257.27**	**$ 253.10**	**(1.62%)**
Extension				
EXT 19-34 M	1,658,045	$ 232.32	$ 298.25	28.38%
EXT 19-34 F	1,476,353	388.32	348.58	(10.23%)
EXT 35-44 M	797,795	448.30	485.18	8.23%
EXT 35-44 F	665,237	565.40	572.33	1.23%
EXT 45-54 M	832,826	730.08	713.97	(2.21%)
EXT 45-54 F	889,807	841.18	718.15	(14.63%)
EXT 55-64 M	626,494	830.63	803.50	(3.27%)
EXT 55-64 F	748,811	916.23	741.05	(19.12%)
Subtotal - Extension	**7,695,368**	**$ 552.96**	**$ 528.74**	**(4.38%)**
ABD				
ABD <21	340,123	$ 739.78	$ 738.55	(0.17%)
ABD 21 +	1,285,509	1,358.67	1,448.26	6.59%
Subtotal - ABD	**1,625,632**	**$ 1,229.18**	**$ 1,299.77**	**5.74%**
CFC & EXT Delivery	**52,654**	**$ 6,353.54**	**$ 5,668.77**	**(10.78%)**
Total	**29,007,665**	**$ 401.71**	**$ 395.17**	**(1.63%)**

APPENDIX F

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APPENDIX G

COVERAGE AND SERVICES

1. Basic Benefit Package

Pursuant to OAC rule 5160-26-03(A), with limited exclusions, limitations and clarifications (see OAC rule 5160-26-03(H) and 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 5160-26-03 and this Agreement. For information on Medicaid-covered services, MCPs must refer to the Ohio Department of Medicaid (ODM) website. MCP represents and warrants that services provided by the MCP to Extension Members comport with the Mental Health Parity and Addiction Equity Act (MHPAEA) and shall provide written evidence of such as requested by ODM. The following includes but is not limited to a general list of services covered through the MCP benefit package:

- 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

- Free-standing birth center services in free-standing birth centers as defined in OAC 5160-18-01
- 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 5160-26-03 for ABD and MAGI members. For Adult Extension members, nursing facility stays are covered as long as medically necessary.
- Hospice care
- Behavioral health services (see section G.2.b.iii of this appendix)
- Immunizations (*MCPs must follow the coverage requirements provided by ODM for any newly approved vaccine under the Vaccines for Children (VFC) program)
- Preventive services covered by Ohio Medicaid in accordance with Section 4106 of the Affordable Act and 42 CFR 440.130(c).
- All U.S. Preventive Services Task Force (USPSTF) grade A and grade B preventive services and approved vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) and their administration, without cost-sharing, as provided in section 4106 of the Affordable Care Act. Additionally, MCPs must cover without cost-sharing, services specified under Public Health Service Act section 2713 in alignment with the Alternative Benefit Plan.
- Screening and counseling for obesity provided during an evaluation and management or preventive medicine visit, as described in OAC rule 5160-4-34
- Respite services for Supplemental Security Income (SSI) members under the age of 21, as approved by CMS within the applicable 1915(b) waiver and as described in OAC rule 5160-26-03.
- Telemedicine

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 5160-26-03. For information regarding Medicaid non-covered services, MCPs must refer to the ODM website. The following includes but is not limited to a general list of the services not covered by the FFS program:

- Services or supplies that are not medically necessary
- Treatment of obesity unless 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*
- Sexual or marriage counseling
- Acupuncture and biofeedback services
- Services to find cause of death (autopsy) or services related to forensic studies
- Paternity testing
- Services determined by another third-party payor as not medically necessary.
- Drugs not covered by the Ohio Medicaid pharmacy program as specified in OAC 5160-9-03, including drugs for the treatment of obesity.
- Assisted suicide services, defined as services for the purpose of causing, or assisting to cause, the death of an individual. This does not pertain to withholding or withdrawing medical treatment, nutrition or hydration or to the provision of a service for the purpose

of alleviating pain or discomfort, even if the use may increase the risk of death, so long as the service is not furnished for the specific purpose of causing death.

- Medical services if the service was caused by a provider-preventable condition as defined in 42 CFR 447.26. The prohibition on payment for provider-preventable conditions shall not result in a loss of access to care or services for Medicaid consumers.

MCPs are 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 ODM.

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

b. Limitations & Clarifications

i. Member Cost-Sharing

As specified in OAC rules 5160-26-05(D) and 5160-26-12, 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, MCPs must notify ODM if they intend to impose a co-payment. ODM 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 ODM determines that an MCP's decision to impose a particular co-payment on their members would constitute a significant change for those members, ODM may require the effective date of the co-payment to coincide with the "Open Enrollment" month.

Notwithstanding the preceding paragraph, MCPs must provide an ODM-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 5160-26-05(D) and 5160-26-12, the MCP's payment constitutes payment in full for any covered services and their subcontractors must not charge members or ODM 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 federal law and OAC rules 5160-17-01 and 5160-21-02.2 are met. MCPs must verify that all of the information on the applicable required forms (ODM 03197, ODM 03199, HHS-687 and HHS-687-1 (SPANISH VERSION)) is provided and that the service meets the required criteria before 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. If MCPs have made the determination that the requirements associated with an abortion, sterilization, or hysterectomy were sufficiently met by the facility/provider, then no additional information (i.e. operative notes, history and physical, ultrasound etc.) is required from ancillary providers.

iii. Behavioral Health Services

Coordination of Services: 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, including the publicly funded community behavioral health system. There are a number of Medicaid-covered mental health services available through Ohio Department of Mental Health and Addiction Services (MHA)-certified Community Mental Health Centers (CMHCs) and Medicaid-covered substance abuse services available through Ohio Department of Mental Health and Addiction Services (MHA)-certified Medicaid providers. 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 MHA's CMHCs as well as substance abuse services offered through MHA-certified Medicaid providers.

MCPs must provide Medicaid-covered behavioral health services for members who are unable to timely access services or are unwilling to access services through the publicly funded community behavioral health system as specified in G.2.b.iv..

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

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

- Medicaid-covered prescription drugs when prescribed by an MHA-certified or MHA-certified provider and obtained through an MCP's panel pharmacy.

- Medicaid-covered, provider-administered medications including:

1. Injectable long-acting 2nd generation antipsychotic drugs, haloperidol, haloperidol decanoate, lorazepam, fluphenazine decanoate, and valium when administered by an ODMH-certified provider.
2. Generic buprenorphone for induction and/or titration and vivitrol (injectable naltrexone) when administered by MHA-certified provider.

When administered as a medical benefit, MCPs shall reimburse MHA-certified or MHA-certified providers for Medicaid-covered, provider-administered medications listed above at the lesser of 100% of the provider's cost or 100% of the Ohio Medicaid program fee-for-service reimbursement rate.

- Medicaid-covered services provided by an MCP's panel laboratory when referred by an MHA CMHC or MHA-certified provider;

- Physician services in an Institution for Mental Disease (IMD), as defined in Section 1905(i) of the Social Security Act, as long as the member is 21 years of age and under, or 65 years of age and older.

- The following Medicaid-covered behavioral health services obtained through providers other than those who are MHA-certified CMHCs or MHA-certified providers when arranged/authorized by the MCP:

  Mental Health: MCPs are 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 laboratory services. For Adult Extension members, MCPs are responsible for providing medically necessary psychological services as described in Ohio's CMS-approved Alternative Benefit Package.

  Substance Abuse: MCPs are 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 laboratory services.

v. <u>Limitations:</u>

- MCPs <u>are not</u> responsible for paying for behavioral health services provided through MHA-certified CMHCs and MHA-certified Medicaid providers;

- MCPs are not responsible for payment of partial hospitalization (mental health), inpatient psychiatric care in a private or public free-standing psychiatric

hospital, outpatient detoxification, substance abuse intensive outpatient programs (IOP) or methadone maintenance; and

- MCPs are not responsible for providing mental health services to persons between 22and 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 are not prohibited from contracting with an IMD to provide mental health services to persons between 22 and 64 years of age, but the MCP will not be compensated by Medicaid for the provision of such services (i.e. either through direct payment or considering any associated costs in the Medicaid rate setting process).

vi. Pharmacy Benefit:

a. 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 5160-26-03(A) and (B). However, pursuant to ORC Section 5167.12, MCPs may, subject to ODM approval, implement strategies for the management of drug utilization. (See appendix K.2.f.i).

b. MCPs must participate in quarterly meetings to obtain prior ODM approval of changes to the MCP list of drugs requiring prior authorization. Unless otherwise authorized by ODM, the quarterly meeting process will ensure that the combined list of drugs requiring prior authorization for each MCP results in a combined percentage agreement that is no less than seventy percent. MCPs must publish a thirty (30) days advance notice of changes to the MCP list of drugs requiring prior authorization, via their website, on both the provider and member web pages.

c. MCPs are not permitted to require prior authorization (PA) in the case of a drug to which all of the following apply:

(i) The drug is an antidepressant or antipsychotic.
(ii) The drug is administered or dispensed in a standard tablet or capsule form, except that in the case of an antipsychotic, the drug also may be administered or dispensed in a long-acting injectable form.
(iii) The drug is prescribed by either of the following:
(a) An MCP panel provider psychiatrist;
(b) A psychiatrist practicing at a CMHC;
(iv) The drug is prescribed for a use that is indicated on the drug's labeling, as approved by the federal food and drug administration.

d. Notwithstanding paragraph 31.g of Appendix C, MCPs may require PA for antidepressant or antipsychotic drugs that do not meet the criteria outlined

in paragraph b, above. MCPs must consider the prescribing provider's verification that the member is stable on the specific medication when making the PA decision.

vii. Organ Transplants: MCPs must ensure coverage for organ transplants and related services in accordance with OAC 5160-2-07.1 (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 ODM prior authorization unit. Reimbursement for bone marrow transplant and hematopoietic stem cell transplant services, as defined in OAC 3701:84-01, is contingent upon review and recommendation by the "Ohio Hematopoietic 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. Additionally, in accordance with OAC 5160-2-03 (A)(4) all services related to organ donations are covered for the donor recipient when the consumer is Medicaid eligible.

3. Information Sharing with Non-Panel Providers

To assist members in accessing medically-necessary Medicaid covered services, MCPs are required to share specific information with certain non-panel providers. The information is to assist non-panel providers to recognize MCP membership, access information needed to provide services and if applicable successfully submit claims to the MCP.

a. ODM-Designated Providers

Per OAC rule 5160-26-03.1(A)(4), MCPs must share specific information with MHA-certified CMHCs, MHA-certified Medicaid providers, FQHCs/RHCs, qualified family planning providers [QFPPs], hospitals and if applicable, certified nurse midwives [CNMs], certified nurse practitioners [CNPs], and free-standing birth centers (FBCs) as defined in OAC 5160-18-01 within the MCP's service area and in bordering regions if appropriate based on member utilization information. The information must be shared within the first month after the MCP has been awarded a Medicaid provider agreement for a specific region and annually thereafter. At a minimum, the information must include the following:

- the information's purpose;
- claims submission information including the MCP's Medicaid provider number for each region (this information is only required to be provided to non-panel FQHCs/RHCs, QFPPs, CNMs, CNPs and hospitals);
- the MCP's prior authorization and referral procedures;

- a picture of the MCP's member ID card (front and back);
- contact numbers for obtaining information for eligibility verification, claims processing, referrals/prior authorization, post-stabilization care services and if applicable information regarding the MCP's behavioral health administrator;
- 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 required to be provided to non-panel MHA-certified CMHCs and MHA-certified Medicaid providers).

b. MCP-authorized Providers

Per OAC rule 5160-26-05(A)(6), MCPs authorizing the delivery of services from a non-panel provider 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 5160-26-05. This notice is provided when an MCP authorizes a non-panel provider to furnish services on a one-time or infrequent basis to an MCP member and must include required ODM-model language and information. This notice must also be included with the transition of services form sent to providers as outlined in Section 31. of Appendix C.

APPENDIX H

PROVIDER PANEL SPECIFICATIONS

1. FEDERAL ACCESS STANDARDS

MCPs must provide or arrange for the delivery of all medically necessary, Medicaid-covered health services, as well as ensure 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 provided by 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 the Ohio Department of Medicaid (ODM), in a format specified by ODM, 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 ODM no less frequently than at the time the MCP enters into a contract with ODM; at any time there is a significant change (as defined by ODM) in the MCP's operations that would affect adequate

capacity and services (including changes in services, benefits, geographic service or payments); and at any time there is enrollment of a new population in the MCP.

2. GENERAL PROVISIONS

The ODM provider panel requirements are specified in the charts included with this appendix and must be met prior to the MCP receiving a provider agreement with ODM. 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.

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, ODM considered, on a county-by-county basis, the population size and utilization patterns of the Ohio Medicaid ABD,MAGI, and Adult Extension consumers, as well as the potential availability of the designated provider types. ODM has integrated existing utilization patterns into the provider network requirements to avoid disruption of care. Most provider panel requirements are county-specific but in certain circumstances, ODM requires providers to be located anywhere in the region.

ODM will recalculate the minimum provider panel specifications if ODM determines that significant changes have occurred in the availability of specific provider types and the number and composition of the eligible population. The Managed Care Provider Network (MCPN) is the tool that will be used for ODM to determine if the MCPs meet all the panel requirements that are identified within Appendix H; therefore, the plans must enter all network providers as specified within the file specs.

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

3. PROVIDER SUBCONTRACTING

Unless otherwise specified in this appendix or OAC rule 5160-26-05, 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 ODM-approved Model Medicaid Addendum. The Model Medicaid Addendum incorporates all applicable OAC rule requirements specific to provider subcontracting and therefore cannot be modified except to add personalizing information such as the MCP's name.

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. Only those providers who meet the applicable criteria specified in this document, and as determined by ODM, will be counted toward meeting minimum panel requirements. MCPs must credential/re-credential providers in accordance with OAC rule 5160-26-05. The MCP must ensure that the provider has met all applicable credentialing criteria before the provider can, be listed as a panel provider. At the direction of ODM, the MCPs must submit documentation verifying that all necessary contract documents have been appropriately completed.

The MCPN is a centralized database system that maintains information on the status of all MCP-submitted providers. MCPs must notify ODM of the addition and deletion of their contracting providers as specified in OAC rule 5160-26-05, and must notify ODM 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. For provider deletions, MCPs must complete and submit an electronic record terminating the provider from the MCPN or other designated system.

4. PROVIDER PANEL REQUIREMENTS

The provider network criteria that 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]), physician assistants, or an advanced practice registered nurse (APRN) 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. 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 ODM.

In order for the PCP to count toward minimum provider panel requirements, each PCP must agree to serve at least 50 Medicaid MCP members at each practice site As part of the MCP's subcontract with a PCP, MCPs must ensure the total Medicaid member capacity is not greater than 2,000 for that individual PCP.

The PCP capacity for a county is the total amount of members that all of the PCPs in an MCP agree to serve in that county. ODM will determine the PCP capacity based on information submitted by the MCP through the MCPN. The PCP capacity must exceed by at least 5% the total number of members enrolled in the MCP during the preceding month in the same county. ODM will determine an MCP's compliance with this PCP capacity requirement each quarter using the ODM enrollment report for the previous month. For example, in April, ODM will review an MCP's countable PCP capacity using one of the April MCPN reports. The countable capacity will be compared to the finalized enrollment report for March.

ODM recognizes that 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.

In addition to the PCP capacity requirement, MCPs 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

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 ODM-specified county within the region or anywhere within the region if no particular county is specified). A full-time practice is defined as one where the provider is available to patients at their practice site(s) in the specified county/region for at least 25 hours a week. ODM will monitor access to services through a variety of data sources, including: consumer satisfaction surveys; member appeals/grievances/complaints and state hearing notifications/requests; clinical quality studies; encounter data volume; provider complaints, and clinical performance measures.

In addition to the PCP capacity requirements, each MCP is also required to maintain adequate access in the remainder of its provider network within the following categories: hospitals, dentists, vision care providers, OB/GYNs, allergists, 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).

Hospitals - MCPs must contract with the number and type of hospitals specified by ODM for each county/region. In developing these hospital requirements, ODM considered, on a county-by-county basis, the population size and utilization patterns of the Ohio Medicaid ABD, MAGI, and Adult Extension consumers and integrated the existing utilization patterns into the hospital network requirements to avoid disruption of care. For this reason, ODM may require that MCPs contract with out-of- state hospitals (i.e. Kentucky, West Virginia, etc.).For each Ohio hospital, ODM utilizes the hospital's most current Annual Hospital Registration and Planning Report, as filed with the Ohio Department of Health (ODH), in verifying types of services that hospital provides. Although ODM has the authority, under certain situations, to obligate a non-contracting hospital to provide non-emergency hospital services to an MCP's members, MCPs must still contract with the specified number and type of hospitals unless ODM approves a provider panel exception (see Section 5 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 at least the minimum 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 which 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 at least the minimum 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 ODM-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 at least the minimum number of 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 ODM 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 ODM 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.

Additionally, MCPs must:

- Provide FQHCs/RHCs the MCP's Medicaid provider number(s) for each region to enable FQHC/RHC providers to bill for the ODM wraparound payment.

- Educate their staff and providers on the need to ensure 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 ensure member access to all Medicaid-covered behavioral health services for members as specified in Appendix G.2. b.iii. herein. Although ODM is aware that certain outpatient substance abuse services may only be available through Medicaid providers certified by the Ohio Department of Mental Health and Addiction Services (MHA) in some areas, MCPs must maintain an adequate number of contracted mental health providers in the region to ensure access for members who are unable to timely access services or unwilling to access services through community mental health centers. MCPs may contract with ODMH community mental health centers and/or MHA alcohol and other drug treatment providers for medical services based on MCP business or operational needs intended to enhance patient-centered medical home and care coordination. These contracts must expressly prohibit payment for services for which the non-federal share of the cost is provided by a board of alcohol, drug addiction and mental health services or a state agency other than ODM.

Pharmacies – Each MCP must provide or arrange for the delivery of all medically necessary Medicaid-covered pharmacy services. When medically necessary, compounding service and same-day home delivery must also be provided or arranged.

Each MCP's pharmacy network must include at least one retail pharmacy provider per county unless any of the following apply:

(1) no retail pharmacies are located in the county;
(2) the MCP has offered the retail pharmacies in the county the opportunity to contract with the MCP at similar rates offered by the Medicaid fee-for-service program so it is anticipated that aggregate payment for dispensed drugs will not be less than the aggregate amount reimbursed by the Medicaid fee-for-service program; or
(3) available retail pharmacies in a county fail to meet the MCP's quality or program integrity standards.

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

Effective July 1, 2015:

- MCP must update maximum allowable cost (MAC) and other pricing benchmarks on a schedule at least as consistent as is required by CMS for Medicare Part D plans found at 42 CFR 423.505(b)(21); and
- MCP must work cooperatively with ODM and its designees, providing ODM with sufficient data and information to enable ODM to secure federal drug rebates for drugs administered to members at pharmacies as well as at physician offices, clinics, and other non-institutional settings. Each MCP must also assist ODM and its designees with the

resolution of drug manufacturer disputes regarding claims for federal drug rebates for drugs dispensed or administered to an MCP's member.

- MCP must establish Medicaid-specific BIN and PCN numbers for point-of-sale pharmacy claims processing, to ensure that MCP's BIN and PCN numbers for Medicaid claims are not the same as for the MCP's commercial or Medicare part D business lines.

Other Specialty Types (allergists, pediatricians, general surgeons, otolaryngologists, orthopedists for the MAGI populationand general surgeons, otolaryngologists, orthopedists, cardiologists, gastroenterologists, nephrologists, neurologists, oncologists, podiatrists, physiatrists, psychiatrists, and urologists for the ABD and Adult Extension populations) - MCPs must contract with at least the minimum number of ODM designated specialty provider types. In order to be counted toward meeting the provider panel requirements, these specialty providers 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.

5. PROVIDER PANEL EXCEPTIONS

Failure to contract with, and properly report to the MCPN, the minimum necessary panel will result in sanctions as outlined in Appendix N. ODM will grant an exception to the issuance of a sanction only when an action taken by ODM has adversely impacted a plan's ability to meet the provider panel network standards.

6. PROVIDER DIRECTORIES

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

MCP provider directories must utilize a format specified by ODM. 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 executing a provider agreement with ODM, all MCPs must develop a printed provider directory that shall be prior-approved by ODM. Once approved, this directory may be regularly updated with provider additions or deletions by the MCP without ODM prior-approval.

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.

Internet Provider Directory

MCPs are required to have an internet-based provider directory available in a format prior approved by ODM. 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 ODM-required provider types listed on the charts included with this appendix. ODM-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.

7. MANAGED CARE PROVIDER NETWORK PERFORMANCE MEASURES

ODM contracts with an External Quality Review Organization (EQRO), to conduct telephone surveys of providers' offices to validate information submitted in the MCPN files. These results will be used to evaluate MCP performance on a SFY basis. Sanctions for these measures are included in Appendix N of this agreement.

The following elements are included in the development of the composite performance measure:

- Rate of primary care provider (PCP) locations that were able to be reached
- Participating PCP locations still contracted with the MCP
- PCP locations accepting new members

In each quarterly telephone audit, these elements are defined by the following measures: Measure 1 (M1) identifies the proportion of the PCP locations not reached during a quarterly audit. The PCP was considered "not reached" after meeting one of the following three conditions: (1) the provider is no longer practicing at the sampled location, (2) the provider did not return phone calls after the EQRO made two contact attempts at different times during the survey, or (3) the provider declined to participate in the survey when contacted. The measure is an inverse measure such that the higher the percentage of PCP locations not reached, the lower the level of performance.

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

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

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

Measure 3 (M3) examines the percentage of PCP locations whose response to the telephone survey question regarding the acceptance of new patients matched the data contained in the MCPN file.

$$\text{(M3) Accepting New Patient Field Accuracy Rate} = \frac{\text{Number of PCP Locations with Accepting New Patients Response Matched with Those in MCPN File}}{\text{Number of Reached PCP Locations Still Contracted With MCP}}$$

During the first two years of implementing new performance measures the performance standards will be established from the baseline results. This method ensures that the initial standards are clearly defined in relation to current MCP performance. In the third year, following implementation of these measures, the standards would begin to incorporate performance levels supported by the historical analysis.

Measure 1: PCP Locations Not Reached

For measure 1, the standards during the first two years following implementation of the measure will be based on the distribution of MCPs' scores during the baseline period. The standard for Year 3 takes into account the historical statewide average over the first two years.

Table 1—Performance Standards for Measure 1: *PCP Location Not Reached*		
Year	**Proposed Standard**	**Methodology**
Year 1[1]	TBD	Upper 95% confidence limit from the statewide average during the baseline period
Year 2	TBD	Statewide average from the baseline period
Year 3	TBD	Five percentage points below the Year 2 standard

[1]Year 1 is considered the first year performance benchmarks are implemented.

Measure 2: PCP Locations Not Contracted With MCP

For Measure 2, the proposed standards are based on the distribution of MCPs' scores during the baseline period for the first two years following implementation of the measure. The standard for Year 3 takes into account the historical statewide average over the first two years.

Table 2—Performance/Compliance Standards for Measure 2: *PCP Location Not Contracted with MCP*		
Year	**Proposed Standard**	**Methodology**
Year 1[1]	TBD	Upper 95% confidence limit from the statewide average during the baseline period
Year 2	TBD	Statewide average from the baseline period
Year 3	TBD	Two standard deviations above the historical statewide average

[1]Year 1 is considered the first year performance standards are implemented.

Measure 3: Accepting New Patient Field Accuracy Rate

For Measure 3, the proposed standards for the first two years are based on baseline estimates. The standard for Year 3 takes into account the anticipated improvement in performance made by the MCPs over the first two years.

Table 3— Performance/Compliance Standards for Measure 3: *Accepting New Patient Field Accuracy Rate*		
Year	**Proposed Benchmark**	**Methodology**
Year 1[1]	TBD	Upper 95% confidence limit from baseline estimate for overall MCP
Year 2	TBD	Statewide average from baseline estimate for overall MCP
Year 3	TBD	Seven percentage points above Year 2

[1]Year 1 is considered the first year performance standards are implemented.

West Region	Adams	Allen	Auglaize	Brown	Butler	Champaign	Clark	Clermont	Clinton	Darke	Defiance	Fulton	Greene	Hamilton	Hancock	Hardin	Henry	Highland	Lucas
Total PCP Member Capacity	At least 5% more than previous month's member enrollment for each county																		
Minimum Contracted PCPs	5.0	9.0	3.0	5.0	27.0	3.0	16.0	13.0	4.0	3.0	3.0	3.0	9.0	66.0	5.0	2.0	2.0	5.0	55.0

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

Hospitals																			
General Hospital		1					1		1	1	1	1	1	1	1			1	
Hospital System														2					1

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

Practitioners																			
Allergists		1												4					1
Cardiovascular														1					1
Dentists	1	5	1	1	13	1	6	5	1	1		2	3	34	2	1	1	3	26
Gastroenterology																			1
General Surgeons		1			3		3	2	2				3	10				2	2
Nephrology																			
Neurology																			1
OB/GYNs		3		2	3		3	1	1				2	13	1				7
Oncology																			
Orthopedists		3			3								2	7	2				3
Otolaryngologist		1			1		1							4					3
Pediatricians		4			7		2	2	1		1		3	39	1				23
Physical Med Rehab																			1
Podiatry					1									2					2
Psychiatry		1											1	3					3
Urology																			1
Vision		3	1		4		3	1	2	1	2		3	14	1			2	9

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

West Region	Mercer	Miami	Montgomery	Ottawa	Paulding	Preble	Putnam	Sandusky	Seneca	Shelby	Van Wert	Warren	Williams	Wood	Wyandot	Additional Required: In-Region	Total
Total PCP Member Capacity	At least 5% more than previous month's member enrollment for each county																
Minimum Contracted PCPs	2.0	6.0	51.0	3.0	2.0	3.0	2.0	5.0	5.0	3.0	2.0	6.0	4.0	5.0	2.0	36.0	375.0
*Any additional required capacity must be located within the region.																	
Hospitals																	
General Hospital	1	1	1					1		1	1		1		1	4	22
Hospital System			1														4
*General hospitals must provide obstetrical services if such a hospital is available in the county/region.																	
Practitioners																	
Allergists			2													10	18
Cardiovascular			1									1				6	10
Dentists	1	3	23	1			1	3	2	1	1	3	1	2	1	11	161
Gastroenterology																4	5
General Surgeons		1	4									1		1		6	41
Nephrology																3	3
Neurology																5	6
OB/GYNs	1	1	9					2	2	1		2		2		4	60
Oncology																3	3
Orthopedists		3	3					1		1				1		7	36
Otolaryngologist			4									1				10	25
Pediatricians		1	22					1						2		31	140
Physical Med Rehab																5	6
Podiatry			2											1		5	13
Psychiatry			2													7	17
Urology																6	7
Vision	2	2	13					2		1	1	2	1	2		9	81
*All required providers and additional required providers must be located within the region.																	

Northeast Region	Ashland	Ashtabula	Carroll	Columbiana	Cuyahoga	Erie	Geauga	Holmes	Huron	Lake	Lorain
Total PCP Member Capacity	At least 5% more than previous month's member enrollment for each county										
Minimum Contracted PCPs	4.0	12.0	3.0	12.0	148.0	6.0	2.0	2.0	6.0	11.0	25.0

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

Hospitals											
General Hospital	1	1		1	1	1	1	1	1	1	1
Hospital System					1						

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

Practitioners											
Allergists					2						1
Cardiovascular					3						1
Dentists	3	3		3	85	2	1		2	6	11
Gastroenterology					2						
General Surgeons				2	18	2			2	2	3
Nephrology					1						
Neurology					2						
OB/GYNs		1		2	24	2			1	1	3
Oncology											
Orthopedists					12	1				1	3
Otolaryngologist					3						2
Pediatricians	1	1		2	66	2				3	8
Physical Med Rehab					2						
Podiatry					4						2
Psychiatry					5						3
Urology					2						
Vision		3			32	2	1		2	6	11

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

Northeast Region	Mahoning	Medina	Portage	Richland	Stark	Summit	Trumbull	Tuscarawas	Wayne	Additional Required: In-Region	Total Required
Total PCP Member Capacity	At least 5% more than previous month's member enrollment for each county										
Minimum Contracted PCPs	27.0	7.0	9.0	12.0	31.0	45.0	20.0	8.0	7.0	10.0	407.0
*Any additional required capacity must be located within the region.											
Hospitals											
General Hospital	1	1	1	1	1	1	1	1	1	2	21
Hospital System						1				1	3
* General hospitals must provide obstetrical services if such a hospital is available in the county/region.											
Practitioners											
Allergists					1	1				4	9
Cardiovascular	1				1	1				4	11
Dentists	14	4	3	7	17	23	11	4	3	3	205
Gastroenterology										4	6
General Surgeons	4	2	1	3	4	6	2	1	2	5	59
Nephrology										3	4
Neurology										4	6
OB/GYNs	4	1		1	7	12	3		1	7	70
Oncology										3	3
Orthopedists	3	1		1	2	3	1		1	11	40
Otolaryngologist	2				3	3				7	20
Pediatricians	10	3	2	3	14	20	6	2	2	17	162
Physical Med Rehab										4	6
Podiatry					1	2				4	13
Psychiatry	3				2	3	2			5	23
Urology										5	7
Vision	5	4		2	7	13	4			8	100
*All required providers and additional required providers must be located within the region.											

Central/Southeast Region	Athens	Belmont	Coshocton	Crawford	Delaware	Fairfield	Fayette	Franklin	Gallia	Guernsey	Harrison	Hocking	Jackson	Jefferson	Knox	Lawrence	Licking	Logan
Total PCP Member Capacity	At least 5% more than previous month's member enrollment for each county																	
Minimum Contracted PCPs	6.0	7.0	4.0	4.0	5.0	10.0	3.0	120.0	5.0	6.0	2.0	4.0	5.0	8.0	5.0	10.0	13.0	4.0
*Any additional required capacity must be located within the region.																		
Hospitals																		
General Hospital	1	1	1	1		1	1	1	1	1				1	1		1	1
Hospital System								2										
*General hospitals must provide obstetrical services if such a hospital is available in the county/region.																		
Practitioners																		
Allergists								2										
Cardiovascular								2	1									
Dentists	3	4	1	1	3	4	1	60	1	3		1	1	3	3	3	4	1
Gastroenterology								1										
General Surgeons		2		1	2	3		20	2	2				2	1		1	1
Nephrology								1										
Neurology								1										
OB/GYNs	2				3	3		18		2				2	1		1	
Oncology																		
Orthopedists						2		10	2								2	
Otolaryngologist					2			14	2						1		1	1
Pediatricians	1	1			4	3		55	2	1				1	1		2	1
Physical Med Rehab								1										
Podiatry		1			1			3										
Psychiatry		1				1		5										
Urology																		
Vision	3	4	1	2	3	3		20	2	2			2	3	2	3	2	2
*All required providers and additional required providers must be located within the region.																		

Central/Southeast Region	Madison	Marion	Meigs	Monroe	Morgan	Morrow	Muskingum	Noble	Perry	Pickaway	Pike	Ross	Scioto	Union	Vinton	Washington	Additional Required: In-Region	Total Required
Total PCP Member Capacity	At least 5% more than previous month's member enrollment for each county																	
Minimum Contracted PCPs	3.0	7.0	4.0	1.0	2.0	3.0	12.0	2.0	5.0	5.0	5.0	10.0	13.0	3.0	1.0	6.0	14.0	317.0
*Any additional required capacity must be located within the region.																		
Hospitals																		
General Hospital	1	1					1			1		1	1	1		1	6	27
Hospital System																		2
General hospitals must provide obstetrical services if such a hospital is available in the county/region																		
Practitioners																		
Allergists																	3	5
Cardiovascular																	4	7
Dentists	1	3				1	4		1	1	1	4	2	1		3	16	135
Gastroenterology																	4	5
General Surgeons		1					2			1		2	2	1		1	6	53
Nephrology																	2	3
Neurology																	2	3
OB/GYNs		1					2					1	1			2	10	49
Oncology																	2	2
Orthopedists		2										2					9	29
Otolaryngologist		1					2					1	1	1			3	30
Pediatricians	1	2					2			1		2	2	1		1	33	117
Physical Med Rehab																	4	5
Podiatry							1										5	11
Psychiatry							1										6	14
Urology																	6	6
Vision		2					4			1		2	2	1		2	11	79
*All required providers and additional required providers must be located within the region.																		

Nursing Facility Provider Panel

MCPs will be held accountable to these standards effective SFY 2017.

Region	County	Nursing Facility Requirement
W	ADAMS	1
W	ALLEN	2
NE	ASHLAND	1
NE	ASHTABULA	3
CEN/SE	ATHENS	1
W	AUGLAIZE	1
CEN/SE	BELMONT	2
W	BROWN	1
W	BUTLER	5
W	CHAMPAIGN	1
W	CLARK	3
W	CLERMONT	2
W	CLINTON	1
NE	COLUMBIANA	3
CEN/SE	COSHOCTON	1
CEN/SE	CRAWFORD	1
NE	CUYAHOGA	19
W	DARKE	1
W	DEFIANCE	1
CEN/SE	DELAWARE	1
NE	ERIE	2
CEN/SE	FAIRFIELD	2
CEN/SE	FAYETTE	1
CEN/SE	FRANKLIN	11
W	FULTON	1
CEN/SE	GALLIA	1
NE	GEAUGA	1
W	GREENE	2
CEN/SE	GUERNSEY	1
W	HAMILTON	14
W	HANCOCK	1
CEN/SE	HARRISON	1
W	HENRY	1
W	HIGHLAND	1
NE	HOLMES	1
NE	HURON	1
CEN/SE	JACKSON	1
CEN/SE	JEFFERSON	2
CEN/SE	KNOX	2
NE	LAKE	2
CEN/SE	LAWRENCE	1
CEN/SE	LICKING	2
CEN/SE	LOGAN	1
NE	LORAIN	4
W	LUCAS	7
NE	MAHONING	5
CEN/SE	MARION	1
NE	MEDINA	2
W	MERCER	1
W	MIAMI	1
W	MONTGOMERY	8
CEN/SE	MORROW	1
CEN/SE	MUSKINGUM	1
W	OTTAWA	1
CEN/SE	PERRY	1
CEN/SE	PICKAWAY	1
CEN/SE	PIKE	1
NE	PORTAGE	2
W	PREBLE	1
W	PUTNAM	1
NE	RICHLAND	2
CEN/SE	ROSS	1
W	SANDUSKY	2
CEN/SE	SCIOTO	2
W	SENECA	1
W	SHELBY	1
NE	STARK	7
NE	SUMMIT	9
NE	TRUMBULL	4
NE	TUSCARAWAS	2
CEN/SE	UNION	1
W	VANWERT	1
W	WARREN	3
CEN/SE	WASHINGTON	1
NE	WAYNE	2
W	WILLIAMS	1
W	WOOD	2

APPENDIX I

PROGRAM INTEGRITY

MCPs must comply with all applicable state and federal program integrity requirements, including, but not limited to, 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 5160-26-06, 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 5160-26-06, 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. Credible allegations of fraud: MCPs must monitor activities on an ongoing basis to prevent and detect activities involving suspected fraud, embezzlement, and theft (e.g., by staff, providers, contractors, etc.) and report promptly as specified in this appendix..

ii. Underutilization of services: In order to assure that all Medicaid-covered services are being provided as required, the following areas must be monitored:

a. The MCPs must annually review their prior authorization (PA) procedures to determine if they unreasonably limit a member's access to Medicaid-covered services;

b. The MCPs must annually review their appeals process for providers following the MCP's denial of a prior authorization request to determine if the appeals process unreasonably limits a member's access to Medicaid-covered services;

c. MCPs must monitor, on an ongoing basis, service denials and utilization in order to identify member services which may be underutilized; and

d. If any underutilized services or limits to a member's access to Medicaid-covered services are identified, the MCP must immediately investigate and, if indicated, correct the problem(s).

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 unbundling, to the satisfaction of the Ohio Department of Medicaid (ODM).

iv. Reporting MCP monitoring of fraud and abuse activities: Pursuant to OAC rule 5160-26-06, the MCP is required to report annually to ODM a summary of the MCP's monitoring of credible allegations of fraud and abuse, underutilization of member services, limits to Medicaid-covered services, and suspicious claims

submission and billing. The MCP's report must also identify any proposed changes to the MCP's compliance plan for the coming year.

c. Reporting Suspected fraud and abuse: MCPs are required to promptly report all instances of suspected provider and member fraud and abuse.

i. Credible allegation of provider fraud: MCPs must promptly refer suspected cases of provider fraud in the ODM specified form to ODM for investigation and determination of whether a credible allegation of fraud exists. If a credible allegation of fraud exists, at the direction of ODM, the MCP must immediately suspend all payments to the provider and must suspend the provider in accordance with Ohio Rev. Code 5164.36. At the request of ODM staff, ODM's designee, the Ohio Attorney General's Office, or federal agencies, the MCP must produce copies of all MCP fraud, waste and abuse investigatory files and data (including, but not limited to records of recipient and provider interviews) in thirty business days unless otherwise agreed upon by ODM.

ii. Credible allegation of member fraud: MCPs are required to promptly report all suspicions of member fraud to ODM for investigation by e-mail to Program_Integrity_County_Referral@medicaid.ohio.gov and copy the appropriate County Department of Job and Family Services (CDJFS).

d. Attestations: The MCP must respond to ODM-initiated fraud, waste and abuse referrals with attestations in the form specified by ODM within 90 days of referral receipt.

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.

f. The MCP must disclose any change in ownership and control information and this information must be furnished to ODM within 35 days in accordance with 42 CFR 455.104 and 5160-1-17.3.

g. In accordance with 42 CFR 455.105, the MCP must submit within 35 days of the date requested by ODM or HHS full and complete information about:

i. the ownership of any subcontractor with whom the MCP has had business transactions totaling more than $25, 000 during the 12-month period ending on the date of the request.

ii. any significant business transactions between the MCP and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

h. The MCP must disclose the following information on persons convicted of crimes in accordance with 42 CFR 455.106 who:
   i. has ownership or control interest in the provider, or is an agent or managing employee of the provider; and
   ii. has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

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

i. In accordance with 42 CFR 1002.3(b), MCPs must notify ODM when the MCPs deny credentialing to providers for program integrity reasons.

j. Non-federally qualified MCPs must report to ODM a description of certain transactions with parties of interest as outlined in section 1903(m)(4)(A) of SSA [42 U.S.C. 1396b].

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 ODM which may affect MCP payment.

a. MCP Submissions: MCPs must submit the appropriate ODM-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. Care Management Data [as specified in the Data Quality Appendix (Appendix L)]

   v. HEDIS IDSS Data/FAR [as specified in the Data Quality Appendix (Appendix L)]

   vi. CAHPS 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,

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

MCPs must provide certification as to the accuracy, completeness, and truthfulness of additional submissions.

3. Pursuant to 42 CFR 455.20, MCPs must have a method for verifying with enrollees whether services billed by providers were received. Therefore, the MCP is required to conduct a mailing of Explanation of Benefits (EOBs) to a 95% confidence level (plus or minus 5 percent margin of error) random sample of the MCP's enrollees once a year. As an option, the MCP may meet this requirement by using a strategy targeting services or areas of concern as long as the number of mailed EOBs is not less than the number generated by the random sample described above. Any MCP opting to use a targeted mailing must submit the proposed strategy in writing to ODM, and receive written prior approval from ODM. The EOB mailing must only include those members that have received health care services within the last six months, comply with all state and federal regulations regarding release of personal health information, outline the recent medical services identified as having been provided to the enrollee, and request that the enrollee report any discrepancies to the MCP. MCPs must inform their Contract Administrator of the date of the EOB mailing and provide results of the mailing 60 to 90 days after the mailing (i.e., number mailed, number of enrollees reporting discrepancies).

4. Breaches of Protected Health Information: MCPs must report the number of breaches of protected health information (PHI) and specify how many breaches were reported to HHS as required by 45 CFR Part 164.408 (b) and (c). This report must be submitted annually as indicated on the "MCP Calendar of Required Submissions."

APPENDIX J

FINANCIAL PERFORMANCE

1. SUBMISSION OF FINANCIAL STATEMENTS AND REPORTS

MCPs must submit the following financial reports to the Ohio Department of Medicaid (ODM):

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 5160-26-09(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 and the Modified Supplemental Health Care Exhibit. The Financial Statements must be submitted to ODM even if the Ohio Department of Insurance (ODI) does not require the MCP to submit these statements to ODI. An electronic copy of the reports in the NAIC-approved format must be provided to ODM;

b. 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 5160-26-09(B);

d. Quarterly and Annual Medicaid MCP ODM Cost Reports for all covered populations specified in Appendix B of this Agreement and the auditor's certification of the cost report, as outlined in OAC rule 5160-26-09(B);

1. The annual and quarterly cost reports must adhere to the ODM Provider Agreement, and be submitted in accordance with the cost report instructions and within established timeframes.

2. Annual and quarterly cost reports must be revised in accordance with the actuaries' observation log and/or ODM instructions.

3. All non-mandatory observations identified in the actuary observation log must be appropriately addressed and responses submitted within established timeframes by ODM.

e. Annual physician incentive plan disclosure statements and disclosure of and changes to the MCP's physician incentive plans, as outlined in OAC rule 5160-26-09(B);

f. Reinsurance agreements, as outlined in OAC rule 5160-26-09(C);

g. Prompt Pay Reports, in accordance with OAC rule 5160-26-09(B). An electronic copy of the reports in the ODM-specified format must be provided to ODM;

h. Notification of requests for information and copies of information released pursuant to a tort action (i.e., third party recovery), as outlined in OAC rule 5160-26-09.1;

i. Financial, utilization, and statistical reports, when ODM requests such reports, based on a concern regarding the MCP's quality of care, delivery of services, fiscal operations or solvency, in accordance with OAC rule 5160-26-06(D);

j. MCPs must submit ODM-specified reports for the calculation of items 2.b, 2.c and 2.d below in 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 ODI authority, ODM's emphasis is on the assurance of access to and quality of care. ODM will focus only on a limited number of indicators and related standards to monitor MCP financial performance. The five indicators and standards for this Agreement period are identified below. The source for each indicator will be the NAIC Quarterly and Annual Financial Statements and Modified Supplemental Health Care Exhibit. The measurement period that will be used to determine compliance will be the annual Financial Statement and Modified Supplemental Health Care Exhibit.

a. **Indicator: Current Ratio**

Please refer to the ODM Methods for Financial Performance Measures for the definition and calculations for the Current Ratio.

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

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

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

c. **Indicator: Administrative Expense Ratio**

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

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

d. **Indicator: Overall Expense Ratio**

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

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

e. **Indicator: Defensive Interval**

Please refer to the ODM Methods for Financial Performance Measures for the definition and calculations for the Defensive Interval indicator.

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

Penalty for noncompliance: Noncompliance with the above standards (a. through e.) will result in penalties, as outlined in Appendix N of this Provider Agreement.

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

3. REINSURANCE REQUIREMENTS

Pursuant to the provisions of OAC rule 5160-26-09(C), the MCP 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 $100,000.00, unless ODM has provided the MCP with prior approval in writing for a higher deductible amount or alternate reinsurance arrangement. Except for transplant services, and as provided below, this reinsurance must cover, at a minimum, 80% of inpatient costs incurred by one member in one year, in excess of $100,000.00 unless ODM has provided the MCP with prior approval in writing for a higher deductible amount or alternate reinsurance arrangement.

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

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

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

b. The MCP's history in complying with financial indicators 2.a., 2.b., 2.c. 2.d and 2.e, 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.

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 ODM upon request:

a. A description of the types of physician incentive arrangements the MCP has in place which indicates whether they involve a withhold, bonus, capitation, or other arrangement. If a physician incentive arrangement involves a withhold or bonus, the percent of the withhold or bonus 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 ODM no later than one working day after receipt from ODI. The ODM 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 ODM procedures. Failure to comply with this provision will result in an immediate enrollment freeze.

Appendix K

Quality Care

This Appendix establishes program requirements and expectations related to Managed Care Plan's (MCP's) responsibilities for developing and implementing a population health management program; developing and implementing a Quality Assessment and Performance Improvement program; and participating in external quality review activities. These program requirements support the priorities and goals set forth in the Ohio Medicaid Quality Strategy.

1. Population Health Management

   The Ohio Department of Medicaid seeks to improve the health of the Ohio Medicaid population by identifying and monitoring individual patients within specified groups. A well designed population health management program is driven by clinical, financial, and operational data from across delivery systems that provides actionable data that can be used to improve quality of care, patient experience, and reduce costs of care. Care management is a critical component of population health management. It brings together well-managed clinician-MCP partnerships, patient self-management, preventive and acute care services, medication management, etc., in an effort to improve the health of a population. This also entails a shift in the locus of responsibility for population health from the payor to the provider when willing and capable. In this instance, the payor, or MCP, must support this provider arrangement. When providers are not ready to fully accept this responsibility, the MCP will perform the population health management activities and integrate the provider's efforts, when possible. To further assist with this transformation, the MCP shall support, and connect members to, patient-centered medical homes (PCMHs).

   The following section outlines the population health and care management requirements that an MCP must address as part of its model of care. Each MCP is required to develop a model of care that broadly defines the way services will be delivered by the MCP.

   The MCP must address the following components as part of its model of care:

   a. Description of the population and specialized services: A comprehensive description of the MCP's population and the specialized services and resources that are tailored to the population are key to the model of care. This section of the model of care must address the following components:

      i. Risk stratification levels: The MCP must develop a risk stratification level framework for the purpose of targeting interventions and allocating resources based on the member's needs. Using a risk stratification framework comprised of five levels (i.e., from lowest to highest: monitoring, low, medium, high and intensive), the MCP will determine the appropriate risk stratification level based on assessed needs.

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

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

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

ii. Population stream: ODM established five population streams—women of reproductive age, behavioral health, chronic conditions, healthy children and healthy adults—that will be used to organize work around population health. The MCP must develop a strategy that assigns each member to a single population stream in accordance with ODM's population stream and corresponding hierarchy. The MCP must have a process to identify and track the population stream assigned to each member.

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

iii. Specialized services and resources: The MCP must include a description of specialized services and other resources (e.g., health and wellness programs, 24/7 nurse advice line, care management, etc.) for each population stream that is tailored to risk level and communities. ODM may provide structured guidance for priority population streams that the MCPs should integrate into the model of care (e.g., *Ohio Department of Medicaid's Guidance for Managed Care Plans for the Provision of Enhanced Maternal Care Services.*)

b. Care management: The MCP must assure that each member is in a care management arrangement. There must be a clear delineation of roles and responsibilities between the MCP and other entities (PCMH, community partners, etc.) that are responsible for, or are contributing, to care management in order to assure no duplication of, or gaps in, services. If no other entity has been identified for the member, then the MCP is responsible for

providing the full scope of care management services to the member. The MCP's approach to care management must emulate the features of a high-performing care management system: person and family centeredness; timely, proactive planned communication and action; the promotion self-care and independence; emphasis on cross continuum and system collaboration and relationships; and the comprehensive consideration of physical, behavioral and social determinants of health. The following components must be addressed in the care management section of the model of care:

i. Assessment: The MCP must have a clear description of the process for conducting or arranging for an assessment that is appropriate for the member's unique circumstances and needs. The goal of the assessment is to identify immediate clinical, social and safety needs in order to facilitate timely follow up and action. The scope and depth of the assessment will vary based on assigned risk level. The MCP must have a process that uses the standardized assessment approved by ODM, for the intensive and high risk levels, to identify and address clinical, safety and social aspects of care for members who are assigned to the high and intensive levels. Assessments that use administrative data for the medium, low and monitoring levels is acceptable.

   The MCP must put forth a good faith effort to establish relationships with the member's primary care provider, or PCMH, and use clinical data collected from the provider in order to prevent duplication of assessment efforts and to assist with identification of priorities for the member. The MCP must identify the trigger(s) for completion of a more in-depth assessment or a disease-specific assessment (e.g., when the member is not connected to a PCMH or the member is displaying risk factors for placement in a higher stratification level).

   The MCP must document the process that will be used to facilitate the completion of the assessments including the mode and the timing of the assessments. The MCP must include a process for how beneficiaries who cannot be reached or who refuse assessments will be handled by the MCP. Re-assessments must be completed when there is a change to the member's health status or needs, a significant change event, a change in diagnosis, or as requested by member or his/her provider.

   The MCP must include in its process an explanation of how it will use the assessment to develop and update the care plan and confirm the risk level for each member. The MCP must also describe how assessment data will be stored and made available to members of the interdisciplinary care team in order to coordinate care.

ii. Individualized Care Plans

   The MCP must develop an individualized care plan (ICP) for each member that is based on the most recent assessment. The scope and depth of the ICP will vary based on the member's risk stratification level. ICPs for the intensive and high levels must include prioritized measureable goals, interventions, and outcomes.

Goals must be developed with, and should be agreed to by, the member and documented in the care plan. When possible, the care plan goals should be congruous with the priority issues identified by the PCMH, PCP, etc. so that the MCP can support the provider-patient relationship. Members assigned to the medium, low, and monitoring levels must have, at a minimum, a plan that identifies primary and preventive services that are appropriate to the age, gender, and condition.

The MCP must have a process to update the care plan as needs change and/or to address any gaps in care and include timeframes for initial development and updates. The MCP must describe how it will document and store the ICP, and make it available to members of the interdisciplinary care team.

iii. Care Transitions

The MCP must effectively and comprehensively manage transitions of care between settings in order to prevent unplanned or unnecessary readmissions, emergency department visits, and/or adverse outcomes. The MCP must have a process to conduct the following:

a. Identify members who require assistance transitioning between settings;
b. Develop a method for evaluating risk of readmission in order to determine the intensity of follow up that is required for the member after the date of discharge;
c. Designate MCP staff who will communicate with the discharging facility and inform the facility of the MCP's designated contacts;
d. Ensure that timely notification and receipt of admission dates, discharge dates and clinical information is communicated between MCP departments, care settings and with the primary care provider, as appropriate;
e. Participate in discharge planning activity with the facility including making arrangements for safe discharge placement and facilitating clinical hand-offs between the discharging facility and the MCP;
f. Obtain a copy of the discharge/transition plan;
g. Arrange for services specified in the discharge/transition plan; and
h. Conduct timely follow up with the member and the member's primary provider to ensure post discharge services have been provided.

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

iv. Care Management Staffing: Accountable Point of Contact and Multi-disciplinary Care Team

At a minimum, each member assigned to the intensive and high risk levels must have an assigned accountable point of contact [care manager]. The MCP must use a multi-disciplinary care team when the member's physical, psychosocial, and/or behavioral conditions would benefit from a range of disciplines with different but

complementary skills, knowledge and experience working together to deliver a comprehensive, integrated approach to care management.

The MCP staffing model must address the following components:

- how the MCP identifies who will be the assigned care manager;
- how the MCP determines the composition of the team;
- the delineation of roles and responsibilities of the team members (with particular emphasis on non-duplication of activities performed by PCPs, PCMHs, etc.);
- how the MCP exchanges member information within and across the team;
- how the MCP will ensure that staff who are completing care management functions are operating within their professional scope of practice, are appropriate for the member's health care needs, and follow the state's licensure/credentialing requirements.
- a staff training model that includes the onboarding of new employees and an annual training for current employees on the MCP's model of care, cultural competency, person centered care planning, motivational interviewing, grievance reporting process/procedure, availability of community resources in the care manager's respective geographic areas, care management strategies for disease specific processes, abuse/neglect/exploitation reporting requirements, and HIPAA;
- maintenance of a staffing ratio within the range below which is defined as one full time equivalent (FTE) per the number of consumers specified for each of the following stratification levels and care management statuses:

Risk Stratification Level	Care Management Status	Staffing Ratio
Intensive	Engaged and Passive Participation	1:25-1:50
High	Engaged and Passive Participation	1:51-1:100

- how the MCP will strive for a single point of care management for each member in order to reduce duplication and gaps in services.
- that the MCP will attest that care managers and MCP employed/delegated members of the care management team are not related by blood or marriage to the member or any paid caregiver, financially responsible for the member, or empowered to make financial or health related decisions on behalf of a member.
- a methodology for assigning consistent and appropriate caseloads for care managers that assures health, welfare and safety for members. The caseload assignment methodology shall consider the following factors: population; acuity status mix; care manager qualifications, years of experience, and

responsibilities; provision of support staff; location of care manager (community, MCP office, provider office);geographic proximity of care manager to members (if community based); and access to and capabilities of technology/IT systems.

v. Contact Schedule

The MCP must establish a contact schedule with the member that is based on his or her needs and facilitates ongoing communication with the member. ODM will prescribe the contact schedule for the intensive and high risk levels. For a member in the intensive risk level, at a minimum, the MCP must have at least one in-person contact with the member every 90 calendar days, and one of the visits every six months must be in the member's residential setting, if allowed by the member. For a member in the high risk level, at a minimum, the MCP must have at least one in-person contact with the member every 180 calendar days, and one visit per year must be in the member's residential setting, if allowed by the member. The MCP will be granted a 7-day grace period for each in- person visit. The MCP may use video communication as a means to conduct the in-person visit. The ODM contact schedule requirements only apply to members who are in an engaged care management status as defined in section 1.b.vi of this appendix. The activity conducted during the in-person visit must be: 1) linked to goals, interventions, or outcomes in the care plan; 2) reported to the care manager; 3) documented in the care management record to assure timely follow up; and 4) integrated into the plan of care. In-person visits with an MCP's provider or partner may count if the partner or provider is a documented member of the care team, is reimbursed, and transmits meaningful data to the MCP (progress notes, request for follow up, etc.).

vi. Care Management Coverage and Status Indicators

ODM will require each MCP to assure that each member is in a care management arrangement. ODM will require that a certain percentage of the membership be care managed at the high and intensive levels.

Beginning January 1, 2016, the MCP must care manage at least one percent (1.00%) of its overall membership at the intensive risk level (engaged and passive participation statuses only as defined in section 1.b.vi of this appendix). By January 1, 2018 at least two percent (2.00%) will be care managed at the high risk level (engaged and passive participation statuses only), and the remainder of the population at the medium, low, and monitoring levels.

A care management status will be assigned to each member regardless of stratification level: outreach and coordination, engaged, passive participation, inactive, and PCMH. A member must only be assigned to one care management status and they are defined as follows:

1. Outreach and coordination: This indicator is used when an MCP performs one or more of the following activities for a member: conducts outreach; educates the member; makes referrals for physical,

behavioral, or social services; or provides service coordination (defined as a planned, active interaction between the MCP and any provider involved with the member).

2. Engaged: A member is classified as engaged after the MCP completed an assessment, and documented at least one goal in the care plan. For members in the intensive and high levels, a member is engaged when the MCP completes the standardized assessment and the member agrees to at least one care plan goal developed during a live interaction that is then documented in the care plan. For the medium, low, and monitoring levels, a member is engaged when the MCP has completed an administrative assessment and documents at least one goal in the care plan. Ongoing, the engaged status can be used when the MCP is able to meet the frequency requirements for the member's contact schedule.
3. Passive participation: A member is classified with a passive participation status only if there was a recent prior engaged status. The passive participation status is used when the member has declined the opportunity to interact with the MCP and/or the MCP is able to meet all care management requirements except the contact schedule. A member cannot be in a passive participation status for more than three consecutive months. Upon conclusion of the three-month passive participation status period, the MCP must transition the member to a different care management status. If the MCP transitions the member back to an engaged status, the MCP must assure the assessment and care plan are updated for the member.
4. Inactive: A member is regarded as inactive if the MCP has assigned a population stream and risk level but is unable to engage the member in care management and/or is not performing outreach and coordination activities for the member.
5. PCMH: A member is classified with a status of PCMH if the member is attributed to and care managed by an Ohio SIM PCMH or the MCP is supporting the PCMH as specified in Appendix K.2.

Each MCP will be required to maintain a certain percentage of members in an engaged status when assigned to the intensive and high levels. At least .80% of the MCP's overall membership must be in an engaged status at the intensive level. At least 1.60% of the MCP's overall membership must be in an engaged status at the high level. Excluding the engaged status, ODM will not establish additional requirements related to the percent of members who should be assigned to the other three care management status indicators; however, ODM may periodically monitor the distribution of members across the four indicators.

c. Care Management Information Technology System

The MCP must have a care management system that captures, at a minimum, the results of the assessment and the care plan content, including goals, interventions, outcomes and completion dates. Members of the care management team who use

the care management system must also have access to relevant data about the member (claims, prior authorization data) in order to coordinate and communicate care needs across providers and delivery systems. The MCP must use information technology systems and processes to integrate the following data elements: enrollment data, care management data, claims, member services, 24/7 nurse advice line, prior authorization data, etc. in order to maximize internal MCP communications (e.g., the Utilization Management reviewer is able to see the care management risk level and the name of a care manager for a member) about a specific member. The MCP's system must also have capability to make care management data available to the member, the PCP and specialists.

d. Data Submission

The MCP must submit three electronic files as follows:

i. Population stream – The MCP must submit to ODM a file that contains a population stream for all specified members. The assigned population stream shall align with ODM's four population streams: women of reproductive age, behavioral health, chronic condition, healthy children, and healthy adults. Requirements for this file submission are specified in *Medicaid Managed Care: Population Stream Data Submission Specifications*.

ii. Risk stratification level – The MCP must submit a file to ODM that contains a risk stratification level for all specified members. The assigned risk stratification level will be intensive, high, medium, low or monitoring. Requirements for this file submission are specified in *Medicaid Managed Care: Risk Stratification Data Submission Specifications*.

iii. Care management status – The MCP must submit a file to ODM that contains a care management status for all specified members. The five care management status indicators are outreach and coordination, engaged, passive participation, inactive, and PCMH. Requirements for this file submission are specified in *Medicaid Managed Care: Care Management Status Submission Specifications.*

For the July 20 and October 20, 2016 submissions to ODM, the MCP will submit a population stream file (i.e., maternal and child health, behavioral health, chronic condition, and healthy adults), a risk stratification level, and a care management status file (i.e., engaged and passive participation statuses for intensive and high risk levels only). Beginning with the January 20, 2017 submissions to ODM, and quarterly thereafter, the MCP will submit complete files in accordance with the specifications referenced in 1.d.i-iii.

ODM, or its designee, will validate the accuracy of the information contained in the three electronic files with the MCP's care management record for the member.

If an MCP fails to submit an updated, complete file as specified by ODM, then ODM will not have the required data to calculate the population health

measures specified in this Appendix, and the MCP will be determined non-compliant with the performance standards.

e. Care Management Performance Measures and Standards

ODM will phase in the following requirements from January 1, 2016 through December 31, 2017. Performance measures and standards have been established to both incent and hold the MCP accountable for meeting key milestones over the next two years. Below is a table that identifies the performance measures, the standards, the measurement periods and if the measure is informational, contract, or a pay-for-performance (P4P) measure. If an MCP fails to meet the minimum performance standard for a contract measure, the MCP will be subject to a non-compliance sanction as specified in Appendix N. Information regarding the pay for performance incentives for meeting specific measures and milestones are outlined in Appendix O.

Care Management Measures and Performance Standards

Measure	Measurement Period	Performance Standard
Contract Measures		
Overall Care Management Rate: Intensive Risk Level (Engaged and Passive Participation Care Management Status) Intensive Risk Stratification Level: Engaged Care Management Status Rate	April – June 2016, July – December 2016, July – December 2017, January – June 2018, etc.	≥1.00% ≥.80%
Overall Care Management Rate: Intensive Risk Level (Engaged, Passive, and PCMH Care Management Status) Intensive Risk Stratification Level: Engaged and PCMH Care Management Status Rate	January – June 2017	≥1.00% ≥.80%
Overall Care Management Rate: High Risk Care Management (Engaged, Passive, and PCMH Care Management Status)	January – June 2017	≥1.00%

Measure	Measurement Period	Performance Standard
High Risk Stratification Level: Engaged and PCMH Care Management Status Rate		≥.80%
Overall Care Management Rate: High Risk Care Management (Engaged and Passive Participation Care Management Status)	July – December 2017	≥1.00%
	January – June 2018, July – December 2018, etc.	≥2.00%
High Risk Stratification Level: Engaged Care Management Status Rate	July – December 2017	≥.80%
	January – June 2018, July – December 2018, etc.	≥1.60%
Intensive Risk Care Management Staffing Ratio (Engaged and Passive Participation Care Management Status Only)[1]	, January – June 2018, July – December 2018, etc.	≥.0200
High Risk Care Management Staffing Ratio (Engaged and Passive Participation Care Management Status Only)[1]	January – June 2018, July – December 2018, etc.	.0196 - 0100
Informational Measures		
Staffing Turnover/Retention Measure[2]	, January – June 2018, July – December 2018, etc.	Not applicable

Measure	Measurement Period	Performance Standard
Overall Care Management Rate: All Risk Stratification Levels	January – June 2018, July – December 2018, etc.	Not applicable
Pay-for-Performance Measures		
a) Project plan for Information Technology system changes submitted. b) Project plan for assessing provider readiness for accepting care management responsibility and how the MCP will support and integrate ready providers into its model of care.	As of June 30, 2016	Must pass milestones a) and b) as determined by ODM.
a) MCP submits a Model of Care that is approved by ODM by June 30, 2016. b) MCP submits a staffing plan monthly hiring benchmarks through December 31, 2017. The MCP will also include a training plan. c) MCP successfully submits a test file to ODM per the file specifications by June 14, 2016: a. Risk Stratification b. Population Stream c. Care Management Status (only engaged and	As of June 30, 2016	Must pass milestones a), b), and c) as determined by ODM

Measure	Measurement Period	Performance Standard
passive participation statuses for intensive and high risk levels)		
a) MCP is on target with staffing plan benchmarks established for July, August and September 2016. b) MCP completes an on-site systems demonstration according to ODM developed scenarios: • File transfer with provider/health system • Integration of internal systems.	As of September 30, 2016	Must pass milestones a) and b) as determined by ODM.

Measure	Measurement Period	Performance Standard
a) MCP is on target with staffing plan benchmarks established for October, November and December 2016.	As of December 31, 2016	Must pass milestones a) and b) and both performance standards for c) as determined by ODM.
b) MCP successfully submits a complete Care Management Status file to ODM by January 20, 2017 which includes all five (5) status indicators for all members.	As of January 20, 2017	≥1.00%
c) Overall Care Management Rate: High Risk Care Management (Engaged, Passive , and PCMH Care Management Status) High Risk Stratification Level: Engaged and PCMH Care Management Status Rate	As of January 1, 2017	≥.80%

Measure	Measurement Period	Performance Standard
a) Overall Care Management Rate: High Risk Care Management (Engaged and Passive Participation Care Management Status) b) High Risk Stratification Level: Engaged Care Management Status Rate	As of December 31, 2017	Must meet both performance standards for a) ≥2.00% and b) ≥1.60%.

Notes:
[1]The MCP must ensure that the FTE count reported for each stratification level and measurement period includes any member of the care management team (e.g., primary care provider, community mental health center, MCP staff) who is documented in the care plan, participates in the care planning process, provides information back to the MCP and is paid by the MCP (e.g., directly employed by the MCP, in a fully delegated care management arrangement with, or contracted with the MCP to provide care coordination, etc.
[2] The MCP will be expected to track and report care manager staffing turnover/retention on a quarterly basis beginning in January 2018. Guidance will be forthcoming from ODM.
[3] Guidance documents and methods for the milestones will be forthcoming from ODM.

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

In the event an MCP's performance cannot be evaluated for a care management measure and measurement period established in this appendix, ODM in its sole discretion will deem the MCP to have met or to have not met the standard(s) for that particular measure and measurement period depending on the circumstances involved.

2. Partnering with State Innovation Model (SIM) Patient Centered Medical Homes (PCMHs) to Improve Population Health

Managed Care Plan members who are attributed to a SIM PCMH shall receive all of their care management, including coordination of behavioral, physical, and social needs, from the SIM PCMH. The PCMH shall be the member's primary care management entity.

The MCP plays a key role in supporting the PCMH to be successful in achieving optimal population-level health outcomes. The level of support provided by the MCP shall be contingent on the PCMH's infrastructure and capabilities (e.g., use of electronic health records, use of care management teams, etc.) to manage coordination responsibilities and share and/or integrate data with other providers and the MCP. Using a standardized assessment tool, the MCP shall evaluate the PCMH's readiness to perform care management activities and to accept the role as primary care management entity for its attributed members. Based on the results of the assessment, the MCP shall provide a level of support, communication, and assistance that appropriately matches the PCMH's ability to perform care management activities. Thereafter, the MCP's level of support must adapt to keep pace with the PCMH as it transitions to a point of accepting full responsibility for care management of its attributed members; this transition shall be completed by June 30, 2017. At a minimum, the MCP shall support each of the PCMH activities and the overall initiative:

For each of the following PCMH activities,	the MCP shall do the following during the start-up and ongoing phases of the initiative:
a. Same day appointments	1. Validate that the PCMH offers same day appointments (e.g., extended weekday hours, weekend hours, etc.) in order to ensure accurate information and appropriate guidance is provided by member facing departments to attributed members.
b. 24/7 access to care	1. Validate that the PCMH offers 24/7 access to care in order to ensure accurate information and appropriate guidance is provided by member facing departments to attributed members.
c. Risk Stratification	1. Generate and provide a list of risk-stratified members attributed to each PCMH on a regular basis and whenever there is a change in risk status. 2. Review the risk stratified list with the PCMH and provide additional data for high priority patients in order to assist the PCMH with ongoing care management responsibilities. 3. Timely notify the PCMH of significant change events (IP hospitalizations, ED visits, etc.) that could impact the assigned risk stratification level.

For each of the following PCMH activities,	the MCP shall do the following during the start-up and ongoing phases of the initiative:
	4. Update the MCP's care management system to reflect changes to the risk stratification level that are initiated and communicated by the PCMH.
d. Outreach to key patients	1. Provide information about MCP-administered specialized services and resources as part of the MCP's model of care for which a PCMH can refer and link members to with assistance by the MCP. 2. Assist with identification of preventive or chronic services that members have not received in order to identify gaps in care. 3. Assist in coordinating services as needed (e.g., schedule appointments, arrange transportation, facilitate referrals and linkages to MCP health and wellness programs, etc) in order to assist with improving health outcomes. 4. Share timely, meaningful, actionable data with the PCMH that can facilitate population health activities.
e. Team based care management	1. Work with each PCMH to delineate roles and responsibilities for high priority patients to assure there are no gaps in or duplication of services. 2. Designate points of contact for each PCMH to clearly identify who will participate in PCMH-led patient care team meetings and who will assist the PCMH with effectively and efficiently navigating MCP processes (e.g., facilitating prior authorizations). 3. Participate in PCMH-led patient care team meetings, when requested. 4. Respond timely to requests from the PCMH for action and follow up by the MCP (e.g., arranging transportation, performing outreach to a patient). 5. Receive and integrate critical PCMH data elements (e.g., social determinants of health identified by the PCMH) into the MCP's care management system and use the information when interacting with members. 6. Share timely, meaningful, actionable data with the PCMH that can facilitate effective team based care management activities (e.g., resolution of PCMH requests for MCP follow up).

For each of the following PCMH activities,	the MCP shall do the following during the start-up and ongoing phases of the initiative:
f. Follow up after hospital discharge	1. Notify the PCMH of ED visits or IP admissions for high priority patients. 2. Participate in discharge planning activities with the PCMH and inpatient facility in order to support a safe discharge placement and to prevent unplanned or unnecessary readmissions, ED visits, and/or adverse outcomes. 3. Support the post discharge services as specified in the discharge/transition plan. 4. Facilitate clinical hand offs, upon request from the PCMH, between the discharging facility and other providers (e.g., home health, community behavioral health agencies). 5. Share timely, meaningful, and actionable data with the PCMH that can facilitate effective care transitions.
g. Tracking of follow up tests and specialist referrals	1. When requested assist with bi-directional communication between the PCMH and specialists, pharmacies, labs and imaging facilities, as needed, in order to facilitate timely exchange of information. 2. Share timely, meaningful, and actionable data with the PCMH that can facilitate tracking and follow up of tests and referrals (e.g., when patients self-refer).
h. Patient Experience	1. Facilitate a warm hand off between the MCP care manager and the PCMH when care management responsibility transitions from the MCP to the PCMH. 2. Provide quantitative or qualitative data with the PCMH that can improve the patient experience (e.g., results from the MCP's member advisory groups, member satisfaction surveys, grievances and complaints, member preferences, etc). 3. Participate in the PCMH's improvement opportunities, as requested, that are aimed at improving overall patient experience and reducing disparities in patient experience.

The MCP must perform the following administrative activities in support of the SIM PCMH initiative:

- Perform ongoing identification of members who could receive care management from a PCMH. Contact identified members and educate them about the benefits of PCMH, assist members with selection of a PCMH, and facilitate referrals to the PCMH.
- Generate and provide a list of attributed members for each PCMH according to a methodology and frequency specified by ODM.
- Track members who are attributed to each PCMH.
- Reimburse PCMHs the agreed upon 'per member per month' (PMPM) payment for attributed members and any shared savings for meeting model requirements in accordance with requirements set forth by ODM;
- Reconcile attribution and payment data for each PCMH.
- Amend contracts, as necessary, with PCMHs to reflect the reimbursement of the PMPM payment and the shared savings payment.
- Provide technical support, as needed, to the PCMH to assist with its understanding and use of data files provided by the MCP.
- Receive and integrate data provided by the PCMH and implement throughout the MCP's systems and operations;
- Integrate results from PCMH metrics into the MCP's overall quality improvement program.
- Use regional and community population health priorities to develop a clear improvement strategy in partnership with PCMHs.
- Assure that member-facing departments (member services or 24/7 nurse advice lines, utilization management) are able to identify when a member is attributed to a PCMH and use related information (e.g., the attributed PCMH, expanded access offered by the PCMH, etc.) when interacting with members.

3. Care Coordination Activities
    a. Collaboration and coordination with:
        1. Certified Medicaid Health Home Providers:

Medicaid Health Home services will be discontinued effective June 30, 2017. Until this date, the MCP must continue to support the Medicaid Health Homes by:

i. Delineating responsibilities between the Health Home and the MCP in order to avoid duplication or gaps in services.
ii. Maintaining a single point of contact for the Health Home.
iii. Transmission of requested data, information and reports in a timely manner.
iv. Responding to requests for assistance or support in a timely manner.

Prior to the discontinuation of Health Home services, the MCP must collaborate with the Health Home to transition the member to other Medicaid service options that will be available as well as transfer the care management responsibility to the MCP, as applicable.

Through June 30, 2017, the MCP may continue to include a member who is receiving health home services in the intensive level as long as the MCP

collaborates with the Health Home on a quarterly basis on care management activities. When the care management responsibility transitions back to the MCP, the MCP must assure it is compliant with care management requirements in section 1 of this appendix.

2. Case management agencies/entities for the Medicaid FFS waivers

The MCP must coordinate and collaborate with agencies that provide case management services to managed care members who receive services from any of the following programs: Ohio Home Care waiver, PASSPORT waiver, Assisted Living waiver, and DODD-administered waivers. The MCP must support waiver case management agencies per the following:

i. Delineating responsibilities between the case management agency and the MCP in order to avoid duplication or gaps in services.
ii. Maintaining a single point of contact for the case management agency.
iii. Transmission of requested data, information and reports in a timely manner.
iv. Responding to requests for assistance or support in a timely manner.

b. Utilization Management Programs – The MCP must implement clearly defined structures and processes to maximize the effectiveness of the care provided to members pursuant to OAC rule 5160-26-03.1(A)(7).

Drug Utilization Management - Pursuant to ORC Sec. 5167.12, MCPs may implement strategies for the management of drug utilization.

MCPs may, subject to ODM prior-approval, require PA of certain drug classes and place limitations on the type of provider and locations where certain drugs may be administered. MCPs must establish their PA system so that it does not unnecessarily impede member access to medically-necessary Medicaid-covered services as follows:

i. As outlined in paragraph 31.g. of Appendix C, MCPs must adhere to specific PA limitations to assist with the transition of new members from FFS Medicaid.

ii. As outlined in paragraph 2.b.vi of Appendix G, MCPs must allow members to receive without PA certain antidepressant and antipsychotic drugs and to take into consideration if the member is stabilized on a specific antidepressant or antipsychotic drug when PA is permitted.

iii. MCPs must comply with the provisions of 1927(d)(5) of the Social Security Act, 42 USC 1396r-8(d)(k), and OAC rule 5160-26-03.1 regarding the timeframes for prior authorization of covered outpatient drugs.

MCPs must develop and submit for prior approval, a coordinated services program as defined in OAC rule 5160-20-01 to address the utilization or pattern of receiving medications at a frequency or in an amount that exceeds medical necessity. MCPs must also develop retrospective drug utilization review programs designed to promote the appropriate clinical prescribing of covered drugs. MCPs must also provide care management services to any member who is enrolled in the coordinated services program.

c. Transition of Care from the Ohio Department of Rehabilitation and Correction's Facilities to the Community for Critical Risk Individuals

The MCP is responsible for facilitating and managing transitions of care for pending members who are designated as critical risk, according to ODM's definition, and are being discharged from Ohio Department of Rehabilitation and Correction's (ODRC's) facilities. Upon receiving notification from ODM and/or ODRC about pending members who will be released from the ODRC facility and will be enrolled with the MCP, the MCP will identify which pending members meet the critical risk criteria. For pending members confirmed as meeting the critical risk criteria, the MCP will receive clinical information from ODRC and other entities. The MCP may request additional information for these pending members from the ODRC facility using the process prescribed by ODM. The MCP will notify ODRC if the requested records are not received within the timeframes established by ODRC & ODM.

The MCP must develop a transition plan using the approved ODM form with information provided by ODRC and other programs/entities (e.g., Ohio Department of Mental Health and Addiction Services' Community Linkages program). The MCP must facilitate input to the transition plan by entities specified by ODM. The MCP will conduct an interactive session (e.g., videoconference) to review the completed transition plan with each pending member who meets the critical risk criteria. The MCP will request the interactive session and submit a copy of the transition plan to the ODRC facility according to the methods and timeframes prescribed by ODM. The MCP shall make reasonable effort to conduct this interactive session at least fourteen (14) calendar days prior to the pending member's scheduled release date from the ODRC facility. The MCP must review the transition plan with the pending member during the interactive session and identify/confirm necessary changes that will be made to the transition plan. The MCP must update the transition plan, as appropriate, and submit the final transition plan to ODRC/Operations Support Center and the ODRC facility as prescribed by ODM.

After the pending member is released from the ODRC facility, the MCP must contact the member as expeditiously as the member's condition warrants but not later than five (5) calendar days to assist the member with accessing care according to the transition plan, including identifying and removing barriers to care, and addressing additional needs that are expressed by the member. If the MCP is unable to contact the member- within the first five calendar days (i.e., three different attempts over the 5 days), the MCP must send a letter to the

member no later than seven calendar days from the release date which includes contact information for member services and the care management department in order to request assistance with accessing services or community supports. The MCP must document all outreach attempts and contacts with the member.

The MCP must assess the member's need for care management using processes established in section 1.b.i of this appendix.

The MCP will report metrics as specified below to ODM for members who were released from an ODRC facility, met the critical risk criteria and are now enrolled with the MCP:

1. Monthly reports: The MCP must report the following information on a monthly basis for critical risk individuals who are enrolled with the MCP:
    a. The total number of members who met the chronic risk criteria;
    b. The total number of members reported in a. who had a transition plan developed by the MCP prior to release from the ODRC facility;
    c. The total number of members reported in b. who the MCP contacted within five calendar days of the release date from the ODRC facility;
    d. The total number of members reported in b. for whom the MCP was unable to contact within the five calendar days and who were sent a letter by the MCP;
    e. The total number of members (reported in a.) for whom the MCP assessed for any level of care management;
    f. The total number of members (reported in a.) for whom the MCP did not assess and the reasons why (refused, unable to reach, unable to contact); and
    g. The total number of members who were assessed (reported in e.) and enrolled in care management by stratification level (high, complex, medium, and low).

    Monthly reports will be due to ODM on the 10th calendar day of each month and will include data for members who were enrolled with the MCP during the prior calendar month.

2. Quarterly reports: The MCP must report the following information on a quarterly basis for critical risk individuals:
    a. The total number of members who met the critical risk criteria and had a Serious Mental Illness designation (C1 per the ODRC definition), and of those who had a follow up visit with a Community Mental Health Center within 30 days and 31-60 days of the release date from the ODRC facility.
    b. The total number of members who met the critical risk criteria and had recovery services level of care (R3 per the ODRC definition), and of those who had a follow up visit with a qualified provider within 30 days of the release date of the facility.
    c. The total number of SMI members who met the critical risk criteria and had any prescription filled within 30 days and 31-60 days of the release date from the ODRC facility.

Quarterly reports due in SFY 2016 must be submitted in accordance with the following due dates:

- The report due on June 10, 2016 will include any critical risk members who were enrolled in the MCP from January 1, 2016 through March 31, 2016.
- The report due on September 10, 2016 will include any critical risk members who were enrolled in the MCP from April 1, 2016 through June 30, 2016.
- The report due on January 10, 2017 will include any critical risk members who were enrolled in the MCP from July 1, 2016 through September 30, 2016.
- The report due on April 10, 2017 will include any critical risk members who were enrolled in the MCP from October 1, 2016 through December 31, 2016.

The MCP will be required to report additional metrics according to the specifications and timeframes established by ODM.

The MCP will implement a method to identify and track all current members who were released from the ODRC facility and enrolled with the MCP.

4. Quality Assessment and Performance Improvement Program

The MCP must administer its Medicaid line of business in an efficient and effective manner while maintaining an organizational focus on quality and continuous learning. As required by 42 CFR 438.330, each MCP must develop a Quality Assessment and Performance Improvement (QAPI) Program that reflects a systematic approach for assessing and improving the quality of care. The QAPI program must be submitted to ODM annually by November 15 and must include the following elements:

4a. Performance Improvement Projects and Quality Improvement Projects (PIPs and QIPs)

i. Performance Improvement Projects
In accordance with federal requirements, each MCP must conduct clinical and non-clinical performance improvement projects (PIPs) using rapid cycle quality improvement science techniques that are designed to achieve, through frequent measurement and intervention, improvements in health outcomes, quality of life and satisfaction for providers and consumers. The MCP must adhere to ODM-specified reporting, submission and frequency guidelines. The MCP must initiate and complete PIPs in topics selected by ODM. All PIPs designed and implemented by the MCP must be approved by ODM.

The external quality review organization (EQRO) will assist MCPs with the development and implementation of PIPs by providing technical assistance, and will annually validate the PIPs in accordance with the Centers for Medicare and Medicaid Services' protocols.

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

iii. The MCP shall actively participate in performance and quality improvement projects that are facilitated by ODM or the EQRO, or both. This includes but is not limited to:
- attending meetings;
- assigning MCP staff to the PIP or QIP efforts who are subject matter experts in the PIP or QIP topic, are familiar with MCP policies and processes related to the topic and who have decision making authority;
- responding promptly to data and information requests;
- dedicating resources to test and implement quality improvement interventions;
- establishing internal mechanisms to frequently communicate PIP or QIP status updates and results to the MCP's Medical Director and the Quality Improvement Director; and
- maintaining regular communication with ODM or EQRO staff.

MCP Medical Directors, Quality Improvement Directors, and at least one MCP staff person assigned to PIP/QIP teams shall be required to complete coursework in the application of rapid cycle quality improvement science tools and methods from an ODM approved entity.

Content should include topics such as:
- The Model for Improvement[1] developed by the Associates in Process Improvement and popularized by the Institute for Healthcare Improvement (IHI)
- Edward W. Deming's System of Profound Knowledge
- Listening to and incorporating the Voice of the Customer (VOC)
- Process mapping/flow charting
- SMART Aim development and the use of key driver diagrams[1] for building testable hypotheses
- Methods for barrier identification and intervention selection (e.g., root cause analyses, Pareto charts, failure mode and effects analysis, the 5 why technique, etc.)
- Selection and use of process, outcome and balancing measures
- Testing change through the use of PDS(C)A cycles[2]
- The use of statistical process control, such as the Shewart control chart[3]

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

[2] Deming WE. *The New Economics for Industry, Government, and Education*. Cambridge, MA: The MIT Press; 2000

[3] Revelle JB. *Quality Essentials: A Reference Guide from A to Z*, ASQ Quality Press, 2004.

- Tools for spread and sustainability planning

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

Medical Directors with a substantial role in improvement projects or who are accountable for the QAPI program, along with QI Directors and at least one MCP staff person involved in each ODM-initiated QIP/PIP must submit training curricula to ODM for approval prior to enrollment. Evidence of coursework completion must be submitted by June 30, 2017. Staff will be exempt from this requirement if one of the following conditions is met: 1) an accredited/certified education course in quality improvement science has been completed since July 1, 2013; or 2) satisfactory completion of NCQA, CPHQ or ASQ CQIA certification after January 1, 2015. Medical Directors with a substantial role in improvement projects or who are accountable for the QAPI program, as well as Quality Improvement Directors who are hired after July 1, 2016, must complete the course within six (6) months of their start date unless they have evidence of course completion within the two years prior to their effective start date.

iv. The MCP shall integrate results from performance and quality improvement projects into its overall quality assessment and improvement program.

4b. Assessment of 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 the annual submission of the QAPI program to ODM. The MCP must ensure the utilization analysis documented in the QAPI is linked to the strategies employed by the MCP for the Health, Wellness, and Prevention programs and the Utilization Management programs sections of this Appendix.

It should also be noted that pursuant to the program integrity provisions outlined in Appendix I, the MCP must monitor for the potential under-utilization of services by its 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 correct the problem(s) which resulted in such underutilization 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 underutilized.

4c. Assessment of the Quality and Appropriateness of Care for Members with 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 the annual submission of the QAPI program to ODM.

4d. Submission of Performance Measurement Data

Each MCP must submit data as required by ODM that enables ODM to calculate standard measures as defined in Appendix M.

Each MCP must also submit self-reported, audited Healthcare Effectiveness Data and Information Set (HEDIS) data (see *ODM Methodology for MCP Self-Reported, HEDIS-Audited Data*) for performance measures set forth in Appendix M.

4e. Quality Measurement Assessment and Improvement Strategy

The MCP must measure, analyze, and track performance indicators which reflect Ohio Medicaid's Quality Strategy clinical focus areas (e.g., behavioral health, high-risk pregnancy/premature births) and other quality initiatives (e.g., high risk care management, emergency department diversion programs) in place to advance the goals of the Quality Strategy. The MCP must include all Provider Agreement measures in Appendices K and M as part of this effort but may also include other measures (e.g., NCQA accreditation set) that assist the MCP in advancing the goals of the Quality Strategy.

The MCP's quality measurement assessment and improvement strategy must include the following activities:

i. Establishing a measureable goal and benchmark for each performance indicator;
ii. Measuring performance and comparing the rate for each indicator to the established goal and benchmark;
iii. Reviewing data trends to detect improvement, decline or stability in the rates at a frequency no less often than quarterly;
iv. Identifying any opportunities for improvement;
v. Conducting a root cause analysis to identify factors that may impact the adequacy of rates;
vi. Developing and implementing quality improvement interventions, using a rapid cycle improvement approach, that will address the root cause of the deficiency; and
vii. Developing a plan to monitor the quality improvement interventions to detect if the changes are an improvement.

The MCP must ensure that these activities are linked to the MCP's annual evaluation of the impact and effectiveness of its QAPI program. Upon request, the MCP must make the performance indicator tracking and reporting mechanisms and any quality improvement work plans available for review by ODM.

4f. Addressing Health Disparities

The MCP must participate in, and support, ODM's efforts to eliminate health disparities in Ohio. The U.S. Department of Health and Human Services – Centers for Disease Control and Prevention

defines health disparities as "differences in health outcomes and their determinants as defined by social, demographic, geographic, and environmental attributes."

The MCP will be required to participate in a Health Equity Workgroup (HEW) which will, at a minimum, be comprised of representatives from each MCP, ODM, Ohio Commission on Minority Health, and the Ohio Department of Health. The HEW will be charged with characterizing the extent of healthcare disparities among health plan members by establishing common health disparity measures and developing a strategy to address disparities revealed by the results of the measures. When establishing disparity measures, the workgroup will determine the data elements (e.g., self-identified race, ethnicity, and language) needed to calculate the health disparity measures. MCPs will collect the data elements and calculate the results of the measures to inform the development of the strategy.

4g. Impact and Effectiveness of the QAPI Program

Each MCP must evaluate the impact and effectiveness of the QAPI program. The MCP must update the QAPI program based on the findings of the self-evaluation and submit annually to ODM for review and approval.

4h. Accountability for the QAPI Program

Each MCP must establish appropriate administrative oversight arrangements and accountability for the QAPI program which includes the following: assignment of a senior official responsible for the QAPI program (e.g., Quality Improvement Director, Medical Director); provision for ongoing communication and coordination between the area that oversees the QAPI program and relevant functional areas of the organization; assurance that the Medical Director is involved in all clinically related projects; and that staff responsible for implementation of the QAPI program have the appropriate education, experience and training.

5. External Quality Review

ODM will select an external quality review organization (EQRO) to provide for an annual, external, and independent review of the quality, outcomes, timeliness of and access to services provided by MCPs. The MCP must participate in annual external quality review which will include but not be limited to the following activities:

4.a. Administrative compliance assessment as required by 42 CFR 438.358 and as specified by ODM.

4.a.i. Non duplication exemption – As allowed by 42 CFR 438.360 and 438.362, an MCP with accreditation from a national organization approved by the Centers for Medicare and Medicaid services may request to be exempted from certain portions of the administrative compliance assessment. ODM will inform the MCP when a non-duplication exemption may be requested.

4.a.ii. The EQRO may conduct focused reviews of MCP performance in the following domains which include, but are not limited to:

1. Availability of services

2. Assurance of adequate capacity and services
3. Coordination and continuity of care
4. Coverage and authorization of services
5. Credentialing and recredentialing of services
6. Sub contractual relationships and delegation
7. Enrollee information and enrollee rights
8. Confidentiality of health information
9. Enrollment and disenrollment
10. Grievance process
11. Practice guidelines
12. Quality assessment and performance improvement program
13. Health information systems
14. Fraud and abuse

4.b. Encounter data studies
4.c. Validation of performance measurement data
4.d. Review of information systems
4.e. Validation of performance improvement projects
4.f. Member satisfaction and/or quality of life surveys

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

The penalties for non-compliance with external quality review activities are listed in Appendix N, Compliance Assessment System.

APPENDIX L

DATA QUALITY

A high level of performance on the data quality standards and requirements established in this appendix is crucial in order for the Ohio Department of Medicaid (ODM) to determine the value of the Medicaid Managed Health Care Program and to evaluate Medicaid consumers' access to and quality of services. Data collected from 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 and/or submission requirements include: encounter data; Healthcare Effectiveness Data and Information Set (HEDIS) data; care management data; appeals and grievances data; utilization management data; Consumer Assessment of Healthcare Providers and Systems (CAHPS) data, third party liability data, and primary care provider data.

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

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

1. ENCOUNTER DATA

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

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

1.a. Encounter Data Completeness

1.a.i. Encounter Data Volume

This measure is calculated separately for ABD adults, ABD children, MAGI members (adults and children combined), and Adult Extension members.

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

Measurement Period: The measurement periods for each population for the State Fiscal Year (SFY) 2016 and SFY 2017 contract periods are listed in Table 1 below.

Table 1. Measurement Periods for the SFY 2016 and SFY 2017 Contract Periods

MAGI Quarterly Measurement Periods	ABD Adult Quarterly Measurement Periods	ABD Child Quarterly Measurement Periods	Adult Extension Members Quarterly Measurement Periods	Data Source: Estimated Encounter Data File Update	Quarterly Report Estimated Issue Date	Contract Period
Qtr 2 thru Qtr 4: 2012, Qtr 1 thru Qtr 4: 2013, 2014, Qtr 1 2015	Qtr 2 thru Qtr 4: 2012, Qtr 1 thru Qtr 4: 2013, 2014, Qtr 1 2015	Qtr 3, Qtr 4: 2013, Qtr 1 thru Qtr 4: 2014, Qtr 1 2015	Qtr 1 thru Qtr 4: 2014, Qtr 1 2015	July 2015	August 2015	SFY 2016
Qtr 3, Qtr 4: 2012, Qtr 1 thru Qtr 4: 2013, 2014, Qtr 1, Qtr 2: 2015	Qtr 3, Qtr 4: 2012, Qtr 1 thru Qtr 4: 2013, 2014, Qtr 1, Qtr 2: 2015	Qtr 3, Qtr 4: 2013, Qtr 1 thru Qtr 4: 2014, Qtr 1, Qtr 2: 2015	Qtr 1 thru Qtr 4: 2014, Qtr 1, Qtr 2: 2015	October 2015	November 2015	
Qtr 4: 2012, Qtr 1 thru Qtr 4: 2013, 2014, Qtr 1 thru Qtr 3: 2015	Qtr 4: 2012, Qtr 1 thru Qtr 4: 2013, 2014, Qtr 1 thru Qtr 3: 2015	Qtr 3, Qtr 4: 2013, Qtr 1 thru Qtr 4: 2014, Qtr 1, thru Qtr 3: 2015	Qtr 1 thru Qtr 4: 2014, Qtr 1 thru Qtr 3: 2015	January 2016	February 2016	
Qtr 1 thru Qtr 4: 2013, 2014, 2015	Qtr 1 thru Qtr 4: 2013, 2014, 2015	Qtr 3, Qtr 4: 2013, Qtr 1 thru Qtr 4: 2014, 2015	Qtr 1 thru Qtr 4: 2014, 2015	April 2016	May 2016	

Qtr 2 thru Qtr 4: 2013, Qtr 1 thru Qtr 4: 2014, 2015, Qtr 1 2016	Qtr 2 thru Qtr 4: 2013, Qtr 1 thru Qtr 4: 2014, 2015, Qtr 1 2016	Qtr 3, Qtr 4: 2014, Qtr 1 thru Qtr 4: 2015, Qtr 1 2016	**Qtr 1 thru Qtr 4: 2014, 2015; Qtr 1 2016**	July 2016	August 2016	SFY 2017
Qtr 3, Qtr 4: 2013, Qtr 1 thru Qtr 4: 2014, 2015, Qtr 1, Qtr 2: 2016	Qtr 3, Qtr 4: 2013, Qtr 1 thru Qtr 4: 2014, 2015, Qtr 1, Qtr 2: 2016	Qtr 3, Qtr 4: 2014, Qtr 1 thru Qtr 4: 2015, Qtr 1, Qtr 2: 2016	Qtr 1 thru Qtr 4: 2014, 2015; Qtr 1, Qtr 2: 2016	October 2016	November 2016	
Qtr 4: 2013, Qtr 1 thru Qtr 4: 2014, 2015, Qtr 1 thru Qtr 3: 2016	Qtr 4: 2013, Qtr 1 thru Qtr 4: 2014, 2015, Qtr 1 thru Qtr 3: 2016	Qtr 3, Qtr 4: 2014, Qtr 1 thru Qtr 4: 2015, Qtr 1, thru Qtr 3: 2016	Qtr 1 thru Qtr 4: 2014, 2015; Qtr 1 thru Qtr 3: 2016	January 2017	February 2017	
Qtr 1 thru Qtr 4: 2014, 2015, 2016	Qtr 1 thru Qtr 4: 2014, 2015, 2016	Qtr 3, Qtr 4: 2014, Qtr 1 thru Qtr 4: 2015, 2016	Qtr 1 thru Qtr 4: 2014, 2015, 2016	April 2017	May 2017	

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

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

Note: MCPs will be held accountable to the data quality standards for this measure beginning with the 'Qtr 1 thru Qtr 4: 2014, 2015; Qtr 1, 2016'measurement period for the Adult Extension population as bolded in Table 1 above.

Table 2. Data Quality Standards

Category	Measure per 1,000/MM	MAGI Standards	ABD Adult Standards	ABD Child Standards	Adult Extension Standards	Description
Inpatient Hospital	Discharges	4.2	18.9	5.1	8.2	General/acute care, excluding newborns and mental health and chemical dependency services
Emergency Department	Visits	65.5	126.0	60.8	90.1	Includes physician and hospital emergency department encounters

Dental		45.2	30.9	35.5	42,3	Non-institutional and hospital dental visits
Vision		14.9	21.3	15.3	17.3	Non-institutional and hospital outpatient optometry and ophthalmology visits
Primary and Specialist Care		224.4	451.6	196.3	285.6	Physician/practitioner and hospital outpatient visits
Behavioral Health	Service	35.9	74.9	120.2	62.4	Inpatient and outpatient behavioral encounters
DME	Service	10.1	116.4	54.8	27.5	Durable Medical Equipment
Pharmacy	Prescrip-tions	600.3	3717.3	834.9	1511.8	Prescribed drugs

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

1.a.ii. Incomplete Rendering Provider Data -

The *Incomplete Rendering Provider Data* measure is calculated to ensure that MCPs are reporting individual-level rendering provider information to ODM so that Ohio Medicaid complies with federal reporting requirements.

Measure: The percentage of rendering providers reported on encounters without individual-level Medicaid and/or Reporting provider numbers as identified in MITS.

Measurement Period: The measurement periods for the SFY 2016 and SFY 2017 contract periods are listed in Table 3. below. MCPs must meet or exceed the standard in all quarters of the measurement period.

Table 3. Measurement Periods for the SFY 2016 and SFY 2017 Contract Periods

Quarterly Measurement Periods	Data Source: Estimated Encounter Data File Update	Quarterly Report Estimated Issue Date	Contract Period
Qtr 1 thru Qtr 4: 2014; Qtr 1: 2015	July 2015	August 2015	SFY 2016
Qtr 1 thru Qtr 4: 2014; Qtr 1, Qtr 2: 2015	October 2015	November 2015	
Qtr 1 thru Qtr 4: 2014; Qtr 1 thru Qtr 3: 2015	January 2016	February 2016	

Qtr 1 thru Qtr 4: 2014; Qtr 1 thru Qtr 4: 2015	April 2016	May 2016	
Qtr 1 thru Qtr 4: 2015; Qtr 1: 2016	July 2016	August 2016	SFY 2017
Qtr 1 thru Qtr 4: 2015; Qtr 1, Qtr 2: 2016	October 2016	November 2016	
Qtr 1 thru Qtr 4: 2015; Qtr 1 thru Qtr 3: 2016	January 2017	February 2017	
Qtr 1 thru Qtr 4: 2015; Qtr 1 thru Qtr 4: 2016	April 2017	May 2017	

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

Data Quality Standard: (effective SFY 2017) Less than or equal to 4.0%

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

1.a.iii. NPI Provider Number Usage Without Medicaid/Reporting Provider Numbers -

The *NPI Provider Number Usage without Medicaid/Reporting Provider Numbers* measure is calculated to ensure that providers reported on encounters can be associated with Medicaid and/or Reporting providers in MITS.

Measure: The percentage of institutional (837 I), professional (837 P), and dental (837 D) EDI transactions with an NPI provider number in the billing provider EDI data field that do not have a NPI and Medicaid or Reporting Provider Number in MITS.

Measurement Period: The measurement periods for the SFY 2016 and SFY 2017 contract periods are listed in Table 3. above. MCPs must meet or exceed the standard in all quarters of the measurement period.

Data Quality Standard: (effective SFY 2017) Less than or equal to 6.0%

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 ODM 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, ODM's encounter data set will be incomplete.

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 ODM that are rejected

Measurement Period: For the SFY 2017 contract period, performance will be evaluated using the following measurement periods: July – September 2016; October – December 2016; January – March 2017; and April – June 2017.

Results from September 2011 through September 2012 were used as a baseline to set a data quality standard for this measure.

Data Quality Standard for measure 1: The data quality standard for measure 1 is a maximum encounter data rejection rate for each file type in the ODM-specified medium per format as follows:

837 Dental:	23%
837 Institutional:	22%
837 Professional:	34%
NCPDP:	19%

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 ODM that are rejected

Measurement Period: The measurement 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. This measure will not be calculated for SFY 2017.

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 ODM-specified medium per format as follows:

Third through sixth month with membership:	Not Applicable SFY 2107
Seventh through twelfth month with membership:	Not Applicable SFY 2017

See Appendix N, *Compliance Assessment System*, for the penalty for noncompliance with the standard for this measure.

1.a.v. Acceptance Rate

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 ODM and accepted (i.e. accepted encounters per 1,000 member months).

Measurement Period: The measurement period for this measure is monthly. Results are calculated and performance is monitored monthly. The first reporting month begins with the third month of enrollment. This measure will not be calculated for SFY 2017.

Data Quality Standard: The data quality standard is a monthly minimum accepted rate of encounters for each file type in the ODM-specified medium per format as follows:

Third through sixth month with membership: Not Applicable for SFY 2017
Seventh through twelfth month of membership: Not Applicable for SFY 2017

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

1.b. Encounter Data Accuracy

1.b.i. Encounter Data Accuracy Studies

As with data completeness, MCPs are responsible for assuring the collection and submission of accurate data to ODM. Failure to do so jeopardizes MCPs' performance, credibility and, if not corrected, will be assumed to indicate a failure in actual performance.

Measure 1 (This measure is calculated for MAGI and Adult Extension members only): The focus of this accuracy study will be on delivery encounters. Its primary purpose will be to verify that 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.

Measurement Period: In order to provide timely feedback on the accuracy rate of encounters, the measurement period will be the most recent from when the measure is initiated. This measure is conducted annually.

Medical records retrieval from the provider and submittal to ODM or its designee is an integral component of the validation process. ODM has optimized the sampling to minimize the number of records required. This methodology requires a high record submittal rate. To aid MCPs in achieving a high submittal rate, ODM will give at least an 8 week period to retrieve and submit medical records as a part of the validation process. A record submittal rate will be calculated as a percentage of all records requested for the study.

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: 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 ODM. Two levels of analysis will be conducted: one to evaluate encounter data completeness for which two rates will be calculated and one to evaluate payment data accuracy. Payment completeness and accuracy rates will be determined by aggregating data across claim types (i.e., professional, pharmacy, and institutional) 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 ODM encounter data files.

Surplus Encounter Rate: The percentage of encounters in the ODM 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 ODM encounter data files and an MCP's fully adjudicated claims files where a payment amount discrepancy was identified.

Measurement Period: In order to provide timely feedback on the omission rate of encounters, the measurement period will be the most recent from when the study is initiated. This study is conducted annually.

Data Quality Standard for Measure 2:

For SFY 2016 and SFY 2017:
For Level 1: An omission encounter rate and a surplus encounter rate of no more than 11% for both claim-level and line-level 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. Encounter Data Payments Compared to Managed Care Cost Report Information

This measure is calculated separately for the ABD, MAGI, and Adult Extension populations.

Measure: The difference between the MCP payment amounts as reported on the encounter data and on the Managed Care Cost Reports, as a percentage of the total cost reported on the Managed Care Cost Reports, by category of service and rate cell as aggregated in Tables 5. and 6. below.

This measure will be designed to account for delayed or rejected encounter data payment submissions when reconciling MCP encounter and cost report data submissions. Adjustments will be made to the reconciliation process to account for items that may be outside of the MCP's control. To accomplish this, the process to validate managed care cost report information will consider the amount and volume of encounter data payments that are rejected or pending. This measure is not intended to result in MCPs delaying or otherwise modifying cost report data submissions due to encounter data payments being delayed or rejected. No portion of this measure should influence the quality of the data submitted in the managed care cost reports.

Measurement Period: The measurement periods for the SFY 2017 and SFY 2018 contract periods are listed in Table 4. below.

Table 4. Measurement Periods for the SFY 2017 and SFY 2018 Contract Periods

Quarterly Measurement Periods	Encounter Data File Update	Quarterly Report Estimated Issue Date
SFY 2017 Contract Period		
Qtr1: 2016	June 2016	June 2016
Qtr2: 2016	September 2016	September 2016
Qtr3: 2016	December 2016	December 2016
Qtr4: 2016	March 2017	March 2017
SFY 2018 Contract Period		
Qtr1: 2017	June 2017	June 2017
Qtr2: 2017	September 2017	September 2017
Qtr3: 2017	December 2017	December 2017
Qtr4: 2017	March 2018	March 2018

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

Data Quality Standards: The data quality standards, per population and category of service, are listed in Table 5. below. This measure is calculated separately for each population. For each population, MCPs must meet the standard for every category of service. SFY 2017 results are informational only. MCPs will be held accountable to the data quality standards for this measure beginning SFY 2018.

Table 5. Data Quality Standards

Category of Service	MAGI Standards	ABD Standards	MAGI Adult Extension Standards	Managed Care Cost Report Categories of Service
Inpatient	TBD	TBD	TBD	Categories of Service 01, 02, 04, 06, and 07
Outpatient	TBD	TBD	TBD	Categories of Service 08-13
Emergency	TBD	TBD	TBD	Categories of Service 14-21
Professional	TBD	TBD	TBD	Categories of Service 22-30
Dental	TBD	TBD	TBD	Category of Service 38
Pharmacy	TBD	TBD	TBD	Category of Service 37
Other	TBD	TBD	TBD	Categories of Service 31-36, and 39-44

*Excludes shadow-priced encounters and sub-capitated costs reported on the Managed Care Cost Reports.

Table 6. Population Rollups by Rate Cell

Populations	Managed Care Cost Report Rate Cell
ABD	RC19 and RC20
MAGI	RC01 to RC09
Adult Extension	RC11 to RC18

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

1.c. Encounter Data Submission

Information concerning the proper submission of encounter data may be obtained from the *ODM Encounter Data Submission Specifications* document. Note, the *ODM Encounter Data Submission Specifications* include: encounter data companion guides for institutional, professional, and dental 837 EDI transactions, NCPDP D.0 files, 824 Application Advice, and 277 Unsolicited Claim/Encounter Status Notifications; *ODM Encounter Data Submission Guidelines*; *ODM Encounter Data Submission Schedule; Encounter Data Letter of Certification*; and *ODM Covered Families and Children Delivery Payment Reporting Procedures*. The encounter data companion guides must be used in conjunction with the X12 Implementation Guide for EDI transactions.

1.c.i. Encounter Data Submission Procedure

The MCP must submit encounter data files to ODM per the specified schedule and within the allotted amount established in the *ODM Encounter Data Submission Specifications.*

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

The letter of certification 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 (see *ODM Encounter Data Submission Specifications).*

See Appendix N, *Compliance Assessment System*, for the penalties for noncompliance with these data submission requirements.

1.c.ii. Timeliness of Encounter Data Submission

ODM requires: MCP-paid encounters be submitted no later than thirty-five calendar days after the end of the month in which they were paid. Beginning in March 2015 for encounters paid in January 2015, MCPs must report encounter data submission lag time on a monthly basis to ODM. Results may be subject to an audit by ODM and/or its designee.

Effective with the September 2017 measurement period of SFY 2017, ODM will evaluate the timeliness of MCP paid encounters.

Measure: The percentage of the MCP's total monthly paid encounters that are submitted to ODM and accepted within 35 calendar days of the month in which they were paid,(e.g., encounters paid by the MCP in January 2015 that are submitted to ODM and accepted on or before March 7th 2015, divided by the total number of encounters paid by the MCP in January 2015).

Measurement Periods: For SFY 2017: July 2016, August 2016, September 2016, October 2016, November 2016, December 2016, January 2017, February 2017, March 2017, April 2017, May 2017, and June 2017. MCPs will be held accountable to the data quality standard for this measure beginning with the July 2016 measurement period of SFY 2017.

Data Quality Standard: The data quality standard is greater than or equal to 90%.

Results from January 2015 through June 2015 were used as a baseline to set the data quality standard for this measure.

The penalty for noncompliance with the standard(s) for this measure will be listed in Appendix N, *Compliance Assessment System*.

1.c.iii. Encounter Submissions Per Encounter Schedule

Measure: The percent of encounters listed on the Encounter Data Submission Schedule as the minimum amount for that month that were submitted to ODM and accepted.

Measurement Periods: For SFY 2017: July 2016, August 2016, September 2016, October 2016, November 2016, December 2016, January 2017, February 2017, March 2017, April 2017, May 2017, and June 2017.

Data Quality Standard: The data quality standard is greater than or equal to 100%.

See Appendix N, *Compliance Assessment System*, for the penalties for noncompliance with this data submission requirement.

2. MCP SELF-REPORTED, AUDITED HEDIS DATA

2.a. Annual Submission of HEDIS IDSS Data

MCPs are required to collect, report, and submit to ODM self-reported, audited HEDIS data (see *ODM Specifications for the Submission of MCP Self-Reported, Audited HEDIS Results*) for the full set of HEDIS measures reported by the MCP to NCQA for Ohio Medicaid members. This must include all HEDIS measures listed in Appendix M. The self-reported, audited HEDIS data are due to ODM no later than five business days after the NCQA due date.

See Appendix N, *Compliance Assessment System*, for the penalties for noncompliance with this data submission requirement.

2.b. Annual Submission of Final HEDIS Audit Report (FAR)

MCPs are required to submit to ODM their FAR that contains the audited results for the full set of HEDIS measures reported by the MCP to NCQA for Ohio Medicaid members. This must include all HEDIS measures listed in Appendix M. The FAR is due to ODM no later than five business days after the NCQA due date (see *ODM Specifications for the Submission of MCP Self-Reported, Audited HEDIS Results*).

See Appendix N, *Compliance Assessment System*, for the penalties for noncompliance with this data submission requirement.

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

2.c. Data Certification Requirements for HEDIS IDSS Data and Final HEDIS Audit Report

In accordance with 42 CFR 438.600, each MCP must submit a signed data certification letter to ODM attesting to the accuracy and completeness of its audited HEDIS IDSS data submitted to ODM. Each MCP must also submit to ODM a signed data certification letter attesting to the accuracy and completeness of its final HEDIS audit report (FAR) submitted to ODM.

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

See Appendix N, *Compliance Assessment System*, for the penalties for noncompliance with these data submission requirements.

2.d. Annual Submission of Member Level Detail Records for Specified HEDIS Measures

MCPs are required to submit member level detail records for specific HEDIS measures, in accordance with *ODM Specifications for the Submission of MCP Self-Reported, Audited HEDIS Results.* The required member level detail will be used to meet CMS reporting requirements for the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set).

See Appendix N, Compliance Assessment System, for the penalties for noncompliance with these data submission requirements.

3. CARE MANAGEMENT DATA

ODM designed a Care Management System (CAMS) in order to monitor MCP compliance with program requirements specified in Appendix K.1.d. Each MCP's care management data submission will be assessed for completeness and accuracy. The MCP is responsible for submitting a care management file every month. Failure to do so jeopardizes the MCP's ability to demonstrate compliance with care management requirements. The MCP must also submit a letter of certification, using the form required by ODM, with each CAMS data submission file. The specifications for submitting the care management file and instructions for submitting the data certification letter are provided in the *ODM Care Management Excel File and Submission Specifications*.

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 the *ODM Care Management Excel File and Submission Specifications.*

See Appendix N, *Compliance Assessment System*, for the penalty for noncompliance with this requirement.

4. APPEALS AND GRIEVANCES DATA

Pursuant to OAC rule 5160-26-08.4, MCPs are required to submit appeal and grievance activity to ODM as directed. ODM requires appeal and grievance activity to be submitted at least monthly in an electronic data file format pursuant to the *ODM Appeal File and Submission Specifications* and *ODM* 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 ODM-specified due date. These data files must be submitted in the ODM-specified format and with the ODM-specified filename in order to be successfully processed.

MCPs who fail to submit their monthly electronic data files to the ODM by the specified due date or who fail to resubmit, by no later than the end of that month, a file which meets the data quality requirements will be subject to penalty as stipulated under the Compliance Assessment System (Appendix N).

5. UTILIZATION MANAGEMENT DATA

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

6. CAHPS DATA

6.a. Annual CAHPS Survey Administration and Data Submission

Each MCP is required to contract with an NCQA Certified HEDIS Survey Vendor to administer an annual CAHPS survey to the MCP's Ohio Medicaid members, per the survey administration requirements outlined in the *ODM CAHPS Survey Administration and Data Submission Specifications*. The survey data must be submitted to NCQA, The CAHPS Database, and ODM's designee per the data submission requirements and by the due dates established in the *ODM CAHPS Survey Administration and Data Submission Specifications*.

See Appendix N, *Compliance Assessment System*, for the penalties for noncompliance with this requirement.

6.b. CAHPS Data Certification Requirements

Each MCP is required to annually submit to ODM three CAHPS data certification letters, one that attests to the MCP's adherence to ODM's requirements for the CAHPS survey administration and data submission to NCQA, a second that attests to the MCP's adherence to ODM's requirements for the CAHPS data submission to The CAHPS Database, and a third that attests to the MCP's adherence to ODM's requirements for the CAHPS data submission to ODM's designee. . The MCP's CAHPS data certification letters must be submitted per the instructions and by the due dates provided in the *ODM CAHPS Survey Administration and Data Submission Specifications*.

See Appendix N, *Compliance Assessment System*, for the penalties for noncompliance with these data submission requirements.

7. THIRD PARY LIABILITY DATA SUBMISSIONS

No later than the 20th of each month, MCPs must either (1) provide ODM with a Third Party Liability (TPL) data file that includes all TPL information for members effective the first day of that month or (2) reconcile the ODM monthly TPL file with their data and provide ODM with a data file that contains any discrepancies, additions, and deletions. MCPs must submit this information electronically to ODM pursuant to the *ODM Third Party Liability File and Submission Specifications*.

8. PRIMARY CARE PROVIDER (PCP) DATA

ODM requires assignment of primary care providers (PCPs) to members as specified in OAC rule 5160-26-08.2. The MCP is responsible for submitting a PCP data file every quarter beginning February 2016. Each MCP's PCP data file submission will be assessed for completeness and accuracy. The MCP must also submit a letter of certification, using the form required by ODM, with each PCP data file submission. The specifications for submitting the PCP data file and instructions for submitting the data certification letter are provided in the *ODM Primary Care Provider Data File and Submission Specifications*.

Timely Submission of PCP Data Files

PCP Data File Submission Requirements: The MCP must submit a PCP data file, and corresponding certification letter, on a quarterly basis according to the specifications established in the *ODM Primary Care Provider Data File and Submission Specifications.*

See Appendix N, *Compliance Assessment System*, for the penalties for noncompliance with these requirements.

9. MEDICAID MANAGED CARE QUARTERLY ENROLLMENT FILES

Accurate MCP enrollment records are a critical component of determining accurate rates for measures where recipient enrollment is used as the basis for calculating rates. In order to ensure the most accurate and complete enrollment records possible for each MCP, ODM is creating Quarterly Enrollment files to be sent to each MCP for the purpose of enrollment verification Details regarding specifications for these enrollment files can be found in *ODM's Medicaid Managed Care Plan Quarterly Enrollment Data File Specifications.*

Effective July 2016, MCPs may voluntary submit to ODM on a quarterly basis addition and deletion files for member enrollment spans. These file submissions must be accompanied by a data certification letter, using the form required by ODM. Specifications for submitting the addition and deletion files, and instructions for submitting the associated data certification letter,

are provided in ODM's *Medicaid Managed Care Plan Addition and Deletion Enrollment Data File Specifications*.

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

APPENDIX M

QUALITY MEASURES AND STANDARDS

The Ohio Department of Medicaid (ODM) has established Quality Measures and Standards to evaluate Managed Care Plan (MCP) performance in key program areas (i.e., access, clinical quality, consumer satisfaction). The selected measures align with specific priorities, goals, and/or focus areas of the ODM Quality Strategy. Most measures have one or more Minimum Performance Standards. Specific measures and standards are used to determine MCP performance incentives, while others are used to determine MCP noncompliance sanctions. A limited number of measures are informational only and have no associated standards, incentives, or sanctions. All of the measures utilized for performance evaluation are derived from national measurement sets (e.g., HEDIS, AHRQ), widely used for evaluation of Medicaid and/or managed care industry data. Performance measures and standards are subject to change based on the revision or update of applicable national measures, methods, benchmarks, or other factors as deemed relevant.

The establishment of Quality Measures and Standards in this Appendix is not intended to limit the assessment of other indicators of performance for quality improvement activities. Performance on multiple measures will be assessed and reported to the MCPs and others, including Medicaid consumers.

1. QUALITY MEASURES WITH STANDARDS

Minimum Performance Standards have been established for the clinical quality measures listed in Table 1. below. Specific measures are designated for use in the Pay-for-Performance (P4P) Incentive System each year (see Appendix O, *Pay-for-Performance (P4P)*). For these measures, performance exceeding the Minimum Performance Standard may result in the receipt of financial incentives for participating MCPs. For the remaining measures, failure to meet a Minimum Performance Standard will result in the assessment of a noncompliance penalty (see Appendix N, *Compliance Assessment System*).

MCPs are evaluated on each measure using statewide results that include all regions in which the MCP has membership. Results for each measure are calculated per MCP and include all of the MCP's Ohio Medicaid members who meet the criteria specified by the methodology for the given measure. MCP performance is assessed using ODM calculated performance measurement data for the CHIPRA, AHRQ, and AMA/PCPI measures; NCQA calculated summary rates for the HEDIS/CAHPS survey measures; and MCP self-reported, audited HEDIS data for the NCQA HEDIS measures listed in Table 1. below. The ODM methodology for the CHIPRA, AHRQ, and AMA/PCPI measures in Table 1. is posted, upon publication, to the *Medicaid Managed Care Program* page of the ODM website. The HEDIS measures and HEDIS/CAHPS survey measures in Table 1. are calculated in accordance with *NCQA's Volume 2: Technical Specifications* and *NCQA's Volume 3: Specifications for Survey Measures*, respectively. The previous calendar year is the standard measurement year for HEDIS data.

1.a. Measures, Measurement Sets, Standards, and Measurement Years

The measures and accompanying Minimum Performance Standards and measurement years for the SFY 2016 and SFY 2017 contract periods are listed in Table 1. below. The measurement set associated with each measure is also provided. The measures used in the Pay for Performance (P4P) Incentive System each year are denoted with an asterisk (*) in the respective Minimum Performance Standard columns and the standard is bolded. The SFY 2016 contract period will be reporting only for nine measures and the SFY 2017 contract period will be reporting only for three measures, as indicated in the table.. No standard will be established or compliance assessed for these measures for the applicable year.

Table 1. SFY 2016, SFY 2017, SFY 2018 and SFY 2019 Performance Measures, Measurements Sets, Standards, and Measurement Years

Measure	Measure-ment Set	SFY 2016 Minimum Perf. Std.	SFY 2016 Measure-ment Year	SFY 2017 Minimum Perf. Std.	SFY 2017 Measure-ment Year	SFY 2018 Minimum Perf. Std.	SFY 2018 Measure-ment Year	SFY 2019 Minimum Perf. Std.	SFY 2019 Measure-ment Year
Quality Strategy Population Stream: **Healthy Children**									
Children and Adolescents' Access to Primary Care Practitioners - 12-24 Months, 25 Months - 6 Years, 7-11 Years, and 12-19 Years	NCQA/ HEDIS	12-24 Mos. ≥ 95.9%	CY 2015	12-24 Mos. ≥ 94.2%	CY 2016	12-24 Mos. TBD	CY 2017	12-24 Mos. TBD	CY 2018
		25 Mos.- 6 Yrs. ≥ 86.1%		25 Mos. - 6 Yrs. ≥ 85.4%		25 Mos. - 6 Yrs. TBD		25 Mos. - 6 Yrs. TBD	
		7-11 Yrs. ≥ 87.8%		7-11 Yrs. ≥ 88.9%		7-11 Yrs. TBD		7-11 Yrs. TBD	
		12-19 Yrs. ≥ 85.8%		12-19 Yrs. ≥ 87.3%		12-19 Yrs. TBD		12-19 Yrs. TBD	
Well-Child Visits in the First 15 Months of Life – Six or More Well-Child Visits	NCQA/ HEDIS	≥ 54.8%	CY 2015	≥ 51.8%	CY 2016	TBD	CY 2017	TBD	CY 2018
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	NCQA/ HEDIS	≥ 66.0%	CY 2015	≥ 65.5%	CY 2016	TBD	CY 2017	TBD	CY 2018
Adolescent Well-Care Visits	NCQA/ HEDIS	**≥ 41.7%***	CY 2015	**≥ 41.8%***	CY 2016	**TBD***	CY 2017	**TBD***	CY 2018
Appropriate Treatment for Children With Upper Respiratory Infection	NCQA/ HEDIS	**≥ 81.6%***	CY 2015	**≥ 84.2%***	CY 2016	Eliminated Effective SFY 2018	Eliminated Effective SFY 2018	Eliminated Effective SFY 2018	Eliminated Effective SFY 2018
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Percentile Documentation	NCQA/ HEDIS	Reporting Only for SFY 2016	CY 2015	Reporting Only for SFY 2017	CY 2016	Reporting Only for SFY 2018	CY 2017	TBD	CY 2018

Measure	Measure-ment Set	SFY 2016 Minimum Perf. Std.	SFY 2016 Measure-ment Year	SFY 2017 Minimum Perf. Std.	SFY 2017 Measure-ment Year	SFY 2018 Minimum Perf. Std.	SFY 2018 Measure-ment Year	SFY 2019 Minimum Perf. Std.	SFY 2019 Measure-ment Year
General Child Rating of Health Plan (CAHPS Health Plan Survey)	NCQA/ HEDIS/ CAHPS	≥2.51	CY 2015 (Survey conducted in CY 2016)	≥2.51%	CY 2016 (Survey conducted in CY 2017)	TBD	CY 2017 (Survey conducted in CY 2018)	TBD	CY 2018 (Survey conducted in CY 2019)
Quality Strategy Population Stream: **Women of Reproductive Age**									
Frequency of Ongoing Prenatal Care – ≥ 81 Percent of Expected Visits	NCQA/ HEDIS	≥ 43.7%	CY 2015	≥ 46.7%	CY 2016	TBD	CY 2017	TBD	CY 2018
Prenatal and Postpartum Care - Timeliness of Prenatal Care	NCQA/ HEDIS	**≥ 77.8%***	CY 2015	**≥ 77.4%***	CY 2016	**TBD***	CY 2017	**TBD***	CY 2018
Prenatal and Postpartum Care - Postpartum Care	NCQA/ HEDIS	**≥ 56.2%***	CY 2015	**≥ 55.5%***	CY 2016	**TBD***	CY 2017	**TBD***	CY 2018
Percent of Live Births Weighing Less Than 2,500 Grams	CHIPRA	≤ 10.3%	CY 2015	≤ 10.3%	CY 2016	TBD	CY 2017	TBD	CY 2018
Quality Strategy Population Stream: **Behavioral Health**									
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics, Total	NCQA/ HEDIS	Reporting Only for SFY 2016	CY 2015	≥ 60.2%	CY 2016	TBD	CY 2017	TBD	CY 2018
Use of Multiple Concurrent Antipsychotics in Children and Adolescents, Total	NCQA/ HEDIS	Not Applicable	Not Applicable	Reporting Only for SFY 2017	CY 2016	TBD	CY 2017	TBD	CY 2018
Metabolic Monitoring for Children and Adolescents on Antipsychotics, Total	NCQA/ HEDIS	Reporting Only for SFY 2016	CY 2015	Reporting Only for SFY 2017	CY 2016	Eliminated Effective SFY 2018	Eliminated Effective SFY 2018	Eliminated Effective SFY 2018	Eliminated Effective SFY 2018
Follow-Up After Hospitalization for Mental Illness	NCQA/ HEDIS	7-Day Follow-up **≥ 31.7%*** 30-Day Follow-up Not Applicable	CY 2015	7-Day Follow-up **≥ 32.0%*** 30-Day Follow-up Not Applicable	CY 2016	7-Day Follow-up **≥ TBD*** 30-Day Follow-up Reporting Only	CY 2017	7-Day Follow-up **≥ TBD*** 30-Day Follow-up TBD	CY 2018
Antidepressant Medication Management – Effective Acute Phase Treatment, Effective Continuation Phase Treatment	NCQA/ HEDIS	Reporting Only for SFY 2016	CY 2015	Reporting Only for SFY 2017	CY 2016	Reporting Only for SFY 2018	CY 2017	Acute Phase TBD Continu-ation Phase TBD	CY 2018
Initiation and Engagement of Alcohol and Other Drug	NCQA/ HEDIS	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Reporting Only for SFY 2018	CY 2017	Initiation Total TBD	CY 2018

Dependence Treatment – Initiation of AOD Treatment Total, Engagement of AOD Treatment Total								Engagement Total TBD	
Measure	**Measure-ment Set**	**SFY 2016 Minimum Perf. Std.**	**SFY 2016 Measure-ment Year**	**SFY 2017 Minimum Perf. Std.**	**SFY 2017 Measure-ment Year**	**SFY 2018 Minimum Perf. Std.**	**SFY 2018 Measure-ment Year**	**SFY 2019 Minimum Perf. Std.**	**SFY 2019 Measure-ment Year**
Quality Strategy Population Stream: **Chronic Conditions**									
Medication Management for People With Asthma – Medication Compliance 50%, Total Rate; Medication Compliance 75 %, Total Rate	NCQA/ HEDIS	50% Total Rate Not Applicable 75% Total Rate Reporting Only	CY 2015	50% Total Rate Not Applicable 75% Total Rate ≥ 23.7%	CY 2016	50% Total Rate Reporting Only 75% Total Rate TBD	CY 2017	50% Total Rate TBD 75% Total Rate TBD	CY 2018
PDI 14: Asthma Admission Rate (ages 2 - 17)	AHRQ	Reporting Only for SFY 2016	CY 2015	Reporting Only for SFY 2017	CY 2016	Eliminated Effective SFY 2018	Eliminated Effective SFY 2018	Eliminated Effective SFY 2018	Eliminated Effective SFY 2018
Comprehensive Diabetes Care – HbA1c Control (<8.0%)	NCQA/ HEDIS	**≥38.2%***	CY 2015	**≥40.0%***	CY 2016	Reporting Only for SFY 2018	CY 2017	Reporting Only for SFY 2019	CY 2018
Comprehensive Diabetes Care – HbA1c Poor Control (>9.0%)	NCQA/ HEDIS	Not Applicable	Not Applicable	Not Applicable	Not Applicable	**TBD***	CY 2017	**TBD***	CY 2018
Comprehensive Diabetes Care – HbA1c Testing	NCQA/ HEDIS	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Reporting Only for SFY 2018	CY 2017	TBD	CY 2018
Comprehensive Diabetes Care - Eye Exam (Retinal) Performed	NCQA/ HEDIS	≥ 46.3%	CY 2015	≥ 47.1%	CY 2016	TBD	CY 2017	TBD	CY 2018
Comprehensive Diabetes Care - Blood Pressure Control (<140/90 mm Hg)	NCQA/ HEDIS	≥ 53.7%	CY 2015	≥56.5%	CY 2016	TBD	CY 2017	TBD	CY 2018
Statin Therapy for Patients With Diabetes, Received Statin Therapy	NCQA/ HEDIS	Not Applicable	Not Applicable	Reporting Only for SFY 2017	CY 2016	TBD	CY 2017	TBD	CY 2018
PQI 16: Lower-Extremity Amputation, Patients w/ Diabetes	AHRQ	Reporting Only for SFY 2016	CY 2015	≤ 2.2	CY 2016	TBD	CY 2017	TBD	CY 2018
Controlling High Blood Pressure	NCQA/ HEDIS	**≥48.6%***	CY 2015	**≥49.9%***	CY 2016	**TBD***	CY 2017	**TBD***	CY 2018
Statin Therapy for Patients With Cardiovascular Disease, Received Statin Therapy, Total	NCQA/ HEDIS	Not Applicable	Not Applicable	Reporting Only for SFY 2017	CY 2016	TBD	CY 2017	TBD	CY 2018
PQI 8: Heart Failure Admission Rate	AHRQ	Reporting Only for SFY 2016	CY 2015	Reporting Only for SFY 2017	CY 2016	Eliminated Effective SFY 2018	Eliminated Effective SFY 2018	Eliminated Effective SFY 2018	Eliminated Effective SFY 2018

Measure	Measure-ment Set	SFY 2016 Minimum Perf. Std.	SFY 2016 Measure-ment Year	SFY 2017 Minimum Perf. Std.	SFY 2017 Measure-ment Year	SFY 2018 Minimum Perf. Std.	SFY 2018 Measure-ment Year	SFY 2019 Minimum Perf. Std.	SFY 2019 Measure-ment Year
PQI 13: Angina without Procedure Admission Rate	AHRQ	Reporting Only for SFY 2016	CY 2015	Reporting Only for SFY 2017	CY 2016	Eliminated Effective SFY 2018	Eliminated Effective SFY 2018	Eliminated Effective SFY 2018	Eliminated Effective SFY 2018
Quality Strategy Population Stream: **Healthy Adults**									
Adults' Access to Preventive/Ambulatory Health Services – Total	NCQA/ HEDIS	≥ 80.7%	CY 2015	≥79.6%	CY 2016	TBD	CY 2017	TBD	CY 2018
Cervical Cancer Screening	NCQA/ HEDIS	Reporting Only for SFY 2016	CY 2015	Reporting Only for SFY 2017	CY 2016	Reporting Only for SFY 2018	CY 2017	TBD	CY 2018
Breast Cancer Screening	NCQA/ HEDIS	Reporting Only for SFY 2016	CY 2015	Reporting Only for SFY 2017	CY 2016	Reporting Only for SFY 2018	CY 2017	TBD	CY 2018
Adult BMI Assessment	NCQA/ HEDIS	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Reporting Only for SFY 2018	CY 2017	TBD	CY 2018
Tobacco Use: Screening and Cessation	AMA-PCPI	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Reporting Only for SFY 2018	CY 2017	TBD	CY 2018
Adult Rating of Health Plan (CAHPS Health Plan Survey)	NCQA/ HEDIS/ CAHPS	≥2.32	CY 2015 (Survey conducte d in CY 2016)	≥2.35%	CY 2016 (Survey conducted in CY 2017)	TBD	CY 2017 (Survey conducted in CY 2018	TBD	CY 2018 (Survey conducted in CY 2019

*This Minimum Performance Standard and associated measure are used in the Pay for Performance (P4P) Incentive System for the respective year listed in Table 1. Above, and as outlined in Section 1. of Appendix O. No penalty will be assessed for noncompliance with this Minimum Performance Standard and measure for the corresponding year.
Note: no standard will be established or compliance assessed for the measures designated 'reporting only' in the Minimum Performance Standard column for the corresponding year.
TBD = To be determined

2. INFORMATIONAL ONLY QUALITY MEASURES

The clinical quality measures listed in Table 2. below are informational only. No Minimum Performance Standards have been established for these measures. Performance results will be used to assess the quality of care provided by MCPs to the managed care population, and may be used for federal reporting and ODM public reporting purposes (e.g., MCP report cards).

MCPs are evaluated on each measure using statewide results that include all regions in which the MCP has membership. Results for each measure are calculated per MCP and include all of the MCP's Ohio Medicaid members who meet the criteria specified by the methodology for the given measure. MCP performance is assessed using the NCQA calculated summary rate for the HEDIS/CAHPS survey measure, and MCP self-reported, audited HEDIS data for the NCQA HEDIS measures listed in Table 2. below. The HEDIS measures and HEDIS/CAHPS survey measure in Table 2. are calculated in accordance with *NCQA's Volume 2: Technical Specifications* and *NCQA's Volume 3:*

Specifications for Survey Measures, respectively. The previous calendar year is the standard measurement year for HEDIS data.

2.a. Informational Only Quality Measures, Measurement Sets, and Measurement Years

The informational only quality measures and measurement years for the SFY 2016 and SFY 2017 contract periods are listed in Table 2. below. The measurement set associated with each measure is also provided.

Table 2. SFY 2016, SFY 2017, SFY 2018 and SFY 2019 Informational Only Quality Measures, Measurements Sets, and Measurement Years

Measure	Measurement Set	SFY 2016 Measurement Year	SFY 2017 Measurement Year	SFY 2018 Measurement Year	SFY 2019 Measurement Year
Quality Strategy Population Stream: **Healthy Children**					
Annual Dental Visits, Total Rate	NCQA/ HEDIS	CY 2015	CY 2016	CY 2017	CY 2018
Childhood Immunization Status (Combo 2)	NCQA/ HEDIS	CY 2015	CY 2016	CY 2017	CY 2018
Childhood Immunization Status (Combo 3)	NCQA/ HEDIS	CY 2015	CY 2016	CY 2017	CY 2018
Childhood Immunization Status (Combo 10)	NCQA/ HEDIS	CY 2015	CY 2016	CY 2017	CY 2018
Immunizations for Adolescents (Combo 1)	NCQA/ HEDIS	CY 2015	CY 2016	CY 2017	CY 2018
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Counseling for Nutrition, Counseling for Physical Activity	NCQA/ HEDIS	CY 2015	CY 2016	CY 2017	CY 2018
Ambulatory Care-Emergency Department (ED) Visits	NCQA/ HEDIS	Not Applicable	CY 2016	CY 2017	CY 2018
Quality Strategy Population Stream: **Women of Reproductive Age**					
Human Papillomavirus Vaccine for Female Adolescents	NCQA/ HEDIS/ CAHPS	CY 2015	CY 2016	CY 2017	CY 2018
Chlamydia Screening in Women, Total	NCQA/ HEDIS	CY 2015	CY 2016	CY 2017	CY 2018
Quality Strategy Population Stream: **Behavioral Health**					
Follow-Up Care for Children Prescribed ADHD Medication	NCQA/ HEDIS	Not Applicable	CY 2016	CY 2017	CY 2018
Mental Health Utilization	NCQA/ HEDIS	CY 2015	CY 2016	CY 2017	CY 2018
Quality Strategy Population Stream: **Chronic Conditions**					
Comprehensive Diabetes Care: Medical Attention for Nephropathy	NCQA/ HEDIS	CY 2015	CY 2016	CY 2017	CY 2018
Pharmacotherapy Management of COPD Exacerbation: Dispensed a Systemic Corticosteroid within 14 Days of the Event; Dispensed a Systemic Bronchodilator within 30 Days of the Event	NCQA/ HEDIS	CY 2015	CY 2016	CY 2017	CY 2018

3. NOTES

3.a. Measures and Measurement Years

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

3.b. Performance Standards – Compliance Determination

In the event an MCP's performance cannot be evaluated for a performance measure and measurement year established in Table 1. of this appendix, ODM in its sole discretion will deem the MCP to have met or to have not met the standard(s) for that particular measure and measurement year depending on the circumstances involved (e.g., if a HEDIS measure was assigned an audit result of "Not Report" on the MCP's Final Audit Report and the "Not Report" designation was determined to be the result of a material bias caused by the MCP, ODM would deem the MCP to have not met the standard(s) for that measure and measurement year).

3.c. Performance Standards – Retrospective Adjustment

ODM will implement the use of a uniform methodology, as needed, for the retrospective adjustment of any Minimum Performance Standard listed in Table 1. of this Appendix, except for the CAHPS measure standards. This methodology will be implemented at ODM's sole discretion when all three of the following criteria are met.

• The methodology for the standard's associated measure is revised. Note, for HEDIS measures, ODM will not adjust performance measure standards retrospectively due to procedural changes such as revisions to medical record hybrid review timelines.

• For the year the methodology is revised, the performance results for all Ohio Medicaid MCPs all increase or all decrease when compared to the standard setting year (e.g., for the SFY 2013 provider agreement, the standard setting year is HEDIS 2011). Note, this excludes MCPs without results for both years.

• For the year the methodology is revised, the performance results for three or more Ohio Medicaid MCPs each change by at least three percentage points (e.g., increase from 56.0% to 59.0%) when compared to the standard setting year.

For a comprehensive description of the standard adjustment methodology, see *ODM Methods for the Retrospective Adjustment of Quality and P4P Measure Standards.*

APPENDIX N

COMPLIANCE ASSESSMENT SYSTEM

I. General Provisions of the Compliance Assessment System

A. The Compliance Assessment System (CAS) sets forth sanctions that may be assessed by the Ohio Department of Medicaid (ODM) against the Managed Care Plan (MCP) if the MCP is found to have violated this Provider Agreement, or any other applicable law, rule, or regulation. It does not in any way limit ODM from requiring Corrective Action Plans (CAPs) and program improvements, or from imposing any of the sanctions specified in OAC rule 5160-26-10 or any other additional compliance actions, including the proposed termination, amendment, or nonrenewal of this Provider Agreement. Any actions undertaken by ODM under this Appendix are not exclusive to any other compliance action it may impose or that is available to ODM under applicable law or regulations.

B. As stipulated in OAC rule 5160-26-10, regardless of whether ODM imposes a sanction, the MCP is required to initiate corrective action for any MCP program violation or deficiency as soon as the violation or deficiency is identified by the MCP or ODM. The MCP is required to report to ODM when it becomes aware of any violation that could impair a member's ability to obtain correct information regarding services, impair member rights, affect the ability of the MCP to deliver covered services, or affect the member's ability to access covered services.

C. If ODM determines that an MCP has violated any of the requirements of sections 1903(m) or 1932 of the Social Security Act that are not specifically identified within this Provider Agreement, ODM may (1) require the MCP to permit any of its members to disenroll from the MCP without cause, or (2) suspend any further new member enrollments to the MCP, or both.

D. Program violations that reflect noncompliance from the previous compliance term will be subject to remedial action under CAS at the time that ODM first becomes aware of this noncompliance.

E. ODM retains the right to use its discretion to determine and apply the most appropriate sanction based on the severity of the noncompliance, a pattern of repeated noncompliance, and number of beneficiaries affected. In instances where the MCP is able to document, to the satisfaction of ODM, that the violation and precipitating circumstances were beyond its control and could not have reasonably been foreseen (e.g., a construction crew severs a phone line, a lightning strike disables a computer system, etc.), ODM may, in its discretion, utilize alternative methods (e.g., performance improvement plan, remediation plans, etc.) in lieu of the imposition of sanctions/remedial actions as defined in section II of this appendix.

F. ODM will issue all notices of noncompliance in writing to the identified MCP contact.

II. Types of Sanctions/Remedial Actions

ODM may impose sanctions/remedial actions, including, but not limited to, the items listed below.

A. Corrective Action Plans (CAPs)

A CAP is a structured activity, process or quality improvement initiative implemented by the MCP to improve identified operational and clinical quality deficiencies. All CAPs must be submitted in the manner specified by ODM.

MCPs may be required to develop CAPs for any instance of noncompliance with applicable rules, regulations or contractual requirements; CAPs are not limited to actions taken in this appendix. All CAPs requiring ongoing activity on the part of an MCP to ensure its compliance with a program requirement will remain in effect until the plan has provided sufficient evidence that it has fulfilled the requirements of the CAP to the satisfaction of ODM. All CAPs requiring implementation of quality improvement initiatives will remain in effect for at least twelve months from the date of implementation.

Where ODM has determined the specific action which must be implemented by the MCP or if the MCP has failed to submit a CAP, ODM may require the MCP to comply with an ODM-developed or "directed" CAP.

Where a sanction is assessed for a violation in which an MCP has previously been assessed a CAP the MCP may be assessed escalating sanctions under this Provider Agreement.

B. Financial Sanctions

B.1. Financial Sanctions Assessed Due to Accumulated Points

Points will accumulate over a rolling 12-month schedule. Points more than 12 months old will expire.

No points will be assigned for a violation if an MCP is able to document that the precipitating circumstances were completely beyond its control and could not have been foreseen (e.g., a construction crew severs a phone line, a lightning strike disables a computer system, etc.).

In cases where an MCP-contracted healthcare provider is found to have violated a program requirement (e.g., failing to provide adequate contract termination notice, marketing to potential members, inappropriate member billing, etc.), ODM may assess points unless to the satisfaction of ODM: (1) the MCP can document that it provided sufficient notification or education to providers of applicable program requirements and prohibited activities; and (2) the MCP took immediate and appropriate action to correct the problem and to ensure that it will not reoccur. ODM will review repeated incidents and determine whether the MCP has a systemic problem. If ODM determines that a systemic problem exists, further sanctions or remedial actions may be assessed against the MCP.

B.1.1. 5 Points

ODM may in its discretion assess five (5) points for any instance of noncompliance with applicable rules, regulations or contractual requirements. Instances of noncompliance can include, but are not limited to those that (1) impair a member's or potential enrollee's ability to obtain accurate information regarding MCP services, (2) violate a care management process, (3) impair a member's or potential enrollee's ability to obtain correct information regarding services or (4) infringe on the rights of a member or potential enrollee. Examples of five (5) point violations include, but are not limited to the following:

- Failure to provide accurate provider panel information.
- 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 his or her right to a state hearing when the MCP proposes to deny, reduce, suspend or terminate a Medicaid-covered service.
- Failure to staff a 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 ODM, health care providers, the MCP's members, or any eligible individuals.
- Use of unapproved marketing or member materials.
- Failure to appropriately notify ODM, or members, of provider panel terminations.
- Failure to update website provider directories as required.
- Failure to comply with an open CAP or a CAP closed in the last twelve (12) months.
- Failure to actively participate in quality improvement projects or performance improvement projects facilitated by ODM and/or the EQRO.
- Failure to meet provider network performance standards.
- A violation of a care management process specified in Appendix K of the Provider Agreement that does not meet the standards for a 10 point violation. Examples include but are not limited to the following:
    - Failure to ensure that staff performing care management functions are operating within their professional scope of practice, are appropriately responding to a member's care management needs, or are complying with the state's licensure/credentialing requirements;
    - Failure to adequately assess an individual's needs including the evaluation of mandatory assessment domains;
    - Failure to update an assessment upon a change in health status, needs or significant health care event;
    - Failure to develop or update a care plan that appropriately addresses assessed needs of a member;
    - Failure to monitor the care plan;
    - Failure to complete a care gap analysis that identifies gaps between recommended care and care that is received by a member;

- Failure to update the care plan in a timely manner when gaps in care or change in need are identified;
- Failure to coordinate care for a member across providers, specialists, and team members, as appropriate;
- Failure to adhere to a documented communication plan, including the contact schedule for in-person visits and telephone calls; or
- Failure to make reasonable attempts to obtain a discharge/transition plan from an inpatient facility; conduct timely follow up with the member and provider, as appropriate; or arrange for services specified in the discharge/transition plan.

B.1.2. 10 Points

ODM may assess ten (10) points when the MCP fails to meet a program requirement that could, as determined by ODM: (1) affect the ability of the MCP to deliver, or a member to access, covered services; (2) place a member at risk for a negative health outcome; or (3) jeopardize the safety and welfare of a member. Examples include, but are not limited to, the following:

- 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 receiving a request from the member.
- Failure to provide medically-necessary Medicaid covered services to members.
- Failure to participate in transition of care activities or discharge planning activities.
- Failure to process prior authorization requests within the prescribed time frames.
- Repeated failure to comply with an open CAP or a CAP closed in the last twelve (12) months.
- The imposition of premiums or charges on members that are in excess of the premiums or charges permitted under the Medicaid program.
- Misrepresentation or falsification of information that the MCP furnishes to ODM.
- Misrepresentation or falsification of information that the MCP furnishes to a member, potential member, or health care provider.
- Failure to comply with the requirements for physician incentive plans, as set forth in 42 CFR 422.208 and 422.210.
- Violation of a care management process as specified in Appendix K.

B.1.3. Progressive Sanctions Based on Accumulated Points

Progressive sanctions will be based on the number of points accumulated at the time of the most recent incident. A CAP or other sanction may be imposed in addition to the fines

listed below. The designated fine amount will be assessed when the number of accumulated points falls within the ranges specified below:

0 -15 Points	CAP + No fine
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 Provider Agreement Termination

B.2 Specific Pre-Determined Sanctions

B.2.1. Adequate network-minimum provider panel requirements

Any deficiencies in the MCP's provider network specified in Appendix H of this Provider Agreement or by ODM, may result in the assessment of a $1,000 nonrefundable fine for each category (practitioners, PCP capacity, hospitals), for each county. Compliance will be assessed at least quarterly.

ODM may assess additional sanctions (e.g., CAPs, points, fines) if (1) an MCP violates any other provider panel requirements or (2) an MCP's member has experienced problems accessing necessary services due to lack of an adequate provider panel.

B.2.2. Late Submissions

All submissions, data and documentation submitted by an MCP must be received by ODM within the specified deadline and must represent the MCP in an honest and forthright manner. If the MCP fails to provide ODM with any required submission, data or documentation, ODM may assess a nonrefundable fine of $100 per day, unless the MCP requests and is granted an extension by ODM. Assessments for late submissions will be done monthly.

If an MCP is 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. Requests for extensions should only be submitted where unforeseeable circumstances have made it impossible for the MCP to meet a deadline stipulated by ODM. All such requests will be evaluated upon this standard. ODM may assess compliance against an MCP for late submission unless ODM has granted written approval for a deadline extension request.

B.2.3. Noncompliance with Claims Adjudication Requirements

If ODM finds that an MCP is unable to (1) electronically accept and adjudicate claims to final status, or (2) notify providers of the status of their submitted claims, ODM may assess the MCP

with a monetary sanction of $20,000 per day for the period of noncompliance. Additionally, the MCP may be assessed 5 points per incident of noncompliance.

If ODM has identified specific instances where an MCP has failed to take the necessary steps to comply with the requirements specified in Appendix C of the Agreement by (1) failing to notify non-contracting providers of procedures for claims submissions when requested or (2) failing to notify contracting and non-contracting providers of the status of their submitted claims, the MCP may be assessed 5 points per incident of noncompliance.

B.2.4. Noncompliance with Financial Performance Measures or the Submission of Financial Statements

If an MCP fails to meet any standard for 2.a., 2.b., 2.c., or 2.d of Appendix J, ODM may require the MCP to complete a CAP and specify the date by which compliance must be demonstrated. Failure by the MCP to meet the standard or otherwise comply with the CAP by the specified date may result in a new enrollment freeze unless ODM determines that the deficiency does not potentially jeopardize access to or quality of care or affect the MCP's ability to meet administrative requirements (e.g., prompt pay requirements). Justifiable reasons for noncompliance may include one-time events (e.g., MCP investment in information system products).

If Financial Statements are not submitted to the Ohio Department of Insurance (ODI) by the due date, the MCP continues to be obligated to submit the report to ODM by ODI's originally specified due date unless the MCP requests and is granted an extension by ODM.

If an MCP fails to submit complete quarterly and annual Financial Statements on a timely basis, ODM will deem this a failure to meet the standards and may impose the noncompliance sanctions listed above for indicators 2.a., 2.b., 2.c., and 2.d, including a new enrollment freeze. The new enrollment freeze will take effect on the first of the month following the month ODM has determined that the MCP was non-compliant for failing to submit financial reports timely.

B.2.5. Noncompliance with Medical Loss Ratio (MLR) Requirements for the Adult Extension Population

B.2.5.1. Establishment of MLR

For Adult Extension members, ODM shall perform an MLR calculation as defined in the ODM Methods for Financial Performance Measures for the periods stated below.

a. ODM shall perform MLR calculations for the incurred periods of January 1, 2014 through December 31, 2014, ("first period"), and January 1, 2015 through December 31, 2015, ("second period").
b. For each period, ODM or its designee will initiate the MLR calculation 12 months after the end of each period.
c. ODM will give consideration to paid claims data through December 31, 2015, for services incurred during the first period, and through December 31, 2016, for the second period. In the determination of Incurred Medical

Claims, no estimate of claims to be paid more than 12 months beyond the end of the period will be considered. Incurred Medical Claims includes an adjustment for pharmaceutical rebates collected by the MCP.

d. The MCP shall provide and certify any data used in the calculation of the MLR in accordance with 42 CFR 438.600 et al. Data submitted to ODM is subject to review or audit by ODM or its designee.
e. Net Capitation Payments equals Earned Premiums minus Federal, State, and Local Taxes and Licensing or Regulatory Fees.
f. Allowed Medical Expense equals Incurred Medical Claims plus Expenses for Activities That Improve Health Care Quality (as defined in 45 CFR 158.150)

B.2.5.2. MLR Rebate

The MCP shall be required to expend at minimum 85 percent of Net Capitation Payments for the Extension population on Allowed Medical Expenses. If the MCP does not meet the minimum 85 percent MLR threshold, then the MCP shall return to the State the difference between 85 percent of total Net Capitation Payments to the MCP and actual Allowed Medical Expenses incurred. After completion of the MLR calculation, if it is determined that the MLR of the MCP is less than 85 percent, then ODM will notify the MCP of the capitation payments to be returned to the State.

a. The MCP shall remit to the State the full amount due no later than ninety (90) calendar days after the date ODM delivers notice to the MCP of that amount.
b. It is explicitly noted that this MLR contract provision may result in payment by the MCP to ODM.
c. In the event of a change in capitation rate for the Extension population, for each period provided in this Provision, a MLR calculation in accordance with the requirements of this Provision shall be re-determined by ODM. Subsequent to this re-determination, adjustments to payments in accordance with this Provision may result in changes in payment by the MCP to ODM.

B.2.6. Noncompliance with Reinsurance Requirements

If ODM determines that (1) an MCP has failed to maintain reinsurance coverage as specified in Appendix J, (2) an MCP's deductible exceeds $100,000 without approval from ODM, or (3) an MCP's reinsurance for non-transplant services covers less than 80% of inpatient costs in excess of the deductible incurred by one member for one year without approval from ODM, then ODM may require the MCP to pay a monetary sanction to ODM. The amount of the sanction will be the lesser of (1) 10% of the difference between the estimated amount of what the MCP would have

paid in premiums for the reinsurance policy if it had been in compliance and what the MCP actually paid while it was out of compliance or (2) $50,000.

If ODM determines that an MCP's reinsurance for transplant services covers less than 50% of inpatient costs incurred by one member for one year, ODM may subject the MCP to a CAP.

B.2.7. Noncompliance with Prompt Payment
ODM may impose progressive sanctions on an MCP that does not comply with the prompt pay requirements as specified in Appendix J of this Agreement.

- The first instance of noncompliance during a rolling 12-month period: ODM may assess a refundable fine equal to the greater of, one quarter of one percent of the amount calculated in accordance with section B.3.2. of this appendix, or 25% of the total dollar amount of clean claims not paid within the timeframes outlined in Appendix J of this agreement. The refundable fine amount will be returned to the MCP if ODM determines the MCP is in full compliance with the prompt pay standards within the five consecutive reporting periods following the report period for which the refundable fine was issued.

- The second instance of noncompliance during a rolling 12-month period: ODM may assess a nonrefundable fine equal to the greater of, one half of one percent of the amount calculated in accordance with section B.3.2. of this appendix, **or** 50% of the total dollar amount of clean claims not paid within the timeframes outlined in Appendix J of this agreement.

- Subsequent violations during a rolling 12-month period may result in an enrollment freeze of not less than three (3) months duration or until the MCP has come back into compliance.

B.2.8. Noncompliance with Clinical Laboratory Improvement Amendments (CLIA)
If an MCP fails to comply with CLIA requirements as specified by ODM, then ODM may impose a nonrefundable fine in the amount of a $1,000 for each documented violation.

B.2.9. Noncompliance with Abortion and Sterilization Hysterectomy Requirements
If an MCP fails to comply with abortion and sterilization requirements as specified by ODM, then ODM may impose a nonrefundable fine in the amount of $2,000 for each documented violation. Additionally, MCPs must take all appropriate action to correct each violation documented by ODM.

B.2.10. Refusal to Comply with Program Requirements
If ODM has instructed an MCP that it 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 ODM may move to terminate or non-renew this Provider Agreement.

B.2.11. Data Quality Submission Requirements and Measures (as specified in Appendix L)

ODM reserves the right to withhold an assessment of noncompliance under section B.2.11. due to unforeseeable circumstances.

B.2.11.1. Data Quality Submission Requirements

B.2.11.1.1. Annual Submission of MCP Self-Reported, Audited HEDIS Data
Performance is monitored annually. If an MCP fails to submit its self-reported, audited HEDIS data to ODM as specified in Appendix L, the MCP will be considered non-compliant with the standards for the self-reported, audited HEDIS performance measures in Appendix M for the corresponding contract period per section B.2.12. of this appendix. In addition, ODM may impose a non-refundable $300,000 monetary sanction if the MCP's HEDIS data submission does not contain any measure(s) designated as 'reporting only' and/or 'informational only' in Appendix M for the corresponding contact period. Furthermore, the MCP may be disqualified from participation in the P4P incentive system in Appendix O for the corresponding contract period

B.2.11.1.2. Annual Submission of Final HEDIS Audit Report (FAR)
Performance is monitored annually. If an MCP fails to submit it's FAR to ODM as specified in Appendix L, the MCP will be considered non-compliant with the standards for the self-reported, audited HEDIS performance measures in Appendix M for the corresponding contract period per section B.2.12. of this appendix. In addition, the MCP may be disqualified from participation in the P4P incentive system in Appendix O for the corresponding contract period.

ODM will review each MCP's FAR in order to determine if any data collection or reporting issues were identified. In addition, ODM will evaluate any issues that resulted in the assignment of an audit result of "Not Report" (i.e., NR) for any measure. An MCP may be required to submit to ODM requested documentation to account for an NR audit designation. Based on its review of an MCP's FAR and any NR audit designations assigned, ODM reserves the right to pursue corrective action (such as requiring the MCP to implement a corrective action plan to resolve data collection and/or reporting issues).

B.2.11.1.3. Data Certification Requirements for HEDIS IDSS Data and HEDIS Audit Report
Performance is monitored annually. If an MCP fails to submit a required data certification letter to ODM within the required time frame, ODM may impose a nonrefundable fine of $100 per day, unless the MCP requests and is granted an extension by ODM.

B.2.11.1.4. Annual Submission of Member Level Detail Records for Specified HEDIS Measures

Performance is monitored annually. If an MCP fails to submit the required HEDIS measure member level detail records to ODM within the required time frame, ODM may impose a nonrefundable fine of $100 per day, unless the MCP requests and is granted an extension by ODM.

B.2.11.1.5. Annual CAHPS Survey Administration and Data Submission

Performance is monitored annually. If an MCP fails to administer a CAHPS survey and submit the survey data to NCQA, the CAHPS Database, and ODM's designee, as specified in Appendix L, ODM may impose a non-refundable $300,000 monetary sanction. In addition, the MCP will be considered non-compliant with the standards for the CAHPS performance measure in Appendix M for the corresponding contract period, per section B.2.12. of this appendix.

B.2.11.1.6. CAHPS Data Certification Requirements

Performance is monitored annually. If an MCP fails to submit a required CAHPS data certification letter to ODM within the required time frame, ODM may impose a nonrefundable fine of $100 per day, unless the MCP requests and is granted an extension by ODM.

B.2.11.2. Data Quality Measures

The MCP must submit to ODM, by the specified deadline and according to ODM's specifications, all required data files and requested documentation needed to calculate each measure listed under subsections of B.2.11.2. If an MCP fails to comply with this requirement for any measure listed under B.2.11.2 then the MCP will be considered noncompliant with the standard(s) for that measure.

Unless otherwise specified, sanctions for noncompliance are assessed per MCP and measure for the MCP's overall Ohio Medicaid population (i.e., ABD, MAGI, and Adult Extension members).

B.2.11.2.1. Encounter Data Volume

Performance is monitored once every quarter for the entire measurement period for each of the following populations: ABD adults, ABD children, MAGI members, and Adult Extension members. Sanctions for non-compliance will be assessed separately, by population. For each population, if the standard is not met for every service category in all quarters of the measurement period, the MCP will be determined to be noncompliant for the measurement period.

ODM will issue a CAP for all instances of noncompliance with this measure that are NOT consecutive. ODM will issue a series of progressive sanctions for consecutive instances of noncompliance. The first time an MCP is determined to be noncompliant with the standard for this measure, ODM will issue a CAP. If an MCP is determined to be noncompliant with the standard in a second, consecutive quarter, ODM will impose a monetary sanction of two percent of the amount calculated in accordance with

section B.3.2. of this appendix. (Monetary sanctions will not be levied in subsequent, consecutive quarters that an MCP is determined to be noncompliant.) If an MCP is determined to be noncompliant with the standard in a third, consecutive quarter, ODM will impose a new member enrollment freeze. A monetary sanction issued under this section will be returned to the MCP if ODM determines the MCP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the monetary sanction was issued. A new member enrollment freeze issued under this section will be lifted after ODM determines the MCP is in full compliance with this program requirement.

B.2.11.2.2. Rejected Encounters

Performance is monitored once every quarter for Measure 1 and once every month for Measure 2. Compliance determination with the standard applies only to the measurement period under consideration and does not include performance in previous measurement periods. Files in the ODM-specified medium per format that are totally rejected will not be considered in the determination of noncompliance. If the standard is not met for every file type, the MCP may be determined to be noncompliant for the measurement period.

Effective SFY 2016, ODM may issue a CAP for all instances of noncompliance with this measure that are NOT consecutive. ODM may issue a series of progressive sanctions for consecutive instances of noncompliance. The first time an MCP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If an MCP is determined to be noncompliant with the standard in a second, consecutive measurement period, ODM may impose a monetary sanction of two percent of the amount calculated in accordance with section B.3.2. of this appendix. If an MCP is determined to be noncompliant with the standard in a third, consecutive measurement period, ODM may impose a new member enrollment freeze. Special consideration may be made for MCPs with less than 1,000 members.

A monetary sanction issued under this section will be returned to the MCP if ODM determines the MCP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the monetary sanction was issued. A new member enrollment freeze issued under this section will be lifted after ODM determines the MCP is in full compliance with this program requirement. B.2.11.2.3. Acceptance Rate

Performance is monitored once every month. Compliance determination with the standard applies only to the month under consideration and does not include performance in previous months. If the standard is not met for every file type, the MCP may be determined to be noncompliant for the measurement period.

ODM may issue a CAP for all instances of noncompliance with this measure that are NOT consecutive. ODM may issue a series of progressive sanctions for consecutive instances of noncompliance. The first time an MCP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If an MCP is determined

to be noncompliant with the standard in a second, consecutive measurement period, ODM may impose a monetary sanction of two percent of the amount calculated in accordance with section B.3.2. of this appendix. If an MCP is determined to be noncompliant with the standard in a third, consecutive measurement period, ODM may impose a new member enrollment freeze. Special consideration may be made for MCPs with less than 1,000 members.

A monetary sanction issued under this section will be returned to the MCP if ODM determines the MCP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the monetary sanction was issued. A new member enrollment freeze issued under this section will be lifted after ODM determines the MCP is in full compliance with this program requirement.

B.2.11.2.4. Encounter Data Accuracy Study - Payment Accuracy Measure
The first time an MCP is determined to be 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 ODM 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 for either level 1 or level 2 for this measure, ODM may impose a monetary sanction of one percent of the amount calculated in accordance with section B.3.2. of this appendix. A monetary sanction issued under this section will be returned to the MCP if ODM determines the MCP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the monetary sanction was issued.

B.2.11.2.5. Encounter Data Accuracy Study - Delivery Payment Measure – Compliance with this measure will only be assessed for the MAGI population and Adult Extension members (combined). The MCP must participate in a detailed review of delivery payments made for deliveries during the measurement period. The required accuracy rate for encounters generating delivery payments is 100%; therefore, any duplicate delivery payments or delivery payments that are not validated must be returned to ODM. For all encounter data accuracy studies that are completed during the contract period, if an MCP does not meet the minimum record submittal rate of 85%, ODM may 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.

B.2.11.2.6. Encounter Data Payments Compared to Managed Care Cost Report Information

Performance is monitored once every quarter for the entire measurement period for each of the following populations: ABD, MAGI, and Adult Extension. Sanctions for

non-compliance will be assessed separately, by population. For each population, if the standard is not met for every service category in all quarters of the measurement period, the MCP will be determined to be noncompliant for the measurement period.

Effective SFY 2017, ODM will issue a CAP for all instances of noncompliance with this measure that are NOT consecutive. ODM will issue a series of progressive sanctions for consecutive instances of noncompliance. The first time an MCP is determined to be noncompliant with the standard for this measure, ODM will issue a CAP. If an MCP is determined to be noncompliant with the standard in a second, consecutive quarter, ODM will impose a monetary sanction of two percent of the amount calculated in accordance with section B.3.2. of this appendix. (Monetary sanctions will not be levied in subsequent, consecutive quarters that an MCP is determined to be noncompliant.) If an MCP is determined to be noncompliant with the standard in a third, consecutive quarter, ODM will impose a new member enrollment freeze.

A monetary sanction issued under this section will be returned to the MCP if ODM determines the MCP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the monetary sanction was issued. A new member enrollment freeze issued under this section will be lifted after ODM determines the MCP is in full compliance with this program requirement.

B.2.11.2.7. Incomplete Rendering Provider Data

Performance is monitored once every quarter for all measurement periods. If the standard is not met in all quarters of the measurement period, the MCP will be noncompliant for the measurement period.

Effective SFY 2016, ODM may issue a CAP for all instances of noncompliance with this measure that are NOT consecutive. ODM may issue a series of progressive sanctions for consecutive instances of noncompliance. The first time an MCP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If an MCP is determined to be noncompliant with the standard in a second, consecutive quarter, ODM may impose a monetary sanction of two percent of the amount calculated in accordance with section B.3.2. of this appendix. If an MCP is determined to be noncompliant with the standard in a third, consecutive quarter, ODM may impose a new member enrollment freeze.

A monetary sanction issued under this section will be returned to the MCP if ODM determines the MCP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the monetary sanction was issued. A new member enrollment freeze issued under this section will be lifted after ODM determines the MCP is in full compliance with this program requirement.

B.2.11.2.8. NPI Provider Number Usage without Medicaid/Reporting Provider Numbers
Performance is monitored once every quarter for all measurement periods. If the standard is not met in all quarters of the measurement period, the MCP may be determined to be noncompliant for the measurement period.

Effective SFY 2016, ODM may issue a CAP for all instances of noncompliance with this measure that are NOT consecutive. ODM may issue a series of progressive sanctions for consecutive instances of noncompliance. The first time an MCP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If an MCP is determined to be noncompliant with the standard in a second, consecutive quarter, ODM may impose a monetary sanction of two percent of the amount calculated in accordance with section B.3.2. of this appendix. If an MCP is determined to be noncompliant with the standard in a third, consecutive quarter, ODM may impose a new member enrollment freeze.

A monetary sanction issued under this section will be returned to the MCP if ODM determines the MCP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the monetary sanction was issued. A new member enrollment freeze issued under this section will be lifted after ODM determines the MCP is in full compliance with this program requirement.

B.2.11.2.9. Encounter Submissions per *ODM Encounter Data Submission Schedule*
Performance is monitored once every month. If the standard is not met for the measurement period, the MCP will be noncompliant for the measurement period.

Effective January 2015, ODM will issue a series of progressive sanctions for all instances of noncompliance. The first time an MCP is determined to be noncompliant with the standard for this measure, ODM may impose a monetary sanction of one percent of the amount calculated in accordance with section B.3.2. of this appendix. If an MCP is determined to be noncompliant with the standard in any subsequent month, consecutive or non-consecutive, ODM will impose a monetary sanction of two percent of the amount calculated in accordance with section B.3.2. of this appendix.

A monetary sanction issued under this section will be returned to the MCP if ODM determines the MCP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the monetary sanction was issued.

B.2.11.2.10. Timeliness of Encounter Data Submission – Performance is monitored once every month. If the standard is not met for the measurement period, the MCP will be noncompliant for the measurement period.

Effective July 2016, ODM will issue a series of progressive sanctions for all instances of noncompliance. The first time an MCP is determined to be noncompliant with the standard for this measure, ODM may impose a monetary sanction of one percent of the amount calculated in accordance with section B.3.2. of this appendix. If an MCP is determined to be noncompliant with the standard in any subsequent month, consecutive or non-consecutive, ODM will impose a monetary sanction of two percent of the amount calculated in accordance with section B.3.2. of this appendix.

A monetary sanction issued under this section will be returned to the MCP if ODM determines the MCP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the monetary sanction was issued.

B.2.12. Quality Measures (as specified in Appendix M)

This section sets forth sanctions for those quality measure standards in Appendix M that are subject to corrective action.

ODM reserves the right to withhold an assessment of noncompliance under this Section due to unforeseeable circumstances.

For each measure in Table 1. of Appendix M, one or more rates are calculated. Each rate has an associated Minimum Performance Standard. When an MCP fails to meet a Minimum Performance Standard listed in Appendix M, for a measure for which noncompliance sanctions are applicable, the MCP may be assessed a sanction for noncompliance with the standard. ODM has established uniform noncompliance sanctions for these standards.

A series of progressive sanctions may be issued for consecutive instances of noncompliance with the standard established for a given rate. For example, four rates, corresponding to the HEDIS age breakouts, are calculated for the *Children and Adolescents' Access to Primary Care Practitioners* measure. An MCP failing to meet the standard established for the '12-24 Months' rate in three consecutive measurement periods would be subject to progressive sanctions. However, an MCP failing to meet the standard established for the '7-11 Years' rate in one measurement period and the '12-19 Years' rate in the next would not be subject to progressive sanctions, as these only apply to the standard established for the same rate.

For the standard established for each rate listed in Table 1. of Appendix M, for measures for which noncompliance sanctions are applicable, an MCP may be assessed sanctions for instances of noncompliance as follows:

- First instance, or subsequent but nonconsecutive instance, of noncompliance: ODM may impose a monetary sanction in the amount of one quarter of one percent of the MCP's average monthly net premium and delivery payment amount for the twelve months prior to the month in which the compliance action is issued to the MCP. If the MCP is determined to be in full compliance with this program requirement within the following five consecutive report periods, the monetary sanction will be returned.

- Second consecutive instance of noncompliance: ODM may impose a monetary sanction in the amount of one quarter of one percent of the MCP's average monthly net premium and delivery payment amount for the twelve months prior to the month in which the compliance action is issued to the MCP. The monetary sanction is non-refundable.
- Third consecutive, and any additional consecutive, instance of noncompliance: ODM may impose a monetary sanction in the amount of one half of one percent of the MCP's average monthly net premium and delivery payment amount for the twelve months prior to the month in which the compliance action is issued to the MCP. The monetary sanction is non-refundable.
- In addition, if ODM determines that an MCP is noncompliant with greater than 50% of the quality standards listed in Appendix M, for which noncompliance sanctions are applicable, for two consecutive contract years, ODM will have the option to terminate the MCP's Provider Agreement.

B.2.13. Quality Care (as specified in Appendix K) ODM reserves the right to withhold an assessment of noncompliance under this Section due to unforeseeable circumstances.

B.2.13.1. Administrative Compliance Assessment Compliance with administrative standards is performed by the external quality review organization, as specified by ODM. For each documented instance of noncompliance with an administrative standard, the MCP may be required to submit a CAP as specified by ODM to remedy the identified deficiency.

B.2.13.2. Care Management Measures
For the standard established for each measure listed in Appendix K.1.e., an MCP may be assessed sanctions for instances of noncompliance as follows:

- First instance, or subsequent but nonconsecutive instance, of noncompliance: ODM may impose a monetary sanction in the amount of one quarter of one percent of the MCP's average monthly net premium and delivery payment amount for the twelve months prior to the month in which the compliance action is issued to the MCP. If the MCP is determined to be in full compliance with this program requirement within the following five consecutive report periods, the monetary sanction will be returned.
- Second consecutive instance of noncompliance: ODM may impose a monetary sanction in the amount of one quarter of one percent of the MCP's average monthly net premium and delivery payment amount for the twelve months prior to the month in which the compliance action is issued to the MCP. The monetary sanction is non-refundable.
- Third consecutive, and any additional consecutive, instance of noncompliance: ODM may impose a monetary sanction in the amount of one half of one percent of the MCP's average monthly net premium and delivery payment amount for the twelve

months prior to the month in which the compliance action is issued to the MCP. The monetary sanction is non-refundable.

In addition, upon a fourth consecutive instance of noncompliance: ODM may terminate the MCP's Provider Agreement.

B.2.13.3. Intensive and High Risk Care Management Staffing Ratio
ODM may assess sanctions on the MCP for instances of non-compliance with the high risk care management staffing ratio minimum performance standard specified in Appendix K.1.e. as follows:

- First instance, or subsequent but nonconsecutive instance, of non-compliance: ODM may impose a monetary sanction in the amount of one quarter of one percent of the MCP's average monthly net premium and delivery payment amount for the twelve months prior to the month in which the compliance action is issued to the MCP. If the MCP is determined to be in full compliance with this program requirement within the following five consecutive report periods, the monetary sanction will be returned.
- Second consecutive instance of noncompliance: ODM may impose a monetary sanction in the amount of one quarter of one percent of the MCP's average monthly net premium and delivery payment amount for the twelve months prior to the month in which the compliance action is issued to the MCP. This amount is non-refundable.
- Third consecutive, and any additional consecutive, instance of noncompliance: ODM may impose a monetary sanction in the amount of one half of one percent of the MCP's average monthly net premium and delivery payment amount for the twelve months prior to the month in which the compliance action is issued to the MCP. This amount is non-refundable.
- In addition, upon a fourth consecutive instance of noncompliance: ODM may terminate the MCP provider agreement.

B.2.13.4. Maintenance of National Committee for Quality Assurance Health Plan Accreditation
For the standard established in Appendix C, ODM may assess the following sanctions for non-compliance as follows:

If the MCP receives a Provisional accreditation status - the MCP will be required to complete a resurvey within 12 months of the accreditation decision. If the resurvey results in a Provisional or Denied status, ODM will consider this a material breach of the provider agreement and may terminate the provider agreement with the managed care plan.

If the MCP receives a Denied accreditation status - then ODM considers this a material breach of the provider agreement and may terminate the provider agreement with the MCP.

B.2.14. Noncompliance with Provision of Transportation Services
If an MCP fails to comply with the transportation requirements specified in Appendix C.19.a. of this Provider Agreement, or if an MCP fails to transport a member to a pre-scheduled appointment on time, which results in a missed appointment, when providing Medicaid-covered transportation services and when members must travel more than 30 miles to receive services, ODM may impose a nonrefundable fine in the amount of $1,000 for each violation. ODM may assess additional sanctions (e.g., CAPs, points, fines) as provided for in section II of this appendix for any violation of the requirements to provide Medicaid-covered transportation services.

B.3. Fines
Refundable or nonrefundable fines may be assessed separately or in combination with other sanctions or remedial actions. The total fines assessed in any one month will not exceed 15% of one month's payments from ODM to the MCP. Unless otherwise stated, all fines are nonrefundable.

B.3.1 Refundable and nonrefundable monetary sanctions/assurances must be paid by the MCP to ODM within thirty (30) calendar days of invoice date by the MCP, or as otherwise directed by ODM in writing. In addition, per ORC Section 131.02, payments owed to the State not received within forty-five (45) calendar days will be certified to the Attorney General's (AG's) office. The AG's Office will assess the appropriate collection fee for MCP payments certified to the AG's Office.

B.3.2. For monetary sanctions calculated in accordance with this section, ODM will use the MCP's average monthly net premium and delivery payment amount for the twelve months prior to the month in which the compliance action is issued to the MCP.
B.3.3. Unless otherwise specified, 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 it has demonstrated full compliance with the particular program requirement, as determined by ODM.

B.3.4. An MCP is required to submit a written request for refund to ODM at the time it believes is appropriate before a refund of monies will be considered.

B.3.5. Refundable monetary sanctions issued under sections B.2.11., B.2.12., and B.2.13. of this appendix will be returned to the MCP in the event ODM replaces or eliminates the sanction's applicable measure(s) from the Provider Agreement for the measurement period immediately following the measurement period for which the sanction was assessed.

B.4. New Enrollment Freezes

Notwithstanding any other sanction or point assessment that ODM may impose on the MCP under this Provider Agreement, ODM may prohibit an MCP from receiving new enrollment through consumer initiated selection or the assignment process if any of the following occur: (1) the MCP has accumulated a total of 51 or more points during a rolling 12-month period; (2) the MCP has failed to fully implement a plan of correction within the designated time frame; (3) circumstances exist that potentially jeopardize the MCP's members' access to care, as solely determined by ODM; or (4) the MCP is found to have a pattern of repeated or ongoing noncompliance, as solely determined by ODM. Examples of circumstances that ODM may consider as jeopardizing member access to care include, but are not limited to, the following:

- The MCP has been found by ODM to be noncompliant with the prompt payment or the non-contracting provider payment requirements;
- The MCP has been found by ODM to be noncompliant with the provider panel requirements specified in Appendix H of the Provider Agreement;
- The MCP has refused to comply with a program requirement after ODM has directed the MCP to comply with the specific program requirement;
- The MCP has received notice of proposed or implemented adverse action by the ODI; or
- The MCP has failed to provide adequate provider or administrative capacity.

Payments provided for under the Provider 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.

B.4.1. New Member Enrollment freezes issued under section B.2.11 of this appendix may be lifted in the event ODM replaces or eliminates the sanction's applicable measure(s) from the Provider Agreement for the measurement period immediately following the measurement period for which the sanction was assessed.

B.4.2. Unless otherwise specified, new enrollment freezes issued under this appendix may be lifted after the MCP is determined to be in full compliance with the applicable program requirement, and the violations or deficiencies are resolved to the satisfaction of ODM.

B.5. Reduction of Assignments

ODM has discretion over how member auto-assignments are made. ODM may reduce the number of assignments an MCP receives to ensure program stability within a region, or upon a determination that the MCP lacks sufficient capacity to meet the needs of the increased enrollment volume. ODM may determine that an MCP has demonstrated a lack of sufficient capacity under circumstances that include, but are not limited to the following:

- The MCP has failed to maintain an adequate provider network;
- The MCP has failed to provide new member materials by the member's effective date;
- The MCP has failed to meet the minimum call center requirements;
- The MCP has failed to meet the minimum performance standards for members with special health care needs; or
- The MCP has failed to provide complete and accurate data files regarding appeals or grievances, primary care providers, or its Care Management System (CAMS) files.

B.6. Death or Injury to Member
ODM may immediately terminate or suspend this Agreement if an MCP's failure to perform, or properly perform, any of the requirements in this Agreement results in the death of or serious injury to, an MCP's member, as determined by ODM.

III. Request for Reconsiderations Unless otherwise specified below, an MCP may seek reconsideration of any sanction or remedial action imposed by ODM including CAPs, (when a CAP is required for the first violation in a series of progressive compliance actions), points, fines, and member enrollment freezes.

An MCP may not seek reconsideration of:

- an action by ODM that results in changes to the auto-assignment of members, or
- the imposition of directed CAPs, as defined in II of this appendix.

The MCP must submit a request for reconsideration on the form required by ODM, in accordance with the following procedure:

A. An MCP must submit a request for reconsideration either by email to the designated Contract Administrator (CA), or by overnight mail to ODM's Bureau of Managed Care (BMC). The request for reconsideration must be received by ODM no later than the tenth business day after the date that the MCP receives notice of the imposition of the remedial action by ODM. If ODM imposes an enrollment freeze based on access to care concerns, the enrollment freeze will be imposed concurrent with initiating notification to the MCP.

B. A request for reconsideration must explain in detail why the specified sanction should not be imposed. At a minimum, the reconsideration request must include: a statement of the proposed action being contested; the basis for requesting reconsideration; and any supporting documentation. In considering an MCP's request for reconsideration, ODM will review only the written material submitted by the MCP.

C. ODM will take reasonable steps to make a final decision, or request additional information, within ten business days after receiving the request for reconsideration. If ODM requires additional time, the MCP will be notified in writing.

D. If ODM approves a reconsideration request, in whole, the associated sanctions or remedial actions will be rescinded. The MCP will not be required to submit a CAP.

E. If ODM approves, in part, the MCP's reconsideration request the sanction, remedial action and/ or remedial actions may be rescinded or reduced, at the discretion of ODM. The MCP may still be required to submit a CAP if ODM, in its discretion, believes that a CAP is still warranted under the circumstances.

F. If ODM denies a reconsideration request, any CAP, sanction, or remedial action, and/or points outlined in the original notice of noncompliance will be assessed.

APPENDIX O

PAY-FOR-PERFORMANCE (P4P)

The Ohio Department of Medicaid (ODM) has established a Pay for Performance (P4P) Incentive System to provide financial rewards to MCPs that achieve specific levels of performance in program priority areas. Standardized clinical quality measures derived from a national measurement set (i.e., HEDIS) and Ohio-specific care management measures and requirements are used to determine incentive payments. Incentive payments made under the P4P Incentive System are funded through the state's managed care program performance payment fund.

1. P4P INCENTIVE SYSTEM

For SFY 2016, 2017, and SFY 2018, two P4P Incentive System determinations will be made per MCP. One determination will evaluate MCP clinical quality, while the other will evaluate MCP care management readiness or performance. Results for each P4P measure or requirement will be calculated per MCP, statewide, and include all regions in which the MCP has membership. For the Clinical Performance P4P determination, MCPs will be required to develop and implement improvement initiatives in areas of low performance.

1.a. SFY 2016 P4P

1.a.i. Determination

For SFY 2016, ODM will make two P4P Incentive System determinations per MCP. The focus, methodology, potential payout, and frequency of assessment differ for each determination, as outlined below.

1) Clinical Performance P4P Incentive System Determination

Frequency: MCP performance is assessed annually (i.e., ODM will issue one assessment and payment, if applicable, per MCP for SFY 2016).

Measures: performance is assessed on seven clinical quality measures, as listed in Table 1. below.

Report Period: the measurement year for the seven clinical quality measures is CY 2015.

Standards: a set of ten performance levels, with corresponding standards, is established for each of the seven measures, as provided in Table 1. below.

Potential Payout: the potential payout for this determination is an amount that is <u>equal to</u> 1.25% of the net premium and delivery payments made to the MCP between January 1, 2015

and December 31, 2015, pursuant to the applicable Medicaid Managed Care Provider Agreements.

Calculation: ODM calculates the MCP's potential payout (i.e., 1.25%) and divides this equally among the seven measures. The MCP is then awarded a percentage (0-100) of the potential payout allotted to each measure. This determination is made on a measure by measure basis, using the MCP's performance measure result in comparison to the ten performance levels, and corresponding standards, established for each measure. MCPs failing to meet the standard for level one are awarded 0% for the measure. The sum of the amount awarded for all seven measures is the total amount awarded to the MCP for the SFY 2016 Clinical Performance P4P determination.

Table 1. SFY 2016 P4P Clinical Performance Measures and Standards

SFY 2016 P4P Clinical Performance Measures and Standards								
		Standards that Determine % of Potential Payout Awarded, by Measure						
P4P Perf. Level	**Percent of Potential Payout Awarded**	Follow-Up After Hospital-ization for Mental Illness (7 Days)	Prenatal and Postpartum Care: Timeliness of Prenatal Care	Prenatal and Postpartum Care: Postpartum Care	Controlling High Blood Pressure (Patients with Hyper-tension)	Adolescent Well-Care Visits	Appropriate Treatment for Children With Upper Respiratory Infection	Compre-hensive Diabetes Care: HbA1c Control (<8.0%)
10	100%	54.5%	89.6%	69.5%	63.8%	59.2%	91.2%	52.9%
9	87%	52.0%	88.6%	68.1%	62.3%	57.1%	90.2%	51.6%
8	74%	49.6%	87.5%	66.8%	60.8%	54.9%	89.2%	50.3%
7	61%	47.2%	86.4%	65.5%	59.4%	52.8%	88.2%	49.0%
6	50%	44.7%	85.4%	64.2%	57.9%	50.7%	87.1%	47.7%
5	39%	42.3%	84.3%	62.8%	56.5%	48.5%	86.1%	46.4%
4	28%	40.2%	83.0%	61.5%	54.9%	47.1%	85.2%	44.8%
3	19%	38.1%	81.7%	60.2%	53.3%	45.8%	84.3%	43.1%
2	11%	35.9%	80.4%	58.8%	51.7%	44.4%	83.4%	41.5%
1	4%	33.8%	79.1%	57.5%	50.1%	43.1%	82.5%	39.8%
	0%	≤33.7%	≤ 79.0%	≤ 57.4 %	≤ 50.0%	≤ 43.0%	≤82.4%	≤ 39.7%
MPS		31.7%	77.8%	56.2%	48.6%	41.7%	81.6%	38.2%

MPS = Minimum Performance Standard (*established in Appendix M, and provided above for reference*)

Note: MCP performance is assessed using MCP self-reported, audited HEDIS data calculated in accordance with *NCQA HEDIS 2016, Volume 2: Technical Specifications.*

2) Care Management P4P Incentive System Determination

Frequency: ODM will issue one assessment, and payment if applicable, per MCP under this section for SFY 2016.
Evaluation Criteria: MCP performance will be assessed, and P4P will be awarded, separately for two groups of care management program readiness milestones, as provided below. The MCP must meet all of the milestones within a group to be awarded P4P for that group.

Group 1 Milestones:

- MCP has submitted to ODM a project plan for care management information technology system changes.
- MCP has submitted to ODM a project plan for assessing provider readiness for accepting care management responsibility, and for supporting and integrating ready providers into its model of care.

Group 2 Milestones:

- MCP has an ODM approved model of care in place.
- MCP has submitted to ODM a staffing plan that includes a training plan and monthly benchmarks through December 31, 2017.
- The MCP successfully submits each of the following test files to ODM per ODM's associated file specifications by June 14, 2016 – risk stratification, population stream, and care management status (only engaged and passive participation status for intensive and high risk levels).

Report Period: MCP performance on the Group 1 and Group 2 milestones will be evaluated as of June 30, 2016.

Group 1 Standard: The MCP meets all ODM-specified criteria for both milestones.

Group 2 Standard: The MCP meets all ODM-specified criteria for all three milestones.

Potential Payout: For Group 1, each MCP's potential payout will be an amount that is equal to 0.25% of the net premium and delivery payments made to the MCP between January 1, 2016 and March 31, 2016. For Group 2, each MCP's potential payout will be an amount that is equal to 0.25% of the net premium and delivery payments made to the MCP between April 1, 2016 and June 30, 2016. Any financial awards to MCPs will be made on or after June 30, 2016.

Calculation: For each MCP and Group, ODM will assess the MCP against the Group Standard. If the MCP meets the Standard, the MCP will receive 100% of the potential payout calculated for the Group. If the MCP does not meet the Standard, the MCP will not be awarded a financial incentive for the Group. The sum of the amount awarded to the MCP

for Group 1 and Group 2 is the total amount awarded to the MCP for the SFY 2016 Care Management P4P determination.

1.a.ii. Quality Improvement

The clinical measures used in the P4P Incentive System evaluate healthcare delivery to clinical populations of high priority to Ohio Medicaid. MCPs are expected to maintain a focus on continuous quality improvement in their provision of care and services to these populations. To monitor MCP quality improvement, ODM will require each MCP to develop and implement one Quality Improvement Project (QIP), as outlined in paragraph 3.a. of Appendix K, for each MCP SFY 2016 P4P clinical measure result that does not meet the corresponding standard listed below. The MCP must adhere to ODM-specified reporting and submission guidelines in completing the QIP.

Follow-Up After Hospitalization for Mental Illness (7 Days)	≥ 11.8%
Prenatal and Postpartum Care: Timeliness of Prenatal Care	≥ 62.3%
Prenatal and Postpartum Care: Postpartum Care	≥ 36.8%
Controlling High Blood Pressure (Patients with Hypertension)	≥ 40.1%
Adolescent Well-Care Visits	≥ 33.1%
Appropriate Treatment for Children with Upper Respiratory Infection	≥ 70.3%
Comprehensive Diabetes Care: HbA1c Control (<8.0%)	≥ 28.7%

1.b. SFY 2017 P4P

1.b.i. Determination

For SFY 2017, ODM will make two P4P Incentive System determinations per MCP. The focus, methodology, potential payout, and frequency of assessment differ for each determination, as outlined below.

1) Clinical Performance P4P Incentive System Determination

Frequency: MCP performance is assessed annually (i.e., ODM will issue one assessment and payment, if applicable, per MCP for SFY 2017).

Measures: performance is assessed on seven clinical quality measures, as listed in Table 2. below.

Report Period: the measurement year for the seven clinical quality measures is CY 2016.

Standards: a set of ten performance levels, with corresponding standards, is established for each of the seven measures, as provided in Table 2. below.

Potential Payout: the potential payout for this determination is an amount that is equal to 1.25% of the net premium and delivery payments made to the MCP between January 1, 2016

and December 31, 2016, pursuant to the applicable Medicaid Managed Care Provider Agreements.

Calculation: ODM calculates the MCP's potential payout (i.e., 1.25%) and divides this equally among the seven measures. The MCP is then awarded a percentage (0-100) of the potential payout allotted to each measure. This determination is made on a measure by measure basis, using the MCP's performance measure result in comparison to the ten performance levels, and corresponding standards, established for each measure. MCPs failing to meet the standard for level one are awarded 0% for the measure. The sum of the amount awarded for all seven measures is the total amount awarded to the MCP for the SFY 2017 Clinical Performance P4P determination..

Table 2. SFY 2017 P4P Clinical Performance Measures and Standards

SFY 2017 P4P Clinical Performance Measures and Standards								
		Standards that Determine % of Potential Payout Awarded, by Measure						
P4P Perf. Level	**Percent of Potential Payout Awarded**	Follow-Up After Hospital-ization for Mental Illness (7 Days)	Prenatal and Postpartum Care: Timeliness of Prenatal Care	Prenatal and Postpartum Care: Postpartum Care	Controlling High Blood Pressure (Patients with Hyper-tension)	Adolescent Well-Care Visits	Appropriate Treatment for Children With Upper Respiratory Infection	Compre-hensive Diabetes Care: HbA1c Control (<8.0%)
10	100%	56.8%	88.7%	68.9%	65.5%	60.0%	92.5%	54.0%
9	87%	54.7%	88.0%	67.6%	63.9%	57.8%	91.6%	52.8%
8	74%	52.6%	87.3%	66.4%	62.3%	55.6%	90.7%	51.6%
7	61%	50.4%	86.6%	65.2%	60.7%	53.5%	89.9%	50.4%
6	50%	48.3%	85.9%	64.0%	59.1%	51.3%	89.0%	49.1%
5	39%	46.2%	85.2%	62.8%	57.5%	49.2%	88.1%	47.9%
4	28%	43.4%	83.6%	61.3%	56.0%	47.7%	87.3%	46.3%
3	19%	40.5%	82.1%	59.9%	54.5%	46.2%	86.6%	44.7%
2	11%	37.7%	80.5%	58.4%	52.9%	44.7%	85.8%	43.2%
1	4%	34.8%	79.0%	56.9%	51.4%	43.2%	85.0%	41.6%
	0%	≤ 34.7%	≤ 78.9%	≤ 56.8%	≤ 51.3%	≤ 43.1%	≤84.9%	≤41.5%
MPS		32.0%	77.4%	55.5%	49.9%	41.8%	84.2%	40.0%

MPS = Minimum Performance Standard (*established in Appendix M, and provided above for reference*)

Note: MCP performance is assessed using MCP self-reported, audited HEDIS data calculated in accordance with *NCQA HEDIS 2017, Volume 2: Technical Specifications.*

2) Care Management Performance Methodology

Frequency: For SFY 2017, ODM will issue two assessments, and two payments if applicable, per MCP.
Evaluation Criteria: MCP performance will be assessed, and P4P will be awarded, separately for two groups of care management program milestones, as provided below. The MCP must meet all of the milestones within a group to be awarded P4P for that group.

Group 1 Milestones:

- The MCP is on target with the benchmarks established in its staffing plan for July, August, and September 2016.
- The MCP completes an on-site systems demonstration that includes the following ODM developed scenarios: File transfer with provider/health system, and integration of internal systems.

Group 2 Milestones:

- As of December 31, 2016, the MCP is on target with the benchmarks established in its staffing plan for October, November, and December 2016.
- As of January 1, 2017, at least 1.00% of the MCP's overall population is care managed at the High Risk Care Management Stratification Level (Engaged, Passive, and PCMH Care Management Status); and
    - At least 0.80% of members care managed at the High Risk Care Management Stratification Level are in the Engaged and PCMH Care Management Status.
- MCP successfully submits to ODM by January 20, 2017 a complete Care Management Status file which includes all five status indicators for all members.

Report Period: MCPs will be evaluated against the Group 1 milestones as of September 30, 2016, and the Group 2 milestones as of December 31, 2016, January 1, 2017, or January 20, 2017 as specified above.
Group 1 Standard: The MCP meets all ODM-specified criteria for both milestones.

Group 2 Standard: The MCP meets all ODM-specified criteria for all three milestones.

Potential Payout: For Group 1, each MCP's potential payout will be an amount that is <u>equal to</u> 0.25% of the net premium and delivery payments made to the MCP between July 1, 2016 and September 30, 2016. Any financial awards to MCPs for Group 1 will be made on or after September 30, 2016. For Group 2, each MCP's potential payout will be an amount that is <u>equal to</u> 0.25% of the net premium and delivery payments made to the MCP between October 1, 2016 and December 31, 2016. Any financial awards to MCPs for Group 2 will be made on or after January 1, 2017.

Calculation: For each MCP and Group, ODM will assess the MCP against the Group Standard. If the MCP meets the Standard,, the MCP will receive 100% of the potential payout calculated for the Group. If the MCP does not meet the Standard, the MCP will not be awarded a financial incentive for the Group. The sum of the amount awarded to the MCP for Group 1 and Group 2 is the total amount awarded to the MCP for the SFY 2017 Care Management P4P determination.

1.b.ii. Quality Improvement

The clinical measures used in the P4P Incentive System evaluate healthcare delivery to clinical populations of high priority to Ohio Medicaid. MCPs are expected to maintain a focus on continuous quality improvement in their provision of care and services to these populations. To monitor MCP quality improvement, ODM will require each MCP to develop and implement one Quality Improvement Project (QIP), as outlined in paragraph 3.a. of Appendix K, for each MCP SFY 2017 P4P clinical measure result that does not meet the corresponding standard listed below. The MCP must adhere to ODM-specified reporting and submission guidelines in completing the QIP.

Follow-Up After Hospitalization for Mental Illness (7 Days)	≥ 16.2%
Prenatal and Postpartum Care: Timeliness of Prenatal Care	≥ 64.3%
Prenatal and Postpartum Care: Postpartum Care	≥ 46.4%
Controlling High Blood Pressure (Patients with Hypertension)	≥ 36.7%
Adolescent Well-Care Visits	≥ 31.1%
Appropriate Treatment for Children with Upper Respiratory Infection	≥ 70.7%
Comprehensive Diabetes Care: HbA1c Control (<8.0%)	≥ 28.7%

1.c. SFY 2018 P4P

1.c.i. Determination

For SFY 2018, ODM will make two P4P Incentive System determinations per MCP. The focus, methodology, and potential payout differ for each determination, as outlined below.

1) Clinical Performance P4P Incentive System Determination

Frequency: MCP performance is assessed annually (i.e., ODM will issue one assessment and payment, if applicable, per MCP for SFY 2018).

Measures: performance is assessed on six measures, as listed in Table 3. below.

Report Period: the measurement year for the six clinical quality measures is CY 2017.

Standards: a set of ten performance levels, with corresponding standards, is established for each of the six measures, as provided in Table 3. below.

Potential Payout: the potential payout for this determination is an amount that is equal to 1.25% of the net premium and delivery payments made to the MCP between January 1, 2017 and December 31, 2017, pursuant to the applicable Medicaid Managed Care Provider Agreements.

Calculation: ODM calculates the MCP's potential payout (i.e., 1.25%) and divides this equally among the six measures. The MCP is then awarded a percentage (0-100) of the potential payout allotted to each measure. This determination is made on a measure by measure basis, using the MCP's performance measure result in comparison to the ten performance levels, and corresponding standards, established for each measure. MCPs failing to meet the standard for level one are awarded 0% for the measure.

Table 3. SFY 2018 P4P Clinical Performance Measures and Standards

SFY 2018 P4P Clinical Performance Measures and Standards							
		Standards that Determine % of Potential Payout Awarded, by Measure					
P4P Perf. Level	**Percent of Potential Payout Awarded**	Follow-Up After Hospitalization for Mental Illness (7 Days)	Prenatal and Postpartum Care: Timeliness of Prenatal Care	Prenatal and Postpartum Care: Postpartum Care	Controlling High Blood Pressure (Patients with Hyper-tension)	Adolescent Well-Care Visits	Comprehensive Diabetes Care: HbA1c Poor Control (> 9.0%)
10	100%	TBD	TBD	TBD	TBD	TBD	TBD
9	87%	TBD	TBD	TBD	TBD	TBD	TBD
8	74%	TBD	TBD	TBD	TBD	TBD	TBD
7	61%	TBD	TBD	TBD	TBD	TBD	TBD
6	50%	TBD	TBD	TBD	TBD	TBD	TBD
5	39%	TBD	TBD	TBD	TBD	TBD	TBD
4	28%	TBD	TBD	TBD	TBD	TBD	TBD
3	19%	TBD	TBD	TBD	TBD	TBD	TBD
2	11%	TBD	TBD	TBD	TBD	TBD	TBD
1	4%	TBD	TBD	TBD	TBD	TBD	TBD
	0%	TBD	TBD	TBD	TBD	TBD	TBD
MPS		TBD	TBD	TBD	TBD	TBD	TBD

MPS = Minimum Performance Standard (*established in Appendix M, and provided above for reference*)

Note: MCP performance is assessed using MCP self-reported, audited HEDIS data calculated in accordance with *NCQA HEDIS 2018, Volume 2: Technical Specifications.*

2) Care Management Performance Methodology

Frequency: MCP performance is assessed annually (i.e., ODM will issue one assessment and payment, if applicable, per MCP for SFY 2018).

Measures: performance is assessed on the following two measures. The MCP must meet the standard for both measures to be awarded P4P.

1) Overall Care Management Rate: High Risk Care Management (Engaged and Passive Participation Care Management Status)

2) High Risk Stratification Level: Engaged Care Management Status Rate

Report Period: MCPs will be evaluated against the standard for each measure as of December 31, 2017.

Measure 1 Standard: ≥ 2.00%

Measure 2 Standard: ≥ 1.60%

Potential Payout: the potential payout for this determination is an amount that is equal to 0.25% of the net premium and delivery payments made to the MCP between January 1, 2017 and December 31, 2017, pursuant to the applicable Medicaid Managed Care Provider Agreements.

Evaluation: The MCP must meet the standard set for measure 1 and the standard set for measure 2 to be awarded P4P for this determination. If the MCP meets both standards, the MCP will receive 100% of the potential payout calculated for this determination. If the MCP does not meet both standards, the MCP will not be awarded a financial incentive for this determination.

1.c.ii. Quality Improvement

The clinical measures used in the P4P Incentive System evaluate healthcare delivery to clinical populations of high priority to Ohio Medicaid. MCPs are expected to maintain a focus on continuous quality improvement in their provision of care and services to these populations. To monitor MCP quality improvement, ODM will require each MCP to develop and implement one Quality Improvement Project (QIP), as outlined in paragraph 3.a. of Appendix K, for each MCP SFY 2018 P4P clinical measure result that does not meet the corresponding standard listed below. The MCP must adhere to ODM-specified reporting and submission guidelines in completing the QIP.

Follow-Up After Hospitalization for Mental Illness (7 Days) ≥ TBD%

Prenatal and Postpartum Care: Timeliness of Prenatal Care	≥ TBD%
Prenatal and Postpartum Care: Postpartum Care	≥ TBD%
Controlling High Blood Pressure (Patients with Hypertension)	≥ TBD%
Adolescent Well-Care Visits	≥ TBD%
Comprehensive Diabetes Care: HbA1c Control (> 9.0%)	≥ TBD%

2. NOTES

2.a. Timing of P4P Incentive System Determinations

ODM will issue results for each P4P Incentive System determination to participating MCPs within six months of the end of each established report period. Given that unforeseen circumstances may impact the timing of this determination, ODM reserves the right to revise the time frame in which the P4P Incentive System determination is issued (i.e., the determination may be made more than six months after the end of the contract period).

2.b. Provider Agreement Termination, Nonrenewal, or Denial

Upon termination, nonrenewal, or denial of an MCP Provider Agreement, the incentive amount in the managed care program performance payment fund will be retained or awarded by ODM, in accordance with Appendix P, *MCP Termination/Non-renewal*, of this Provider Agreement.

2.c. P4P Measures, Requirements, and Measurement Years

ODM reserves the right to revise P4P measures, requirements, and measurement years, as needed, due to unforeseen circumstances. Unless otherwise noted, the most recent report or study finalized prior to the end of the contract period will be used in determining the MCP's overall performance level for that contract period.

2.d. P4P Potential Payout Amounts – Status Determination

In the event an MCP's performance cannot be evaluated on a particular P4P measure, ODM in its sole discretion will award or retain 100% of the incentive amount (potential payout) allocated to that particular measure. This determination will be based on the circumstances involved (e.g., for SFY 2016, if a HEDIS measure was assigned an audit result of "Not Report" on the MCP's Final Audit Report and the "Not Report" designation was determined to be the result of a material bias caused by the MCP, ODM will retain 100% of the incentive amount [potential payout] allocated to that measure).

2.e. P4P Performance Standards – Retrospective Adjustment

ODM uses a uniform methodology, as needed, for the retrospective adjustment of any P4P Incentive Standard, except for the care management standards, listed in Section 1. of this Appendix. This methodology will be implemented at ODM's sole discretion when all three of the following criteria are met.

- *The methodology for the standard's associated measure is revised.* Note, for HEDIS measures, ODM will not adjust performance measure standards retrospectively due to procedural changes such as revisions to medical record hybrid review timelines.

- *For the year the methodology is revised, the performance results for all Ohio Medicaid MCPs all increase or all decrease when compared to the standard setting year* (e.g., for the SFY 2013 provider agreement, the standard setting year is HEDIS 2011). Note, this excludes MCPs without results for both years.

- *For the year the methodology is revised, the performance results for three or more Ohio Medicaid MCPs each change by at least three percentage points (e.g., increase from 56.0% to 59.0%) when compared to the standard setting year*.

For a comprehensive description of the standard adjustment methodology, see *ODM Methods for the Retrospective Adjustment of Quality and P4P Measure Standards.*

APPENDIX P

MCP TERMINATION/NONRENEWAL

1 . MCP-INITIATED TERMINATIONS/NONRENEWALS

If an MCP provides notice of the termination/nonrenewal of their provider agreement to ODM, pursuant to Article VIII of the agreement, the MCP will be required to comply with the following:

a. Fulfill Existing Duties and Obligations

MCP agrees to fulfill all duties and obligations as required under Chapter 5160-26 of the Administrative Code and any provider agreements related to the provision of services for the Medicaid population during periods of time when MCP was under contract with ODM. Such duties and obligations include, but are not limited to, the submission by the MCP of any previously reported appeals and grievances data which were unresolved for the Medicaid population after the termination/nonrenewal date, resolution of provider and consumer complaints for the Medicaid population served by the MCP for the MCP provider agreement time periods, and provision of data to support audits related to the Medicaid population served by the MCP for the MCP's provider agreement time periods.

b. Refundable Monetary Assurance

The MCP will be required to submit a refundable monetary assurance. This monetary assurance will be held by ODM until such time that the MCP has submitted all outstanding monies owed, data files, and reports, including, but not limited to, grievance, appeal, encounter and cost report data related to time periods through the final date of service under 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 ODM in the month the termination/nonrenewal notice is issued, whichever is greater.

The MCP must remit the monetary assurance in the specified amounts via separate electronic fund transfers (EFT) payable to *Treasurer of State, State of Ohio (ODM)*. The MCP must contact their Contract Administrator to verify the correct amounts required for the monetary assurance and obtain an invoice number prior to submitting the monetary assurance. Information from the invoices must be included with each EFT to ensure monies are deposited in the appropriate ODM 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 is not received as specified above, ODM will withhold the MCP's next month's capitation payment until such time that ODM receives documentation that the monetary assurance is received by the Treasurer of State. If within one year of the date of issuance of the invoice, 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.

c Bonus Amount

The bonus amount in the managed care program performance payment fund will be retained by ODM.

d. Final Accounting of Amounts Outstanding

MCP must submit to ODM a final accounting list of any outstanding monies owed by ODM no later than six (6) months after the termination/nonrenewal date. Failure by the MCP to submit a list of outstanding items will be deemed a forfeiture of any additional compensation due to MCP. ODM payment will be limited to only those amounts properly owed by ODM.

e. Monetary Sanctions

All previously collected refundable monetary sanctions shall be retained by ODM.

f. 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 ODM and may include information on the following: care management, prior authorizations, inpatient facility stays, PCP assignments, and pregnant members. The timeline for providing these files will be at the discretion of ODM. The terminating MCP will be responsible for ensuring the accuracy and data quality of the files.

g. Notification

i. Provider Notification - The MCP must notify contracted providers at least 55 days prior to the effective date of termination. The provider notification must be approved by ODM prior to distribution.

ii. Member Notification – Unless otherwise notified by ODM, the MCP must notify their members regarding their provider agreement termination at least 45 days in advance of the effective date of termination. The member notification must be approved by ODM 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 ODM model language to create the notices and receive approval by ODM prior to distribution. The notices will be mailed to the provider and copied to the member for all requests received during the last month of MCP membership.

2. ODM-INITIATED TERMINATIONS FOR CAUSE UNDER OAC 5160-26-10

a. If ODM initiates the proposed termination, nonrenewal or amendment of this Provider Agreement pursuant to OAC rule 5160-26-10 by issuing a proposed adjudication order pursuant to O.R.C. 5164.38, and the MCP submits a valid appeal of that proposed action pursuant to O.R.C. Chapter 119, the MCP's provider agreement will be extended through the issuance of an adjudication order in the MCP's appeal under ORC Chapter 119.

   During this time, the MCP will continue to accrue points and be assessed penalties for each subsequent compliance assessment occurrence/violation 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 5160-26-10(H), if ODM has proposed the termination, nonrenewal, denial or amendment of a provider agreement, ODM may notify the MCP's members of this proposed action and inform the members of their right to immediately terminate their membership with that MCP without cause. If ODM has proposed the termination, nonrenewal, denial or amendment of a provider agreement and access to medically-necessary covered services is jeopardized, ODM may propose to terminate the membership of all of the MCP's members. The appeal process for reconsideration of the proposed termination of members is as follows:

   - All notifications of such a proposed MCP membership termination will be made by ODM via certified or overnight mail to the identified MCP Contact.

   - MCPs notified by ODM 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 Director, Ohio Department of Medicaid, and received by 3PM Eastern Time on the third working day following receipt of the ODM notification of termination. The address and fax number to be used in making these requests will be specified in the ODM notification of termination document.

   - 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 Director within three working days of receipt of the request for reconsideration. Should the Director require additional time in rendering the final reconsideration decision, the MCP will be notified of such in writing.

- The proposed MCP membership termination will not occur while an appeal is under review and pending the Director's decision. If the Director denies the appeal, the MCP membership termination will proceed at the first possible effective date. The date may be retroactive if the ODM determines that it would be in the best interest of the members.

b. Fulfill Existing Duties and Obligations

MCP agrees to fulfill all duties and obligations as required under Chapter 5160-26 of the Administrative Code and any provider agreements related to the provision of services for the Medicaid population during periods of time when MCP was under contract with ODM. Such duties and obligations include, but are not limited to, the submission by the MCP of any previously reported appeals and grievances data which were unresolved for the Medicaid population after the termination/nonrenewal date, resolution of provider and consumer complaints for the Medicaid population served by the MCP for the MCP provider agreement time periods, and provision of data to support audits related to the Medicaid population served by the MCP for the MCP's provider agreement time periods.

c. Refundable Monetary Assurance

The MCP will be required to submit a refundable monetary assurance. This monetary assurance will be held by ODM until such time that the MCP has submitted all outstanding monies owed, data files, and reports, including, but not limited to, grievance, appeal, encounter and cost report data related to time periods through the final date of service under the MCP's provider agreement. The monetary assurance must be in an amount of either $50,000 or 5 % of the capitation amount paid by ODM in the month the termination/nonrenewal notice is issued, whichever is greater.

The MCP must remit the monetary assurance in the specified amounts via separate electronic fund transfers (EFT) payable to *Treasurer of State, State of Ohio (ODM)*. The MCP must contact their Contract Administrator to verify the correct amounts required for the monetary assurance and obtain an invoice number prior to submitting the monetary assurance. Information from the invoices must be included with each EFT to ensure monies are deposited in the appropriate ODM 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 is not received as specified above, ODM will withhold the MCP's next month's capitation payment until such time that ODM receives documentation

that the monetary assurance is received by the Treasurer of State. If within one year of the date of issuance of the invoice, 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.

d. Bonus Amount

The bonus amount in the managed care program performance payment fund will be retained by ODM.

e. Monetary Sanctions

All previously collected refundable monetary sanctions shall be retained by ODM.

f. Final Accounting of Amounts Outstanding

MCP must submit to ODM a final accounting list of any outstanding monies owed by ODM no later than six (6) months after the termination/nonrenewal date. Failure by the MCP to submit a list of outstanding items will be deemed a forfeiture of any additional compensation due to MCP. ODM payment will be limited to only those amounts properly owed by ODM.

g. Data Files

In order to assist members with continuity of care, the MCP must create data files to be shared with each newly enrolling MCP. The data files will be provided in a consistent format specified by ODM and may include information on the following: care management, prior authorizations, inpatient facility stays, PCP assignments, and pregnant members. The timeline for providing these files will be at the discretion of ODM. The terminating MCP will be responsible for ensuring the accuracy and data quality of the files.

h. Notification

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 ODM prior to distribution.

ii. 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

ODM model language to create the notices and receive approval by ODM prior to distribution. The notices will be mailed to the provider and copied to the member for all requests received during the last month of MCP membership.

3. TERMINATION DUE TO NON-SELECTION THROUGH ODM PROCUREMENT PROCESSES

Should this Provider Agreement end or not be extended in the event MCP is not awarded a provider agreement as a result of an ODM procurement and MCP selection process pursuant to OAC rule 5160-26-04, MCP has no right to appeal the selection process under ORC Chapter 119 pursuant to ORC 5164.38 and will be required to comply with the following:

a. Fulfill Existing Duties and Obligations

MCP agrees to fulfill all duties and obligations as required under Chapter 5160-26 of the Administrative Code and any provider agreements related to the provision of services for the Medicaid population during periods of time when MCP was under contract with ODM. Such duties and obligations include, but are not limited to, the submission by the MCP of any previously reported appeals and grievances data which were unresolved for the Medicaid population after the termination/nonrenewal date, resolution of provider and consumer complaints for the Medicaid population served by the MCP for the MCP provider agreement time periods, and provision of data to support audits related to the Medicaid population served by the MCP for the MCP's provider agreement time periods.

b. Refundable Monetary Assurance

The MCP will be required to submit a refundable monetary assurance. This monetary assurance will be held by ODM until such time that the MCP has submitted all outstanding monies owed, data files, and reports, including, but not limited to, grievance, appeal, encounter and cost report data related to time periods through the final date of service under 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 ODM in the month the termination/nonrenewal notice is issued, whichever is greater.

The MCP must remit the monetary assurance in the specified amounts via separate electronic fund transfers (EFT) payable to *Treasurer of State, State of Ohio (ODM)*. The MCP must contact their Contract Administrator to verify the correct amounts required for the monetary assurance and obtain an invoice number prior to submitting the monetary assurance. Information from the invoices must be included with each EFT to ensure monies are deposited in the appropriate ODM 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 is not received as specified above, ODM will withhold the MCP's next month's capitation payment until such time that ODM receives documentation

that the monetary assurance is received by the Treasurer of State. If within one year of the date of issuance of the invoice, 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.

c. Bonus Amount

The bonus amount in the managed care program performance payment fund will be awarded by ODM in accordance with the pay-for-performance system set forth in Appendix O for the current provider agreement year.

d. Monetary Sanctions

All previously collected refundable monetary sanctions shall be returned to the MCP.

e. Final Accounting of Amounts Outstanding

MCP must submit to ODM a final accounting list of any outstanding monies owed by ODM no later than six (6) months after the termination/nonrenewal date. Failure by the MCP to submit a list of outstanding items will be deemed a forfeiture of any additional compensation due to MCP. ODM payment will be limited to only those amounts properly owed by ODM.

f. Data Files

In order to assist members with continuity of care, the MCP must create data files to be shared with each newly enrolling MCP. The data files will be provided in a consistent format specified by ODM and may include information on the following: care management, prior authorizations, inpatient facility stays, PCP assignments, and pregnant members. The timeline for providing these files will be at the discretion of ODM. The terminating MCP will be responsible for ensuring the accuracy and data quality of the files.

g. Notification

a. 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 ODM prior to distribution.

b. 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 ODM model language to create the notices and receive approval by ODM prior to distribution. The notices will be mailed to the provider and copied to the member for all requests received during the last month of MCP membership.

4. TERMINATION OR MODIFICATION OF THIS PROVIDER AGREEMENT DUE TO LACK OF FUNDING

Should this Provider Agreement terminate or be modified due to a lack of available funding as set forth in the Baseline of this Agreement, MCP has no right to appeal the selection process under ORC Chapter 119 pursuant to ORC 5164.38 and will be required to comply with the following:

a. Fulfill Existing Duties and Obligations

MCP agrees to fulfill all duties and obligations as required under Chapter 5160-26 of the Administrative Code and any provider agreements related to the provision of services for the Medicaid population(s) during periods of time when MCP was under contract with ODM. Such duties and obligations include, but are not limited to, the submission by the MCP of any previously reported appeals and grievances data which were unresolved for the Medicaid populations, resolution of provider and consumer complaints for the Medicaid population served by the MCP for the MCP provider agreement time periods, and provision of data to support audits related to the Medicaid population served by the MCP for the MCP's provider agreement time periods.

b. Refundable Monetary Assurance

The MCP will be required to submit a refundable monetary assurance should the Provider Agreement terminate. This monetary assurance will be held by ODM until such time that the MCP has submitted all outstanding monies owed, data files, and reports, including, but not limited to, grievance, appeal, encounter and cost report data related to time periods through the final date of service under the MCP's provider agreement. The monetary assurance must be in an amount of either $50,000 or 5 % of the capitation amount paid by ODM in the month the termination notice is issued, whichever is greater.

The MCP must remit the monetary assurance in the specified amounts via separate electronic fund transfers (EFT) payable to *Treasurer of State, State of Ohio (ODM)*. The MCP must contact their Contract Administrator to verify the correct amounts required for the monetary assurance and obtain an invoice number prior to submitting the monetary assurance. Information from the invoices must be included with each EFT to ensure monies are deposited in the appropriate ODM 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 is not received as specified above, ODM will withhold the MCP's next month's capitation payment until such time that ODM receives documentation that the monetary assurance is received by the Treasurer of State. If within one year of the date of issuance of the invoice, an MCP does not submit all outstanding monies owed and required submissions, including, but not limited to, grievance, appeal, fines or sanctions, encounter and cost report data related to time periods through the final date of service under the MCP's provider agreement, the monetary assurance will not be refunded to the MCP.

c. Bonus Amount

The bonus amount in the managed care program performance payment fund will be awarded by ODM in accordance with the pay-for-performance system set forth in Appendix O for the current provider agreement year.

d. Monetary Sanctions

Previously collected refundable monetary sanctions directly and solely related to the termination or modification of this Provider Agreement shall be returned to the MCP.

e. Final Accounting of Amounts Outstanding

MCP must submit to ODM a final accounting list of any outstanding monies owed by ODM no later than six (6) months after a termination/nonrenewal date of this Provider Agreement. Failure by the MCP to submit a list of outstanding items will be deemed a forfeiture of any additional compensation due to MCP. ODM payment will be limited to only those amounts properly owed by ODM.

f. Data Files

In order to assist members with continuity of care, the MCP must create data files if requested by ODM. The data files will be provided in a consistent format specified by ODM and may include information on the following: care management, prior authorizations, inpatient facility stays, PCP assignments, and pregnant members. The timeline for providing these files will be at the discretion of ODM. The MCP will be responsible for ensuring the accuracy and data quality of the files.

g. Provider Notification

The MCP must notify contracted providers within 30 days of notice from ODM of the effective date of termination or modification of this Provider Agreement. The provider notification must be approved by ODM prior to distribution.

APPENDIX Q

PAYMENT REFORM

I. Introduction.

On January 9, 2013, Governor John Kasich's Advisory Council on Health Care Payment Reform adopted the Catalyst for Payment Reform (CPR) principles as part of a comprehensive strategy to prioritize and coordinate multi-payer health care payment innovation activities in Ohio. The Ohio Department of Medicaid (ODM) is committed to reforming the health care delivery system by designing and implementing systems of payment that signal powerful expectations for improved health care delivery. As such the following principles have been adopted by Ohio Medicaid:

1. Payment reforms should promote health by rewarding the delivery of quality, cost effective and affordable care that is patient-centered and reduces disparities.

2. Health care payments should encourage and reward patient-centered care that coordinates services across the spectrum of providers and care setting while tailoring health care service to the individuals patient's needs.

3. Payment policies should encourage alignment between public and private sectors to promote improvement, innovations and meeting national health priorities, and to maximize the impact of payment decisions of one sector on the other.

4. Decisions about payment should be made through independent processes that are guided by what serves the patient and helps society as a whole, and payment decisions must balance the perspectives of consumers, purchasers, payers, physicians and other health care providers.

5. Payment policies should foster ways to reduce expenditure on administrative processes (e.g., claims payment and adjudications).

6. Reforms to payment should balance the need for urgency against the need to have realistic goals and timelines that take into account the need to change complex systems and geographic and other variations.

In order to improve the delivery of health care, including its quality, efficiency, safety, patient-centeredness, coordination, and outcomes, there must be significant changes in existing payment structures and methodologies as well as the environment in which payments are made. This Appendix outlines ODM's expectations for how MCP shall achieve progress in the following areas:

A. **Value-Oriented Payment:** MCP shall design and implement payment methodologies with its network providers that are designed either to cut waste or reflect value. For the purposes of this Provider Agreement, payments that cut waste are those that by their design reduce unnecessary payment and unnecessary care (e.g. elective cesarean deliveries). Value is defined as the level of the quality of care for the amount of money paid to the provider. Payments designed to reflect value are those that are tied to provider performance so that they may rise or fall in a predetermined fashion commensurate with different levels of performance assessed against standard measures.

B. **Market Competition and Consumerism:** MCP shall design contracting methodologies and payment options and administer the benefit package to members in a manner that enhances competition among providers and reduces unwarranted price and quality variation. To stimulate provider competition further, MCP shall establish programs to engage MCP members to make informed choices and to select evidence-based, cost-effective care.

C. **Transparency:** MCP shall participate in ODM initiatives to design and implement member-accessible comparisons of provider information including quality, cost, and patient experience, among providers in the plan's network. The MCP shall contribute to the program design, provide data as specified by ODM, and publish results in accordance with standards established by the Department.

These commitments are included to support and advance MCP initiatives to develop a health care market where (a) payment increasingly is designed to improve and reflect the effectiveness and efficiency with which providers deliver care, and (b) consumers are engaged in managing their health, selecting their providers, and sensitive to the cost and quality of services they seek. The term "provider" is defined in OAC rule 5160-26-01. The MCP must use its best efforts to ensure that these commitments and initiatives apply to the benefits offered and services provided under this Provider Agreement and administered by the MCP.

II. Obligations of MCP

A. VALUE-ORIENTED PAYMENT, MARKET COMPETITION & CONSUMERISM

MCP shall implement payment strategies that tie payment to value or reduce waste, as those terms are defined herein. In doing so, MCP shall provide ODM with its strategy to make 50% of aggregate net payments to providers value-oriented by 2020. Examples of strategies include the following:

1. Pay providers differentially according to performance (and reinforce with benefit design).

2. Design approaches to payment that cut waste while not diminishing quality, including reducing unwarranted payment variation.

3. Payments designed to encourage adherence to clinical guidelines. At a minimum, MCPs must address policies to discourage elective deliveries before 39 weeks.

4. Payment strategies to reduce unwarranted price variation, such as reference or value pricing (e.g. analysis of price variation among network providers by procedure and service types, pilot value pricing programs, encouragement of member value-based pricing information , center of excellence pricing, and rebalance payment between primary and specialty care).

B. The Current SIM Project

In February 2013, Ohio was awarded a federal State Innovation Model (SIM) grant to design payment models that increased access to patient-centered medical homes and support episode-based payments for acute medical event. The purpose of both models is to achieve better health, better care, and cost savings through improvement. Medicaid is a major participant in the project and the involvement of the MCP is important to the success of these models. MCPs are required to participate in, and ensure the participation of contracted providers in the State Innovation Model (SIM) project.

III Reporting

MCPs must submit a quarterly progress report as specified by ODM that addresses progress towards meeting the obligations as outlined in II above.